CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**Inquest into the death of Adrian Pitman**
Citation:	**[2019] ACTCD 13**
Hearing Date(s):	11, 12, 13 June 2019
Decision Date:	14 October 2019
Before:	**Coroner Stewart**
Decision:	See [34]–[40]
Catchwords:	**CORONERS ACT** – deemed death in custody – quality of care, treatment and supervision
Legislation Cited:	*Coroners Act* 1997 (ACT) *Mental Health (Treatment and Care) Act* 1994 (ACT) *Mental Health Act* 2015 (ACT)
Parties:	Counsel Assisting the Coroner Australian Capital Territory
Representation:	**Counsel** Ms S Baker-Goldsmith (Counsel Assisting the Coroner) Ms K Musgrove (Australian Capital Territory)
File Number(s):	CD 64 of 2016

CORONER STEWART:

Introduction

1. Adrian Pitman was born in 1961. There is no dispute that he died from multiple injuries after his car hit a stone retaining wall and caught on fire on Fairburn Avenue, Campbell, ACT. This happened at about 12.01 am on Tuesday 15 March 2016. The Court is aware of the sadness caused by my determination that the manner of Mr Pitman's death was suicide by intentional motor vehicle collision. Those interim findings were made on 13 June 2019.

2. Mr Pitman had a long history of mental illness. He had completed school and commenced studying architecture at university. Mr Pitman's mental health declined to the point where he had a long term diagnosis of treatment-resistant schizophrenia by the time of his death. Unfortunately, by March 2016 Mr Pitman was a social recluse, was subject to a community treatment order to enforce medication regimes and he was obsessed with delusions. He had been in the care of 33 different case managers since the year 2000.

How the Coronial Jurisdiction arises

3. At his time of death Mr Pitman was deemed to be in custody. This is because Mr Pitman was subject to a community-based Psychiatric Treatment Order ("PTO") through ACAT and under the *Mental Health (Care and Treatment) Act 1994* ("the MHCT Act"). Section 3C of the *Coroners Act 1997* ("the CA") dictates that when someone dies whilst subject to an order under the MHCT Act that death is deemed to be a death in custody. [The MHCT Act has now been repealed and replaced by the *Mental Health Act 2015* with consequential amendments to the CA.]

4. Section 13(1)(k) of the CA mandates that an inquest must be held when there is a death in custody – thus my jurisdiction as a Coroner is enlivened. Further, under section 34A(2), I must hold a hearing for the purposes of my inquest.

What are the issues to be determined in this inquest?

5. The CA sets out in sections 52(1) and 74 what must be determined by me. The s 52(1) issues of identity, time, place and manner and cause of death are not disputed. S 74 dictates as follows:

> ***74 Findings about quality of care, treatment and supervision***
>
> *The coroner holding an inquest into a death in custody must include in a record of the proceedings of the inquest findings about the quality of care, treatment and supervision of the deceased that, in the opinion of the coroner, contributed to the cause of death.*

Short chronology

6. I have taken this chronology largely from the statement of CONST Barlee, my coronial investigator. The references to Mr Pitman's early life are taken from a conversation between CONST Barlee and Mr Pitman's mother:

January 1961	Mr Pitman born.
1980	Mr Pitman left family home in ACT and moved to Sydney.
1991	Mr Pitman was admitted to hospital following psychotic episode. He was admitted for a number of weeks and then returned to the ACT to reside with his parents.

