IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 001875

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Michael Stephen Delaney
Date of birth:	30 April 1982
Date of death:	06 April 2020
Cause of death:	1(a) Plastic bag asphyxia
Place of death:	9 Ebdale Street, Frankston, Victoria, 3199
Keywords:	Suicide, intentional death, plastic bag asphyxia, inpatient, recommendation

INTRODUCTION

1. On 06 April 2020, Michael Stephen Delaney was 37 years old when he was found deceased at his home following an apparent suicide attempt. At the time of his death, Michael lived in his own unit at The Haven Frankston ("The Haven"), a supported independent living property.

Mental health history

2. Michael was diagnosed with schizophrenia at the age of 14,[1] and had a lengthy history of suicide attempts and involvement with mental health services. Michael's schizophrenia was described as "extremely pernicious", with "harrowing symptoms" including hearing male and female voices that were often derogatory and commanding.[2] He also experienced "brain probes", where he described his brain and vision being watched by another entity.

3. Michael was trialled on multiple medications in an attempt to manage his schizophrenia, though continued to experience distressing symptoms. Whilst taking clozapine, Michael's mental health improved and his suicidal ideation reduced, though he had to cease taking clozapine after developing tachycardia.

4. In October 2018 Michael moved to The Haven, a supported independent living property for individuals with serious mental illness. The Haven is staffed 24 hours a day by community mental health practitioners (**CMHP**) and peer workers from Mind Australia[3], with each resident provided with their own 'key worker'. Residents can participate in a range of group programs, as well as receive individualised support to themselves and their families.

5. Michael's sister Laura reported that he enjoyed his surroundings at The Haven, that it was the best living environment he had experienced for his wellbeing and whilst his mental health was not improving, his quality of life was better.[4]

6. Whilst residing at The Haven, Michael reported that he experienced suicidal or violent imagery up to 25 times a day, with some of the violent thoughts directed towards staff.

[1] Coronial Brief (**CB**), Statement of Mary Delaney.
[2] CB, Statement of Associate Professor Brendan Murphy, Consultant Psychiatrist.
[3] Mind Australia provides individualised, evidence based and recovery focussed support to individuals experiencing mental health and wellbeing concerns in Australia. Mind provides community-managed psychosocial services with a range of residential, mobile outreach, centre based and online services. https://www.mindaustralia.org.au/about-mind/about-mind
[4] CB, Statement of Laura Delaney.

Michael did not like these thoughts and did not want to act on them. He rated himself 2-5 out of 10 in terms of severity of intent for suicide.[5]

7. On 27 September 2019 Michael was admitted to Monash Hospital following an attempt to take his own life by overdosing on medication. Michael remained in hospital until 7 October 2019 and was followed up by the Monash Crisis Assessment and Treatment Team (**CATT**) post-discharge.

8. Following his discharge, The Haven developed a support plan involving staff checking in with Michael before 11am, before 2pm and before 8pm to review the intensity and frequency of his suicidal thoughts. Staff would explore the activities that Michael had engaged in that day and check that he had completed his gratitude journal. Further, staff were to check with Michael twice weekly to ascertain how often he had been staying in bed and playing video games (as these were signs of decline in his mental health) and to check his medication compliance.

9. On 17 October 2019 a case meeting between Peninsula Mental Health Services (**PMHS**), The Haven and Michael took place. Whilst Michael denied suicidal thoughts, he stated "*I have no intent to kill myself, but if you gave me a gun, I would find it very hard not to shoot myself."*[6] Accordingly, Michael was referred to the PMHS Intensive Treatment Team (**ITT**). The ITT would visit Michael every three days for two weeks to monitor his symptoms and would advise Michael's General Practitioner (**GP**) Dr Burhan Khelil of any medication changes, and refer him to the Prevention and Recovery Care service (**PARC**)[7] should he require increased clinical support.

