IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 002109

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Darren J. Bracken
Deceased:	AB[1]
Date of birth:	Born in 2002
Date of death:	21 April 2020
Cause of death:	1(a) HYPOXIC ISCHAEMIC ENCEPHALOPATHY 1(b) HANGING
Place of death:	Eastern Health, Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128

[1] A pseudonym.

INTRODUCTION

1. AB was 17 years old when on 14 April 2020 his mother, Ms R, found him hanging in his bedroom. At the time of his death on 21 April 2020, AB lived with his mother in an inner eastern suburb of Melbourne. AB was born female and had recently begun transitioning his gender to male.

2. AB went to two local schools where his parents felt that he struggled. AB had medical difficulties that seriously affected his education, 'gastro type issues', he was diagnosed with Hyper Mobility Disorder and Post Viral Fatigue. AB was considerably affected by the deaths of his great-grandmother and his grandmother. In 2015 AB fell and injured his back. Doctors discovered that AB had Spondylolisthesis and placed him in traction for a week at the Royal Children's Hospital. After the fall AB experienced considerable ongoing pain which was treated first by Dr C a 'pain management specialist' and then when he was 15 AB had spinal fusion surgery.

3. In 2018 AB and his parents went to Europe on holiday and AB's parents became concerned that AB's mental health was suffering. The family returned to Melbourne and after some difficulty AB was admitted into the Austin Hospital Child and Adolescent Mental Health Services (CAMS).

4. AB's parents separated in 2018-2019. AB was admitted to the Royal Children's Hospital for treatment of his mental health condition and after discharge was managed by the CAMS team at the Austin Hospital. Despite this AB was admitted to the Austin Hospital 12 times during 2019 as a psychiatric patient. Medical records reveal that AB had used illicit drugs in 2018.

5. At the beginning of 2019 AB decided to transition gender from female to male and unsuccessfully sought admission to the Royal Children's Hospital Gender Clinic. Mr and Ms R were very disappointed that AB was not admitted because he was more than 17 years old (1 day more). In 2020 and aided by his parents AB made application for entry to the Monash Gender Clinic. What seems to have been an administrative error resulted in the Clinic telling Mr & Ms R that they, the Clinic had lost the referral, and that AB would have to wait 12 months before he would be able to be admitted to the Clinic. In April 2020 because of COVID 19 in Melbourne the Clinic paused all appointments.

6. AB's last admission to the Austin was on 9 April 2020 and he was discharged home on 13 April 2020. AB's then case manager Mr A went to AB's home on 14 April 2020 but AB refused to engage with him.

THE CORONIAL INVESTIGATION

7. AB'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. AB's death was unexpected and did not occur as a result of natural causes.

8. 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.

9. 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.

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

11. This finding draws on the totality of the coronial investigation into the death of AB 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.[2]

[2] 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.

Medical History

12. AB's medical history is very complex. The Coronial Brief contains statements from some 15 treating doctors as well as statements from allied health practitioners; it also contains poignant statements from AB's parents.

13. AB's parents describe AB enjoying both primary and at least the first few years of secondary school. In 2015 AB developed 'post viral fatigue' which caused him to miss a considerable amount of school that year. That year was not a good year for AB; he also injured his back suffering Spondylolisthesis which later required surgery and caused him on-going pain. AB's parents felt that the school didn't support AB through trying to deal with his injury. Until this injury AB had been active and played a considerable amount of sport. After this injury he was unable to continue with his sporting activities. In their statements AB's parents make it quite clear that AB not being able to play sport had a considerable ongoing effect on him. In 2017 AB had surgery for Spondylolisthesis and had two vertebrae fused; he was only 15 years old.

14. AB eventually changed schools and went to a local College which he liked at first but ultimately found that his anxiety was further provoked.

15. At least initially 2018 was a better year for AB, but also saw his mental health decline. AB's parents took him to the Royal Children's Hospital on a number of occasions. AB also saw doctors at the Camberwell Junction Clinic who referred him to a Paediatrician and a Psychologist. AB's parents also sought help for him from the Austin Hospital and after much difficulty managed to have him admitted to the 'CAMHS (Child Adolescent Mental Health Service) Program' there. AB was admitted to the Marion Drummond Ward for adolescents at the Austin on 12 occasions and had 3 case managers.