1990's	Mr Pitman diagnosed with schizophrenia and received treatment through ACT Mental Health (ACTMH).
2000	Mr Pitman moved to a one bedroom unit at Lyneham owned by his mother. His financial matters become managed by the Public Trustee. In this year his father died and he experienced increasingly severe psychotic episodes. He became involved with people at the Aboriginal Embassy and from then was also known by the name Mirri Ngunnawal. He expressed an ongoing delusional view that he could not be subject to a Psychiatric Treatment Order (PTO) as he was Aboriginal.
20 September 2000	Mr Pitman hospitalised until 13 March 2006 due to mental ill-health.
26 September 2002	Mrs Pitman advised ACTMH that Mr Pitman was in Fiji.
24 June 2003	Mr Pitman deported from Fiji and was reported to be highly delusional.
23 February 2006	Mr Pitman hospitalised until 11 October 2006 due to mental ill-health.
21 June 2011	Mr Pitman hospitalised until 12 July 2011 due to mental ill-health.
22 May 2014	Dr Garside commences the first of 14 face to face interviews with Mr Pitman.
14 January 2015	Mr Pitman was admitted to Canberra Hospital's Adult Mental Health Unit (AMHU) psychiatric treatment ward until 30 January 2015.
22 January 2015	Six month PTO granted by ACAT.
09 July 2015	Six month PTO granted by ACAT.
22 September 2015	Mr Pitman was admitted to AMHU for about eight weeks. He had attended the offices of ASIO and reported that mental health had attempted to poison him.
16 November 2015	Mr Pitman's symptoms had improved and he was released from hospital to the Step Up Step Down program. In accordance with his privacy requests, Mr Pitman's family are not advised of his discharge or involved in that process. He self-discharged from Step Up Step Down six days later and refused to be admitted to Bryan Hennessey House.
17 November 2015	Mr Pitman reiterated that he did not consent to members of his family being informed about his medication and management.
23 November 2015	Ms Johnson (Mr Pitman's final care worker and clinical manager) conducted her first home visit with Mr Pitman. His home was tidy and he was polite, but short-spoken and declined to engage in conversation about treatment. This behaviour was to be repeated in future visits.
14 January 2016	Six month PTO granted by ACAT.
21 January 2016	Dr Garside reviewed Mr Pitman who displayed a low level of self-care.
10 February 2015	Ms Johnson conducted home assessment with Mr Pitman. He did not express suicidal ideation and displayed impaired insight into his mental health.
10 March 2016	Ms Johnson spoke with Mr Pitman on the telephone to determine if he needed transport for his appointment that day.

	Mr Pitman attended his appointment with Dr Garside and Ms Johnson at City Mental Health. He presented with no insight into his mental illness, but there was nothing about Mr Pitman's presentation that caused concern to Dr Garside or Ms Johnson. Mr Pitman was again prescribed 300mg Olanzipine every two weeks and the next review was set for June 2016.
13 March 2016	Mr Pitman and his mother enjoyed an uneventful and happy Sunday lunch.
14 March 2016	Mr Pitman was seen on supermarket CCTV footage. He later (apparently) resolved to drive to Mt Ainslie.
15 March 2016	In the first few minutes of the day Mr Pitman died after his car struck a retaining wall at the bottom of Mt Ainslie. He was declared life extinct at 3.00am that day. At about the same time a note commonly called a 'suicide note' was found by police in Mr Pitman's bedroom.

Witness evidence

7. The Court received evidence from seven witnesses as well as the coronial brief. The majority of these witnesses gave evidence in relation to their dealings with Mr Pitman in a medical and clinical setting. Evidence was also given by an Assistant Director of Traffic Safety and Transport Canberra and City Services in relation to the intersection where Mr Pitman died.

Medical and Clinical Evidence

Dr Renate Mundl

8. The Court received evidence from Dr Renate Mundl. Dr Mundl was formerly an employee of ACT Health. Her work with Mr Pitman commenced on 30 November 2010, while she was working in the City Mental Health Team.

9. Dr Mundl issued Mr Pitman with two prescriptions of the drug Clozapine on 30 November 2010 and 23 February 2011. She did not see Mr Pitman prior to issuing these prescriptions and explained that Mr Pitman had previously been prescribed Clozapine and that she was simply continuing the prescription as part of an existing protocol for the issue of that drug.

10. For present purposes, Dr Mundl next dealt with Mr Pitman in 2015. At that time, she was working as a consultant at the Adult Mental Health Unit (AMHU) at The Canberra Hospital.