10. On 5 November 2019 a Wellness and Safety Plan was completed with Michael which identified strategies to assist Michael in staying well, as well as identifying triggers[8] and early warning signs that his mental health was deteriorating[9]. Michael's management strategies included lying or sitting down, closing his eyes, speaking to support people (his mother, father, sister and aunt) and taking his PRN[10] medication.

[5] CB, Statement of Associate Professor Brendan Murphy, Consultant Psychiatrist.
[6] Court File **(CF**), The Haven Frankston Client File.
[7] Prevention and Recovery Care (PARC) aims to support people experiencing a significant mental health problem but who do not need or no longer require a hospital admission. In the continuum of care, they sit between acute psychiatric inpatient units and a client's usual place of residence. PARC aims to assist in averting acute inpatient admissions and facilitate earlier discharge from inpatient units.
[8] Michael's triggers were stress and talking for extended periods of time.
[9] The early warning signs were closed body language, being short in conversation and Michael's eyes 'glazing over'.
[10] Pro re nata (PRN) medication is prescribed medication taken by the patient as necessary, rather than on a fixed schedule.

11. On 7 January 2020 Michael saw his GP who provided a referral to psychiatrist Dr Ricardo Peralta-Huezo. An appointment with Dr Peralta-Huezo was scheduled for 4 March 2020.

12. On 30 January 2020, Michael's mother Mary called The Haven and expressed concerns regarding Michael's suicidality. She believed he needed an earlier appointment with Dr Peralta-Huezo to review his medication, and/or an admission to PARC. Staff discussed Mary's concerns with Michael, and he confirmed that he "didn't see the point in being here" and had a strong thought of cutting his throat with a kitchen knife the night prior.[11]

13. Following the discussion with Michael, a plan was made to seek an earlier appointment with Dr Peralta-Huezo, contact PMHS to arrange a PARC referral, to remove knives from Michael's unit and to check in with him during the night. Michael agreed to an inpatient admission if his symptoms intensified.

14. Staff at The Haven contacted the ITT who liaised with Michael's GP, arranging an assessment to determine suitability for PARC. At this assessment on 5 February 2020, Michael was advised that urgent medical review was required, which occurred the following day. At this review on 6 February 2020, Michael's medication was adjusted, and a plan was made to admit Michael to either PARC or a private hospital.

15. On 18 February 2020, Michael was admitted to The Victoria Clinic[12] (**TVC**) as an inpatient due to his deteriorating mental health and suicidal ideation. On his admission to TVC, he was discharged from PMHS and the ITT.

16. On 4 March 2020, whilst an inpatient at TVC, Michael was assessed by Dr Peralta-Huezo, accompanied by a staff member from The Haven. Dr Peralta-Huezo observed that Michael suffered from treatment resistant schizophrenia and assessed him as high risk owing to the severity of his symptoms and history of suicide attempts.

17. By letter to Michael's GP, Dr Peralta-Huezo advised that he felt he did not have the resources to treat Michael and that he would not change Michael's medication given his inpatient status. According to Dr Peralta-Huezo, he assessed the severity of Michael's condition as requiring a specialist multidisciplinary team and referral back to the Peninsula

[11] CF, The Haven Frankston Client File.
[12] The Victoria Clinic is private mental health facility operated by Healthscope.

Health Community Care Unit (**CCU**).[13] Dr Peralta-Huezo did not communicate directly with TVC.

18. On 22 March 2020 Michael was discharged from TVC to The Haven with a plan to follow up with his GP and a psychiatrist, though the psychiatrist was not identified given Dr Peralta-Huezo had declined to provide ongoing care to Michael.[14] The discharge summary indicated that Michael's mental state had improved, and he had less intrusive thoughts.

19. At around 11:50pm on 26 March 2020, Michael called The Haven staff member Petros Galanoulis to advise that he had attempted suicide by placing a plastic bag over his head and securing it with a phone cord. Michael advised Mr Galanoulis that he called the ITT and left a voice message.