16. In 2019 AB was unsuccessful in gaining entry to the Royal Children's Hospital Gender Clinic because he was too old (one day too old when his application was assessed). AB's parents tried to get him into the Monash Gender Clinic to be told, firstly that there was a 12 month wait list and then when COVID took hold in Melbourne that all appointments had been suspended.

17. Ms R describes AB 'losing control of his behaviour and hitting and banging his head on walls, trying to jump off staircases and running out in front of traffic.' Ms R described 10 February 2019 as one of those days when AB ran out in front of traffic, the police 'pepper sprayed him'

and took him to the Austin Hospital where he was "…*sectioned…*" but discharged to his mother's care a few hours later. The next day, after being assessed by Dr I, AB was again apprehended by police and admitted to the Austin Hospital on an "*Assessment Order*" then admitted to the Banksia Ward of the Royal Children's hospital where he stayed until he was discharged seven days later and his care reverted to the Austin Hospital. AB had a number of Case Managers at the Austin Hospital the last of which was Mr A with whom AB seemed to get along.

18. Early in 2019 AB told his mother that he was transgender and thought that he had gender dysphoria in 2019. AB's then psychiatrist Dr I referred AB to the gender clinic at the Royal Children's Hospital. Ms R called the hospital on 22 July 2019 to be told that AB could not be accepted into the program there because he was too old (one day over 17). Another referral, this time to the Monash Gender Service was drawn. When Ms R contacted the service in January 2020 she was advised that AB could not be seen for some 12 months and then, with COVID-19 difficulties the service paused all services.

19. Mr R describes AB first attempting suicide on 1 September 2019 by trying to hang himself with shoelaces on a cupboard door in his bedroom. Subsequently AB's back pain persisted, and he was also diagnosed with 'pancolitis' as a result of which, in mid March 2020 AB was in the Cabrini Hospital for a week. AB's ongoing health problems meant that he missed more school.

20. On 8 April 2020 Ms R called an ambulance and AB told the call taker that he was suicidal and that if his mother had to take him to hospital that he would jump out of the car. In her statement Ms R refers to hearing the 'call taker' tell AB that he could suicide in the hospital. Ms R recounts AB being 'triggered' by his discussion with the call taker and 'putting his head through a wall'. She describes the police being called and AB having to be held down until an ambulance arrived. AB was taken to the Box Hill Hospital where Ms R was told by a 'mental health clinician' that AB's file was in the middle of being transferred and they '…*could not do much with AB that evening.*" AB and his mother went back home and Ms R took him to the Austin where on 9 April 2020 she successfully had had him admitted.

21. AB was discharged and went with Ms R on 13 April 2020. In her statement Ms R recounts checking on AB at about 3.00am the next day and of him telling her that "…*there's nothing you can do for me mum*.". At about 3.00pm on 14 April 2020 AB's case manager Mr A visited AB at home but AB would not see him. At about 7.30pm Ms R took AB's dinner into

his bedroom to him. AB was on the telephone to his ex-girlfriend and Ms R left his dinner there for him. At about 8.30pm Ms R heard "…*unusual banging of the cupboards…*"; she went to AB's bedroom and found him hanging from a wardrobe door. Ms R cut AB down, called an ambulance and commenced CPR. An ambulance arrived, treated AB and took him to the Box Hill Hospital where, ultimately, on 21 April 2020 he died.

22. Dr I saw AB and his mother generally fortnightly after October 2018 and in her statement described AB's presentation as being very mixed and many aspects of his development and family / genetic history being suggestive of a possible underlying Autism Spectrum Disorder. Dr I's statement refers to her belief as at March 2020 that AB to be in a 'new house', which he loved with his mother, his cat and where his ex-girlfriend often stayed. Dr I refers to Ms R telephoning her on 7 April 2020 and telling her that AB was asleep, and that his relationship with his ex-girlfriend had broken down 'against his will' but that he was reaching out to other friends for support.

23. In his statement Mr A refers to exploring strategies for AB to manage with emotional regulation to enable him to participate at college and to assisting him with his family and intimate relationships. Mr A refers to seeing AB on 1 April 2020 "…*in response to a crisis…*"; Ms R was concerned about his emotional distress following his relationship break down with his ex-girlfriend and that he was expressing suicidal ideation. Mr A also refers to going to AB's home on 7 April 2020 and trying, unsuccessfully, to talk to AB about this "…*crisis*…". Mr A refers to speaking to Ms R and encouraging her to follow the crisis plan that had been developed. Mr A refers to returning from leave to be told that AB had been discharged from the Austin Adolescent Inpatient Psychiatric Unit ("AIPU") the previous day and of going to AB's home on 14 April 2020 to meet with AB and his mother. Mr A refers to not having been able to speak to AB despite his mother encouraging AB to speak to Mr A. Ms R referred to AB's mood being low and him being unmotivated, having low energy, isolating himself in his room and having occasional angry outbursts toward her. In his statement Mr A notes that Ms R "…*reported no expression by AB of suicidal ideation*." and them discussing the crisis plan including potential presentation to the emergency department.