11. Dr Mundl assessed Mr Pitman on 30 September 2015. She assessed him as suffering from an ongoing psychosis, the effects of which had been reduced since Mr Pitman had been admitted to hospital and treated. Dr Mundl's recommendations on this occasion were to the effect that, in order to better assess future treatment options for Mr Pitman:

    (a) Further information was required about Mr Pitman's past treatment; and

    (b) It would be necessary for clinical staff to liaise with Mr Pitman's community case manager in relation to planning for discharge.

12. Dr Mundl also dealt with Mr Pitman on 7 October 2015. On this occasion, either by her own recommendation or in collaboration with the community case manager it was suggested that Mr Pitman be put back on Clozapine. It was also noted at the time that Mr Pitman was more unwell than previously thought. Dr Mundl was unable to recall in her evidence what prompted this note to be made.

13. Dr Mundl was asked some general questions by Counsel Assisting about the type of treatment provided under Psychiatric Treatment Orders (PTO). Her evidence was that treatment under a PTO could be what was described as "bio-psycho-social"[1] – that is, such orders consist not only of medical or pharmaceutical forms of treatment, but also other forms of therapies which she described broadly as "psycho-social". Dr Mundl noted, however, that any such therapies available under a PTO would need to be balanced against a patient's ability to cope with whatever form of therapy was proposed. Further, such therapies were only available while the patient was housed within an "approved facility", like the AMHU, rather than in the community at large. The reasons given for this distinction related to difficulties in forcing patient compliance while they were in the community at large.

14. Dr Mundl was also asked questions about doctor-patient confidentiality, particularly focussed on the issue of whether details of a patient's treatment ought to be disclosed to that patient's carer. Dr Mundl was specifically asked about whether, in a case like Mr Pitman's where his mother was supporting his accommodation needs in the community, the patient's carer ought to be told what the status of the patient's care is. Dr Mundl's answers on this topic were expressed in the hypothetical. She stated that she had not herself been in a situation where any such step was necessary. Nevertheless, her evidence was to the effect that she would attempt to advise the patient to tell their carer. Her concern in this regard was directed towards the possible effect on the patient upon interacting with their parent after discharge if the parent did not know about the discharge.

15. Dr Mundl gave general evidence that the risk of suicide is heightened for those suffering from schizophrenia. She told the inquest that in treating people like Mr Pitman, suicide risk was assessed, inter alia, as part of a standard set of interview questions, involving both direct and indirect questioning. In cases like Mr Pitman's, his affect – described as "blunted" with little or no insight – was such that the treating professionals would have had to rely more heavily on indirect questioning.

16. Counsel Assisting described the behaviour of Mr Pitman observed by his mother on the morning prior to his death. Dr Mundl noted that the behaviour described was consistent with what appeared in some medical literature as "pre-suicidal syndrome". However, as was clarified during questioning by Counsel for the Territory, Dr Mundl conceded that this answer was only hypothetical, and that she could not say that Mr Pitman did suffer from any such condition.

17. Dr Mundl was asked questions about her experience from other jurisdictions. In particular, she was asked whether her experience of other jurisdictions could shed light on the treatment of mental health in the ACT. She briefly canvassed her experience in Austria, Victoria and South Australia. Dr Mundl noted briefly that in Austria there are no community treatment orders because of legal and geographical differences. In the Australian context, Dr Mundl commented that, in her experience, the level of

[1] Transcript – Day 1 – Page 19, Line 4.

communication in the ACT mental health system was superior to the other jurisdictions. She qualified this statement by noting that she was not sure whether this difference was due to a difference in culture or legal framework.

18. When asked if she could make any recommendations for improvements to the mental health system in the ACT, Dr Mundl focussed on resourcing constraints, and an apparent disjunct between in-patient care and community care. However, she did not consider in hindsight that there was anything different that she would have done in Mr Pitman's case.