20. Mr Galanoulis provided support to Michael via phone and then called Mind On Call After Hours Support (**MOCA**) for advice. MOCA advised Mr Galanoulis to review Michael and engage him in safety planning. If Michael presented as well and engaged in safety planning then he did not need to go to hospital, but if staff assessed him to be unsafe or he did not engage in safety planning then they should call 000.

21. Mr Galanoulis subsequently visited Michael at his unit and noted that he appeared engaged, and there was no evidence of his suicide attempt. Mr Galanoulis reminded Michael that he could access his psychologist via NDIS funding. Mr Galanoulis removed knives and plastic bags from Michael's room and developed a written safety plan with Michael which included check-ins at 10.30am, 3.00pm and 6.00pm. It was noted on this plan that plastic bags were locked in a safe, and the listed interventions included a reminder to staff to review access to plastic bags and remove them if Michael rated his symptoms as 8 or above.

22. The following morning, staff checked in with Michael who reported sleeping well. Michael declined a suggestion to return to TVC, though agreed to contact his psychologist to schedule an appointment. Michael asked that staff regularly check with him on whether he felt that life was too much to cope with. He would respond by rating this feeling, with a rating of 7-9 indicating a need to call PMHS and a rating of 10 indicating a need to call 000.

[13] Community care units provide medium to long-term accommodation, clinical care and rehabilitation services for people with a serious mental illness and psychosocial disability. Located in residential areas, they provide a 'home like' environment where people can learn or re-learn everyday skills necessary for successful community living. While it is envisaged that people will move through these units to other community residential options, some consumers require this level of support and supervision for a number of years.

[14] CB, Discharge Summary from the Victoria Clinic.

23. Staff at The Haven advised Mary of Michael's suicide attempt. She reported that she had offered to assist Michael to be re-admitted to TVC or to stay with her, though he had declined both. Mary requested that The Haven staff contact her later in the day to advise of Michael's progress, which they did. Mary requested that staff check in with Michael at 9pm. During this check-in, Michael again declined re-admission to TVC.

24. On 28 March 2020 Michael requested that the knives from his unit be returned to him, though staff were to keep the plastic bags, as he would not suicide using knives due to pain but still had some thoughts of wanting to use plastic bags to suicide.

THE CORONIAL INVESTIGATION

25. Michael's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

26. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

27. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

28. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Michael's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

29. This finding draws on the totality of the coronial investigation into the death of Michael Stephen Delaney including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary

for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[15]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

30. From 2 to 5 April 2020 Michael stayed with Mary, as he did every second weekend. Michael returned to The Haven at approximately 3pm on 5 April and sent a text message to the team at The Haven stating, "I don't feel the best at the moment so I'll catch up face to face later".[16]

31. On 5 April 2020 at 3pm, Mary called CMHP Theodoraki Georgopoulos at The Haven and expressed her concerns about Michael's mental health. Mary held concerns that Michael may attempt to take his own life, that he appeared to be "shutting down" and that his condition was worsening. She reported that whilst visiting her, Michael spoke of suicide and "doesn't see any reason to be alive".[17]

32. Mr Theodorakis relayed Mary's concerns verbally to other staff on shift. Further, he emailed Michael's key worker CMHP Stephanie Brady and the team leader Jacqueline Murdoch and updated the handover sheet noting her concerns.

33. Support staff checked in with Michael periodically via text message over the evening of 5 April 2020. Michael reported that "things were hard for a while" and that he was having trouble with the voices in his head.[18]

34. At around 8:10pm Michael requested in-person support and sat with CMHP Jessica Patterson for ten minutes. They discussed strategies to ease his symptoms, such as keeping in touch with family and other support staff members, as well as discussing activities he enjoyed such as video gaming. Michael expressed interest in attending an upcoming shopping trip later that week.[19] Michael returned to his room at approximately 8:20pm.