24. Dr V reviewed AB on 13 April 2020 because he was requesting 'self-discharge' – he had been admitted on 9 April 2020 and was otherwise to be discharged on 14 April 2020. In her statement Dr V refers to having read AB's clinical file and the notes in relation to his transfer to the Austin health emergency department on 11 April 2020. Dr V also refers to reading emergency department notes and outpatient case management notes recorded over the

preceding weeks. Dr V refers to speaking to Ms R before reviewing AB. She notes Ms R told her that she was supportive of AB being discharged that day and that she felt he was doing much better since his admission the preceding Thursday evening. Dr V's statement refers to her speaking to Ms R about the context of AB's admission including his recent relationship separation. Ms R told Dr V that she wouldn't need extra medication if AB was discharged because she had an adequate supply and that there was an appointment scheduled with AB's outplacement case manager the following day.

25. Dr V's statement refers to her undertaking a 40-minute review of AB during which she recorded AB describing the context of his admission; that he had been very low in mood, that he had struggled to get out of bed and was having suicidal thoughts. Dr V noted that AB told her that he felt he'd gotten that which he was seeking out of the admission which was to provide 'containment' and respite from home in order to ultimately lead to reduction in his suicidal and self-harm thoughts. He said that he currently had no suicidal ideation or intent to harm himself. When asked, AB explained to Dr V that he had a safety plan and would trial strategies such as exercise or video games or distraction if he felt more distressed or started to have suicidal thoughts. Dr V said that AB explained that if such techniques weren't helping he would use Quetiapine to manage his distress and that if both of those strategies weren't helping he would alert his mother and decide on a plan about whether to return to hospital or utilise other strategies. Dr V explains that when she asked AB why he wanted to be discharged earlier than originally planned that he told her that his feelings of distress and thoughts of suicide had resolved and that it would be detrimental for him to stay any longer because there were no groups running over the Easter long weekend and because there was a lack of access to the usual coping strategies he used at home including the presence of his mother. AB told Dr V about his plans for the upcoming week and indicated his excitement about returning to school because he felt school was protecting in terms of his mental health. Dr V assessed AB as presenting as a well engaged youth who was reactive in effect and warm and humorous. After the review Dr V consulted psychiatrist Dr J and they discussed AB's case. Dr V noted that Dr J said that, given the plan had been for discharge the following day and follow-up was already arranged that she, Dr J was agreeable to his, AB's self-initiated discharge a day early. Dr V refers to having completed AB's discharge summary the next day, 14 April 2020 which was countersigned by Dr B consultant psychiatrist.

26. The Coronial Brief contains a statement signed by Dr L consultant Child and adolescent psychiatrist which contains a summary of events and Dr L's involvement in AB's treatment between 8 April 2020 and 12 April 2020.

27. The Coronial Brief contains a statement by Dr T, from Cabrini Emergency Department. Dr T summarises AB's admissions to Cabrini in 2020 and nominates the doctors who treated him. Dr T refers to AB having had a history of L5\S1 spinal fusion in 2017 asthma and a psychiatric history of depression, anxiety and previous suicide attempts. Dr T notes that AB was accompanied by his father on occasion when he attended Cabrini in 2020 and on other occasions by his mother. Dr T notes that common to these attendances was back pain and on most attendances AB was seeking opiates as a pain relief measure.

Circumstances in which the death occurred

28. AB was in his room on the night of 14 April 2020. His mother took him dinner at about 7.30pm at which time AB was on the telephone talking to his ex-girlfriend. At about 8.30pm Ms R heard 'unusual banging on wardrobe doors' coming from AB 's room. She went to his room and found him hanging from a door handle of a wardrobe. Ms R cut AB down and called '000' and commenced CPR. Paramedics who arrived at AB 's home at about 9.05pm treated him and took him to the Box Hill Hospital. AB died on 21 April 2020.