Ms Annaliese Johnson

19. Ms Johnson was Mr Pitman's clinical manager while he was being treated in the community from November 2015 to March 2016. Her formal training was as a social worker.

20. Ms Johnson saw Mr Pitman at least once a fortnight when he attended the City Mental Health offices for his fortnightly medication injection. Almost every week in between, Ms Johnson would have a short phone call with Mr Pitman. She also visited his home once a month.

21. The questions asked of Ms Johnson canvassed a range of topics.

22. Ms Johnson was asked about Mr Pitman's decision to discharge himself from the Step Up Step Down ("SUSD") program. That program is a voluntary residential program established to enable persons in intensive in-patient care for mental illness to transition back into the community. When Ms Johnson became Mr Pitman's clinical manager she knew that he was coming from that facility. As far as she understood, his reason for discharging himself was his belief that he did not need to be there anymore. Ms Johnson did not form a view at that time about Mr Pitman's decision to leave SUSD.

23. Following conversations that Ms Johnson had with Mrs Pitman about the challenge in maintaining Mr Pitman's apartment, Ms Johnson offered to organise a cleaner for Mr Pitman's apartment. Mr Pitman initially agreed to Ms Johnson making some enquiries. Some weeks later, when the matter was raised with Mr Pitman again after Ms Johnson had identified an appropriate service, Mr Pitman indicated that he did not wish to proceed. He offered that Ms Johnson attend his apartment to confirm that he did not need any assistance. Ms Johnson attended the apartment in November. She commented that, at the time of her visit, it was tidy and sparsely furnished, with a slight odour of cigarette smoke. Thereafter, Ms Johnson would attend Mr Pitman's apartment approximately once per month. She did not observe much of a change to the state of the apartment. She formed the view that his refusal of assistance was reasonable. Ms Johnson conceded that she did not check the cupboards for clutter that had been put away perhaps in anticipation of her visit.

24. Ms Johnson was also responsible for submitting an application for Mr Pitman to receive support under the National Disability Insurance Scheme ("NDIS"). NDIS has the potential to offer psychosocial support to persons experiencing mental illness. However, Mr Pitman expressed that he did not have a desire for social interaction outside of his interactions with elders at the Aboriginal Tent Embassy. When asked if she had a concern about this lack of willingness to socialise, Ms Johnson responded

that the lack of desire for social interaction was consistent with the diagnosis of schizophrenia.

25. During her fortnightly telephone conversations with Mr Pitman, Ms Johnson would attempt to assess Mr Pitman's mood and behaviour. She would ask certain questions periodically, such as whether Mr Pitman thought life was worth living, or whether he had any thoughts about harming himself or others. However, such questions were not asked commonly, because, on Ms Johnson's evidence, it would be something that would generally be asked only if there had been some change in circumstances. In Mr Pitman's case, however, Ms Johnson indicated that she would only ask those questions "if it had been quite some time since they had been asked, because that was really the only indicator to ask them as a matter of routine".

26. According to Ms Johnson, Mr Pitman's mental state was roughly consistent during the period that she was his clinical manager. Had there been any evidence of deterioration, she would have discussed it with the multidisciplinary team.

27. Ms Johnson was asked about whether she held any instructions from Mr Pitman in relation to the engagement of Mr Pitman's family – particularly, his mother Maureen. She deposed that she was only instructed to discuss with Mr Pitman's family the state of his flat upon visits. Mr Pitman did not give her instructions to share progress about his condition.

28. Ms Johnson's final interaction with Mr Pitman was on 10 March 2016, during a review with Dr Joseph Garside. Dr Garside's assessment at that review was that Mr Pitman's "presentation seemed quite consistent with what he would expect when Mr Pitman was reasonably well, as in not in an escalated state with his mental illness". Nothing on this occasion gave Ms Johnson any cause for concern. I note that this was only five days prior to his passing.

29. Ms Johnson did not think that there was anything that, in hindsight, she would have done differently. She also stated that she thought the policies and guidelines available to her at the time were sufficient, and that she felt she had sufficient support.