35. At around 9:07am on 6 April 2020 Mary called The Haven and spoke with CMHP Remy Pugh. Mary expressed concern that Michael had not answered her calls or text messages that

[15] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.
[16] CB, Statement of Theodoraki Georgopoulos.
[17] Ibid.
[18] CB, Statement of Rodrigo Petrosky.
[19] CB, Statement of Jessica Patterson.

morning. Ms Pugh reassured Mary that Michael's usual check-in time was 10am, but that she would check on him soon.

36. At around 9:10am Ms Pugh called Michael, though he did not answer his phone. She and another CMHP Micaela Vanderslik attended Michael's unit and knocked three times to no response. They entered the unit and observed Michael laying on his back with a purple plastic bag over his head and an electrical cord around his neck. The lights were on and music was playing.

37. Ms Pugh and Ms Vanderslik ran to the office and called emergency services. Ms Vanderslik returned to Michael's unit, removed the bag from his head and cord from his neck and commenced cardio-pulmonary resuscitation (**CPR**).

38. The Metropolitan Fire Brigade[20] arrived on scene at 9:20am and firefighters took over CPR on Michael, with Ambulance Victoria paramedics attending shortly thereafter. Unfortunately Michael was unable to be revived and was declared deceased at 9:30am.[21]

Identity of the deceased

39. On 10 April 2020, Dr Lyndall Smythe, Forensic Odontologist at the Victorian Institute of Forensic Medicine (**VIFM**) compared the dental records of Michael Stephen Delaney with the dentition of the deceased. The similarities gave rise to a probable dental identification, however due to a lack of equivalent radiographs making an outright positive dental identification was not possible.

40. Dr Smythe also had regard to the circumstances in which the deceased was found, and the comparison of medical records for Michael Stephen Delaney with features on the body of the deceased. Dr Smythe submitted an identification report in which she opined that the deceased was Stephen Michael Delaney.

41. On the same date, my colleague Coroner Paresa Spanos determined that the cogency and consistency of all evidence relevant to identification supported a finding that the deceased was Michael Stephen Delaney, born 30 April 1982. Accordingly, Coroner Spanos signed a Determination by Coroner of the Identity of the Deceased (Form 8).

[20] Now Fire Rescue Victoria, as of 1 July 2020.
[21] CF, Ambulance Victoria Verification of Death Form.

Medical cause of death

42. Forensic Pathologist Dr Paul Bedford from the VIFM conducted an external examination on the body of Michael Stephen Delaney on 7 April 2020. Dr Bedford reviewed the Victoria Police Report of Death (Form 83), medical records and post-mortem computed tomography (CT) scan and provided a written report of his findings dated 8 April 2020.

43. The post-mortem examination revealed some conjunctival suffusion (reddening of the front surface of the eye), though no petechiae or haemorrhage. There were no ligature marks or injuries to the neck.

44. Toxicological analysis of post-mortem blood samples identified the presence of medications prescribed to Michael:[22]

    a) Diazepam ~ 0.03 mg/L and its metabolite nordiazepam ~ 0.05 mg/L

    b) Clomipramine ~ 0.2 mg/L

    c) Amisulpride ~ 0.9 mg/L

    d) Olanzapine ~ 0.04 mg/L

    e) Lurasidone

45. Dr Bedford provided an opinion that the medical cause of death was 1 (a) PLASTIC BAG ASPHYXIA.

CPU REVIEW

46. To assist my investigation into the circumstances of Michael's death and with a view to considering any prevention opportunities in line with my prevention role as articulated in the Preamble and Purposes of the Act, I referred the matter to the Coroners Prevention Unit (**CPU**)[23].

47. As part of their review, the CPU sought statements from the following:

[22] CF, Toxicology Report of Melissa Peka, Forensic Toxicologist, dated 8 May 2020.