Identity of the deceased

29. On 17 April 2020 Ms R identified the deceased as AB, born in 2002.

30. Identity is not in dispute and requires no further investigation.

Medical cause of death

31. On 22 April 2020 Dr Melanie Archer a specialist Forensic Pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination of the deceased. Dr Archer drew a report dated 15 May 2020 in which she opined that cause of the deceased's death was 1(a) hypoxic ischaemic encephalopathy and 1(b) Hanging.

32. The post mortem revealed marks on palmar surface of the left forearm which have the appearance of self-harm marks.

33. I accept Dr Archer's opinion.

FAMILY CONCERNS

34. Ms R wrote a detailed letter to the court marked 'Private and Confidential', the details of which I will not set-out. The letter is, amongst other things a testament to a mother's

determination to have her child's dynamic, complex medical conditions effectively treated and disappointment with the way that various elements of the health system interact. In his statement Mr R too expressed disappointment with his experience of the way in which the hospital system dealt with his child's conditions.

35. The multifarious effects of COVID-19 on the hospital system were arguably at their peak at just the wrong time for AB. Lock-downs and other restrictions on the population and in particular the operations of hospitals had their most unsettling effects over the period of time when AB was experiencing his most acute needs. Ms R's main concerns were not the individuals in the system providing care to AB so much as a lack of co-ordination between services. I address this issue in the 'Comments' section below.

SECTION 67 *CORONERS ACT* (2008)

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

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

    a) the identity of the deceased was AB, born in 2002;

    b) the death occurred on 21 April 2020 at Eastern Health, Box Hill Hospital, 8 Arnold Street, Box Hill, Victoria, 3128, from 1 (a) HYPOXIC ISCHAEMIC ENCEPHALOPATHY; 1 (b) HANGING; and

    c) the death occurred in the circumstances described above.

37. A person's decision to take their own life can be, and often is impulsive. It can be a reaction to an event or events rather than a considered thought-through decision. A labile state of mind sometimes facilitates impulsive action. The events that can suddenly trigger such impulsive actions may not always be considered as significant to others as they are to the person taking the impulsive decision. A person's decision to take their own life is not always immediately preceded by them 'showing signs' of such an intention. A person's decision to take their own life and the act or actions carrying that decision into effect often occur, as here, without warning. Suicide is always a tragedy and it is all the more so in AB's case; he was so very young. Having considered all of the circumstances, I am satisfied that AB deliberately acted and took his own life.

COMMENTS

Comments pursuant to section 67(3) of the Act.

38. The apparent 'disconnect' that Ms and Mr R found with various hospitals and health services may, to some degree be explained by their services having been sought in the midst of COVID-19 stresses. Such an explanation goes someway and perhaps a long way to explaining the 'difficulties' Mr and Ms R encountered. It is not however clear that this explanation is a panacea. Why, if AB was said to be too old (by a day) for admission to the one 'gender clinic program' his entry into another – a suitable one was not facilitated is not clear. It seems to me that there may be scope for this case to be the genesis for an assessment of interoperability between at least the mental health programs which various hospitals, the Austin Hospital, the Royal Children's Hospital et al. conduct. Any lacuna between these programs as perhaps referred to in Ms and Mr R's statements is not a proximal matter that constitutes a cause of AB's death but perhaps a 'background circumstance' of it. It is in any case a structural issue for the Victorian Health System that might be assessed with a view to improvement. Such a task is not one for this court.
39. 'Safer Care Victoria' is Victoria's quality and safety improvement specialist and conducts a 'mental health improvement program aimed at improving mental healthcare in Victorian publicly funded mental health and well-being services.' Safer Care works with consumers, carers, families and supporters, and the mental health and well-being workforce and leaders to co-design quality improvement programs. Safer Care works closely with the Departments of Health including the Office of the Chief Psychiatrist to implement the new quality and safety architecture.
40. With that in mind I propose to provide this Finding and the brief to Safer Care Victoria for their consideration with a view to the 'disconnects' that Ms and Mr R set out in their statements in the context of the statements provided to the Court and set out in the brief.

41. Pursuant to section 73(1A) of the Act, I order that this finding (in a redacted format) 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:

KR - Senior Next of Kin;

DR - Senior Next of Kin;

Safer Care Victoria; and

Senior Constable K. M. Dinnan – Coronial Investigator

Signature:

Coroner Darren J. Bracken

Date: 7 September 2022

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.