Dr Joseph Garside

30. Dr Garside is a senior clinical medical officer practising as a psychiatrist at ACT City Mental Health. He was Mr Pitman's treating psychiatrist in the community, and was responsible for Mr Pitman's care between 22 May 2014 and 10 March 2016.

31. Focussing on the period when Mr Pitman was admitted to the AMHU, Dr Garside gave evidence that he was made aware of Mr Pitman's discharge to the SUSD program. He deposed that, while he was aware, he had not been consulted about this decision to discharge Mr Pitman. He stated that, while ideally he would have been part of that decision-making process, the discharge plan did not cause him any concern.

32. Dr Garside was asked a number of questions about whether it would have been an option for Mr Pitman to be sent to undertake a period of rehabilitation at Brian Hennessy House ("BHH") (also referred to during the inquest as the Brian Hennessy Rehabilitation Centre). Dr Garside's evidence was that while it was possible to make it a condition of Mr Pitman's PTO that he reside at BHH, the purpose of BHH is as a rehabilitation unit. As such, it requires a willingness on the part of the patient to comply. Mr Pitman could not have been forced to participate in the activities directed towards rehabilitation. Although a PTO could be used to compel a person to attend

such activities, forced compliance would be out of line with the model of imposing the least restrictive form of care, for non-compliance could result in the person being taken to hospital. Further, Dr Garside noted that due to the fact that Mr Pitman usually kept to himself, he could not say whether forcing Mr Pitman to reside at BHH would actually have made him engage with others.

33. When asked why he did not discuss the possibility of going to BHH with Mr Pitman on a number of occasions, Dr Garside stated that Mr Pitman was not open to having a discussion about residential rehabilitation. In order for the suggestion to be made, Mr Pitman would have had to displace some "willingness to accept support and some awareness that there may be some advantage to entering into a rehabilitation process". Dr Garside's clinical judgment was that Mr Pitman would be dismissive of such a suggestion.

34. Counsel Assisting raised with Dr Garside the question as to whether Mr Pitman was capable of making decisions regarding the disclosure of information to his family members. Mr Pitman generally consented to only a limited sharing of information about his interaction with his medical and clinical team with his family. When asked if he thought it was appropriate that Mr Pitman could direct his medical and clinical team not to disclose updates about his condition to his mother, Dr Garside stated that such a restriction was appropriate, and that the fact that Mr Pitman had a chronic illness did not deny him the right to confidentiality. The fact that, in order for a PTO to be made Dr Garside suggested that such lack of capacity is only in relation to the mental illness itself, rather than decision-making capacity more broadly. Dr Garside stated that the factors which are taken into account when deciding to make a PTO do not necessarily look at a person's capacity to make decisions in other dimensions of that person's life. More particularly, while no formal testing was done, Dr Garside deposed that there was nothing which caused him to doubt Mr Pitman's ability to make decisions.

35. When asked follow-up questions about whether Mr Pitman was capable of making the decision about not going to BHH, Dr Garside stated that Mr Pitman knew what it would have meant to go to BHH in terms of taking him away from the things in his life that he wanted to pursue at that point in time. His evidence was that there was nothing to be gained by being more restrictive in Mr Pitman's care.

36. Dr Garside was asked questions about whether directly addressing issues of suicide or self-harm increased the risk of Mr Pitman entertaining suicidal thoughts. Dr Garside did not believe that asking Mr Pitman about suicide would have put the idea in his head. His evidence was to the effect that Mr Pitman had not previously attempted suicide, and the manifestations of his "delusional system" did not suggest that suicide would be one of the ways in which that system played out. Mr Pitman showed a sense of future purpose.

37. Dr Garside was asked if he could make any recommendations for the improvement of mental care for those in Mr Pitman's position. He stated that he would like to see the provision of more services, along with a change of mindset, in the community.