[23] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

a) Allison Carr, The Victoria Clinic General Manager

b) Dr Ricardo Peralta-Huezo, Psychiatrist

c) Dr Keryn Fitzpatrick, Psychiatrist

d) Belinda McCullough, Executive Director of Victoria Operations, Mind Australia

48. Whilst the CPU advised me that the care provided to Michael by individual services was generally reasonable and appropriate in the circumstances, they did however identify a number of examples of poor communication and coordination of Michael's care.

Communication between The Victoria Clinic and Dr Peralta-Huezo

49. The evidence suggests that Dr Peralta-Huezo did not communicate with TVC after assessing Michael on 4 March 2020, despite Michael being an inpatient at TVC at that time.

50. It appears that there was a significant difference in Dr Peralta-Huezo's assessment of Michael's mental health, and TVC's assessment of the same. Dr Peralta-Huezo felt that Michael was not suited to be treated by him in private practice and that he instead required the specialist multidisciplinary input of a public mental health team, including admission to a CCU. In contrast, TVC records indicated that Michael's mental state was stable on discharge and recommended follow up with his GP and private psychiatrist.

51. Dr Peralta-Huezo stated that Michael was referred to him by Dr Khelil for ongoing and long-term management. Medical records do not indicate the type of referral made by Dr Khelil, however the typical process is for a GP to make a referral for an Opinion and Report (MBS item 291) which allows the psychiatrist to assess whether ongoing management is required. The psychiatrist is required to provide a written report to the GP within two weeks and if the psychiatrist recommends ongoing specialist psychiatric treatment, the GP should discuss options with the patient and refer the patient to a psychiatrist for ongoing treatment if required.[24]

52. While it would have been good practice for Dr Peralta-Huezo to liaise with TVC given he was aware that Michael was a current patient, this was not required of him given the requirements of an Opinion and Report referral.

[24] https://www.ranzcp.org/practice-education/guidelines-and-resources-for-practice/gps-andpsychiatrists/opinion-and-report-(mbs-item-291)

53. In her statement to the Court, Allison Carr stated that it was not usual practice for nursing or allied health staff at TVC to make contact with external treating professionals as this was the responsibility of the admitting psychiatrist.[25] As such, nursing and allied health staff at TVC made no attempts to seek feedback about the outcome of Dr Peralta-Huezo's assessment of Michael, other than from Michael himself.

54. Michael's inpatient treating psychiatrist Dr Keryn Fitzpatrick stated that she did not attempt to contact Dr Peralta-Huezo as Michael was clear in his understanding that he would receive ongoing treatment by PMHS given Dr Peralta-Huezo declined to accept Michael as an ongoing patient, and that she would have contacted Dr Peralta-Huezo if he had accepted Michael's treatment.

55. Dr Fitzpatrick did not respond when asked whether it was her usual practice to contact health professionals who provide assessment or treatment to a patient at TVC, however she did state that she could not recall other situations where a patient had been assessed during their admission as an initial assessment and for ongoing management.

56. Had direct contact occurred between Dr Peralta-Huezo and Dr Fitzpatrick (or TVC staff), this would have allowed for Dr Peralta-Huezo to provide his assessment that Michael required public mental health involvement and CCU admission, which was critical collateral information for TVC to consider and could have allowed for a referral to PMHS while Michael was an inpatient at TVC.

Who was responsible for referring Michael to PMHS following discharge from TVC?

57. Michael was not a current patient of PMHS at the time of his admission to TVC. The evidence suggests that there was a significant degree of confusion between services as to who was to facilitate Michael's referral back to PMHS once he had been discharged from TVC.

58. Dr Peralta-Huezo had recommended Michael's referral to PMHS and appeared to be of the belief that either Dr Khelil or TVC would facilitate the referral. The Haven staff believed that Dr Khelil would facilitate the referral. It is unclear who TVC thought would facilitate the referral.