Dr Alfiya Mutlu

38. Dr Mutlu is a psychiatrist working for ACT Health. She was involved in Mr Pitman's care while he was an in-patient at AMHU at The Canberra Hospital.

39. On 23 September 2015, she conducted a review of Mr Pitman. He stated at the time that his life was over. When asked whether she thought that indicated any suicidal ideation on Mr Pitman's part, she stated that her interpretation was that it was not an indication of increased suicide risk. Her impression was that the danger to his life was from some external cause, which would have been consistent with certain delusional thoughts he was having at the time of his admission.

Dr Astika Kappagoda

40. Dr Kappagoda is a practising psychiatry registrar, who was formerly employed by ACT Health. His interactions with Mr Pitman were while Mr Pitman was admitted as an in-patient in the AMHU.

41. Dr Kappagoda first saw Mr Pitman on 25 September 2015, during which Dr Kappagoda assessed Mr Pitman's mental state. His evidence was that Mr Pitman appeared agitated, suspicious and guarded about giving information. He walked out of the interview before a full assessment could take place. When asked whether he had concerns about Mr Pitman's ability to make decisions about non-medical issues, he stated that, at that point in time, Mr Pitman's level of thought disorder caused him to make a reasonable assumption that Mr Pitman's decision-making capacity across a variety of domains would be severely affected. It should be noted that it was clarified during examination by Counsel for the Territory that, because there was no formal cognitive assessment, Dr Kappagoda was not able to form a final view as to Mr Pitman's capacity to make decisions. Furthermore, later during the course of his admission in the AMHU, Dr Kappagoda held the opinion that Mr Pitman had the capacity to make a decision regarding the disclosure of information about his treatment to his family.

42. Dr Kappagoda deposed that, during the course of his interactions with Mr Pitman, he observed that Mr Pitman became more forthcoming in discussing his thoughts and concerns with his treating team. His evidence was that this was a possible indication that the medication that had been prescribed – Olanzapine – was starting to take effect.

43. Dr Kappagoda attended a meeting with Mr Pitman and his mother on 15 October 2015. Mrs Pitman expressed concerns about Mr Pitman's capacity to live at the apartment she provided for him. The possibility of a period of time at BHH was proposed to Mr Pitman, which he rejected. After a sustained discussion, as an alternative to BHH, Mr Pitman agreed to participate in the SUSD program,

44. Following Mr Pitman's discharge from the AMHU, Dr Kappagoda had discussions with Mrs Pitman, who expressed surprise at Mr Pitman's discharge. Dr Kappagoda stated that it would have been ideal to include her in the discharge planning, but that that was contrary to Mr Pitman's wishes. He noted to Mrs Pitman that the team responsible for Mr Pitman's care in the community should consider applying for an order to ACAT for Mr Pitman to reside at BHH. He stated that he did not consider making an application for this order himself, because Mr Pitman's overall mental state and organisation had seemed to improve during his time at the AMHU, such that Dr Kappagoda wanted to see if there would be some further functional recovery that would not make such an order necessary.

45. When asked if there was anything he would have done differently in relation to Mr Pitman's care, Dr Kappagoda stated that opportunities to involve family members in

patient care were more limited than he would have liked. Nevertheless, he was of the view that the in-patient team provided Mr Pitman with medical treatment that benefited his mental state, and provided the community team with sufficient informational to enable his care to be effective after discharge.

46. In suggesting any recommendations for reform, Dr Kappagoda stated he would like to see "more guidance under what circumstances a patient's privacy can be breached in the interests of advancing their care."

Dr Florian Wertenauer

47. Dr Wertenauer is a practising psychiatrist, and was previously the director of Adult Acute Mental Health Services at The Canberra Hospital.