59. Dr Peralta-Huezo recommended to Dr Khelil that Dr Khelil facilitate the referral. Accepted practice requires a GP to discuss specialist recommendations with the patient in the first

[25] Psychiatrists at private mental health wards are not employees of the hospital, but private practitioners with admitting rights who consult to the hospital.

instance, and action the recommendations if agreed upon. This would have required Michael to return to see Dr Khelil before his death, which he did not.

60. It was unclear whether The Haven staff expected Dr Khelil to make this referral without seeing Michael, whether Dr Peralta-Huezo assumed that Michael and The Haven staff would make an appointment with Dr Khelil to facilitate the referral, or whether The Haven staff expected Michael to make this appointment himself.

61. Ultimately, given the accepted clinical practice outlined at paragraph 59, Dr Peralta-Huezo's expectation that Dr Khelil facilitate the referral was appropriate. Given there were no current acute risks, there was no indication that Dr Peralta-Huezo needed to make a referral to PMHS himself, but rather to allow Michael and Dr Khelil to discuss the recommendation and Dr Khelil to facilitate if Michael agreed.

62. However, Dr Peralta-Huezo also stated that he thought The Victoria Clinic would make this referral, despite not communicating his recommendation to The Victoria Clinic. While the available information remains conflictual regarding whether Michael was understood to be a current patient of PMHS at the time of his admission, Dr Peralta-Huezo reported to be of the opinion that TVC would refer Michael to PMHS for post-discharge follow up, which did not occur.[26]

63. Dr Fitzpatrick stated that when Dr Peralta-Huezo declined to accept Michael's treatment, "he would remain under the care of his treating team at Frankston Psychiatric Services [PMHS]".[27] This was not reflected in the medical record, no contact was made with PHMS and the discharge summary was not sent to PMHS.

64. If Dr Fitzpatrick was under the mistaken impression that Michael would receive ongoing treatment from PMHS on discharge, it was unclear why 1) this was not documented in the medical record, 2) no contact was made with PMHS during the admission, 3) a discharge summary was not sent to PMHS and 4) the documented suggested follow up was to occur via Michael's GP and an unknown psychiatrist rather than PMHS.

Communication between The Haven and PMHS

<u>Michael's suicide attempt on 26 March 2020</u>

[26] "Once Michael was to be discharged from the inpatient unit (once the current acute episode had resolved), a referral to Peninsula Health would have taken place for the management of the chronic risk (and overall management of his illness)" - Statement of Dr Ricardo Peralta-Huezo dated 20 December 2022.
[27] Statement of Dr Keryn Fitzpatrick dated 12 April 2023.

65. It is of concern that The Haven staff did not contact PMHS following Michael's suicide attempt on 26 March 2020, given that Michael's safety plan included calling PMHS if he rated his intent to act on suicidal thoughts as 7-9.

66. In her statement to the Court, Belinda McCullough stated that staff did not contact PMHS as Michael had engaged in safety planning, including taking PRN medication, engaging with staff and providing assurances that he would not suicide overnight. This decision appears at odds with Michael's safety plan, as the plan did not provide for staff to exercise their own judgment as to whether they should follow the plan or not.

67. Nevertheless, according to records provided by PMHS, Michael himself contacted their Psychiatric Triage Service on 26 March 2020 at 11.58pm and left a message requesting a call back, noting that he had attempted to put a plastic bag over his head and wrap a cord around his neck.

68. Clinician Naitia Nagel returned Michael's call at 12.59am on 27 March 2020. During the call, Michael advised Dr Nagel that he had spoken with his support worker at The Haven, taken some diazepam and planned to make an appointment with his psychologist. Dr Nagel documented that Michael had been discharged from TVC the previous week. Michael was noted to be reasonable, settled and feeling safe, with ongoing chronic suicidal thoughts but no distress. It was noted that he lived in supported accommodation. A plan was made for no further contact.

69. There is no evidence that PMHS attempted to speak with The Haven staff, despite noting that Michael lived at The Haven and had spoken with his support worker after he attempted suicide, nor did The Haven attempt to contact PMHS despite their belief that PMHS did not return Michael's call.

70. Although it cannot be known what information may have been shared if PMHS did communicate with The Haven on this occasion, it is possible that The Haven staff may have noted that they were awaiting Dr Khelil to make a referral to PMHS. This may have changed the context of the triage, which was thought to be to manage the immediate crisis. However there appeared to be an intention from Dr Peralta-Huezo for Michael to be referred for ongoing case management and CCU admission, which PMHS were unaware of at the time of their contact with Michael.

71. Otherwise, The Haven staff appeared to respond to Michael's suicide attempt reasonably, contacting MOCA for advice, removing access to means, increasing support to Michael and assisting him to take PRN medication.

72. Over the following days, staff at The Haven continued to provide Michael with support according to his needs and updated his safety plan, including a risk assessment when Michael requested to have access to knives returned. It was decided with Michael that knives would be returned but plastic bags would not, which appeared to be a reasonable and patient-centred decision. According to Ms McCullough, plastic bags were not returned to Michael prior to his death and the bag that Michael used to suicide had not been sighted previously by staff.

Night prior to Michael's death 5 April 2020

73. It appeared reasonable that The Haven staff did not contact PMHS the night prior to Michael's death, despite Mary's phone call to The Haven that day. Staff engaged with Michael throughout the evening without any indication that he was planning to suicide overnight. Staff attempted to check in with Michael at 6pm as per the safety plan and he declined, however he accepted contact with staff at 8pm. It was unclear whether Michael was asked to rate the intensity of suicidal thoughts at 8pm, however he was asked this at 3.30pm which he responded currently 6/10.[28] There was no indication that Michael needed immediate hospitalisation and as such it would have been reasonable for The Haven staff to explore Mary's suggestion of re-admission to TVC at a later date.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

1. With the aim of promoting public health and safety and preventing like circumstances, I recommend that Healthscope develop a policy or procedure whereby admitting psychiatrists and/or The Victoria Clinic staff communicate directly (subject to consent) with external health professionals involved in the care of current inpatients to ascertain the outcome of any assessment and/or treatment recommendations.

FINDINGS AND CONCLUSION

2. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Michael Stephen Delaney, born 30 April 1982;

    b) the death occurred on 06 April 2020 at 9 Ebdale Street, Frankston, Victoria, 3199;

[28] Haven staff were to contact ITT if Michael rated his thoughts as 7-9/10

c) I accept and adopt the medical cause of death as ascribed by Dr Paul Bedford and find that Michael Stephen Delaney died from plastic bag asphyxia, in circumstances where I also find that he intended to take his own life.

3. AND, whilst I find that each of the services providing treatment and care to Michael did so reasonably and appropriately, I find that there were shortcomings in the communication between these services particularly with respect to Michael Stephen Delaney's referral to Peninsula Mental Health Service after being discharged from The Victoria Clinic.

4. AND FURTHER, whilst these shortcomings in communication likely resulted in appropriate and timely treatment options not being available to a man with complex treatment needs, it cannot be concluded that this contributed to Michael Stephen Delaney's death and as such I am unable to find that his death was preventable.

I convey my sincere condolences to Michael's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Mary Delaney

Glenn Delaney

Senior Constable James Mabarrack, Coroner's Investigator

Barry Nilsson Lawyers on behalf of Dr Ricardo Peralta-Huezo

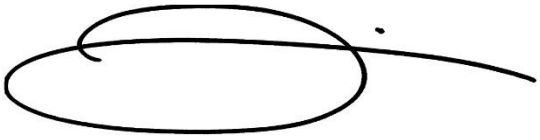
Dr Keryn Fitzpatrick

Healthscope

Peninsula Health

Mind Australia

Signature:



AUDREY JAMIESON

CORONER

Date: 6 June 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.