48. Dr Wertenauer was asked a number of questions relating to his treatment of Mr Pitman during his admission at the AMHU. A number of these questions focussed on the topic of Mr Pitman's mental state following his discharge from the AMHU. Counsel Assisting asked Dr Wertenauer whether, had Mr Pitman not agreed to participate in the SUSD program, a decision would have been made to discharge Mr Pitman straight into the community. Dr Wertenauer's evidence was to the effect that if Mr Pitman had not agreed to go to SUSD, he would not have been discharged at that point from the AMHU. Dr Wertenauer was subsequently asked whether he considered that Mr Pitman was capable of forming a plan of agreeing to participate in the SUSD program, and then discharging himself, as actually occurred. Dr Wertenauer's evidence was that Mr Pitman was capable of forming such a plan. Dr Wertenauer clarified his evidence by subsequently stating that part of the plan in discharging Mr Pitman to SUSD was to enable him to try residential rehabilitation, and that Mr Pitman needed to be willing to participate.

Mr Pawel Potapowicz

49. Mr Potapowicz is an Assistant Director of Traffic Safety at Transport Canberra and City Services. He conducted checks of Roads ACT records in relation to vehicle suicide risk at the intersection of Mount Ainslie Drive and Fairbairn Avenue in Campbell. Prior to Mr Pitman's death at that site, the rea was not known to be an intersection where there was a high risk of vehicle or crash-related suicides.

50. No action was taken in relation to this site following Mr Pitman's death on 15 March 2016. On 1 August 2017, another death occurred which was found subsequently by a Coroner to be a suicide attempt. There was also another attempted suicide at the site on 6 August 2017.

51. Following these events, temporary traffic measures were implemented on 11 August 2017. Consequently, a report was commissioned by Roads ACT for the recommendation of permanent measures. Work on the project, acting on the recommendations of the report, commenced on 12 May 2019.

52. At the time Mr Potapowicz gave his testimony, the substantive works on this intersection were mostly complete. A number of measures had been put in place for the purposes of traffic management in this area. Of note are the introduction of a permanent chicane, a deflection on the road on the approach to the intersection Fairbairn Avenue, greater street lighting, extensive line marking and a speed limit reduction.`

53. In my view these measures have satisfied public safety concerns arising out of this incident.

Submissions

54. The inquest received detailed, accurate and helpful written submissions from Counsel Assisting, Counsel for the Territory and the family of Mr Pitman. They have all been considered. There is a very clear tension between the 'least restrictive' approach of ACT Mental Health and a loving family who did not wish to see Mr Pitman repeatedly returned to isolation and poor self-care in his flat at Lyneham. There is also an understandable level of frustration at the privacy afforded to Mr Pitman.

Quality of care, treatment and supervision by the Adult Mental Health Unit (AMHU)

55. The evidence disclosed that Mr Pitman was a challenging patient to treat. He had little or no insight into his illness and appeared to have a broad ongoing capacity to entertain his delusions. The nine months that Mr Pitman spent in Fiji prior to his deportation in June 2003 would have been a frightening experience for his family, but were no doubt fuelled by delusion on his part (and a capacity to access his pension).

56. Mr Pitman was also very resistant to treatment of any type – including any attempts to get him to socialise or into residential treatment. This represented further challenges for AMHU in their attempts to increase his quality of life. My overall view is that there was a desire to improve Mr Pitman's situation, but that his resistance made those attempts almost futile.

57. Prior to Mr Pitman's release from AMHU in November 2015 the options for residential care were canvassed. He agreed to enter the Step Up Step Down program, but refused to be voluntarily admitted to Bryan Hennessey House. The witnesses agreed that forcing Mr Pitman to attend Bryan Hennessey House was possible, but would have been counter-productive for him and possibly the other residents as well. It should be remembered that Mr Pitman did not accept his diagnosis and did not believe that he was subject to the jurisdiction of ACAT, the PTO or anyone else who treated him. There was no evidence that suggested there was merit for an admission on such a basis.

58. Mr Pitman was subject to regular psychiatric review and by virtue of the PTO had to attend City Mental Health each fortnight for medication. His home was visited regularly and, amongst other things, this ensured that his living standard was monitored. As well as these face to face contacts there were multi-disciplinary reviews held for his benefit.

59. Ultimately, upon review of all of the evidence I find that there was no indication of Mr Pitman forming an intention to take his own life other than his private preparations during the day prior. Those who treated him and his family were not aware of those preparations or his intention. Mr Pitman must have intended that.

60. The extraordinary number of workers that Mr Pitman had received the care of over the years was a shock to me. Common sense would dictate that it would be preferable to have greater consistency or length of tenure in clinical managers, but this should not be taken as negative comment. Rather, it is a matter that I simply draw to the attention of ACT Health.

61. Overall, my view is that there was nothing in the quality of care treatment and supervision of Mr Pitman pre or post release from the AMHU that contributed to Mr Pitman's death.

Privacy v family notification

62. Mr Pitman's family set out why they were frustrated by a lack of information being passed to them. The most obvious example of this was when Mr Pitman was discharged from the AMHU on 16 November 2016 and they were not notified of this fact (Mr Pitman himself had directed that his family were not to be notified of this).

63. We have the benefit of being in a human rights jurisdiction and s12 of the *Human Rights Act* 2004 (HRA) applied to Mr Pitman – he had the right not to have his privacy, family, home or correspondence interfered with unlawfully or arbitrarily.

64. Clearly for Mr Pitman, ACAT had decided to waive his right to choose about whether or not he was medicated. This is very different to waiving his right to privacy.

65. The situation as at March 2016 was that Mr Pitman's family, and in particular his mother, were able to communicate one-way with those who treated Mr Pitman. That is, Mrs Pitman shared her concerns with the treatment team regularly, but they did not respond with any information about his treatment or care.

66. I have great sympathy for Mrs Pitman's position. She obviously loved her son and was also quite fearful that she would die and leave him without her strong family advocacy. She had been very generous in the initial provision of and later repairs to Mr Pitman's home. It must have been very hurtful for her to be excluded by her son from his confidential medical matters – all the more so because of her professional experience in this area.

67. All of those who treated Mr Pitman formed a view that he had capacity to make decisions about the confidentiality of his medical issues. *The Health Records (Privacy and Access) Act 1997* reinforced his position by law. In Principle 6 to Schedule B of that Act, the legislature has made it clear that compassionate disclosure cannot be made without a reasonable belief that the patient would expect disclosure and only in circumstances where the patient had not expressed a view contrary to disclosure in the past.

68. There was overwhelming evidence at the inquest of Mr Pitman's expressed desire to maintain confidentiality over his medical issues and treatment.

69. In these circumstances I can make no criticism of any failure to disclose to Mr Pitman's family.

Matters of public safety

70. Because of the changes that Roads ACT have made to the intersection of Mt Ainslie Drive and Fairburn Avenue Campbell since March 2016 I find that there is no longer a public safety issue at that intersection. There are no further public safety issues or recommendations arising from this inquest.

Cause of death

71. I confirm my earlier interim findings:

    ADRIAN NICHOLAS PITMAN (born 1961) died on 15 March 2016 from multiple injuries due to a motor vehicle collision with a retaining wall which occurred at the intersection of Mt Ainslie Drive and Fairburn Avenue, Campbell, in the Australian Capital Territory. The manner of Mr Pitman's death was suicide, in that the collision was caused by Mr Pitman with the intention of ending his own life.

Recommendation

72. That given her unique combination of health industry experience and personal experience, Mrs Pitman be expressly consulted as part of the development of the *Operational Procedure on Discharge of a Person from MHJADS Adult Inpatient Unit – Sharing Information with Carers*, discussed in the statement of Michelle Hemming at Exhibit F.

73. I direct that copies of my findings and my recommendation be forwarded to the Ministers for Health and Transport, and the Directors-General of the ACT Health Directorate and Transport Canberra and City Services, for their information and action.

74. I direct that these findings be published in due course on the Coroner's Court website, together with any response received from Government.

75. I extend my condolences to Mrs Pitman, family and friends.

DATED 14 October 2019

J M STEWART

CORONER