IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4255

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: ELAINE ELIZABETH SYKES

Delivered On:	24 September 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank VIC 3006
Hearing Date:	25 May 2015
Finding Of:	JOHN OLLE, CORONER
Appearances:	Ms Deborah Foy of counsel for Southern Health
Counsel Assisting	Sergeant David Dimsey, Police Coronial Support Unit

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

I, JOHN OLLE, Coroner having investigated the death of ELAINE ELIZABETH SYKES

AND having held an inquest in relation to this death on 25 May 2015

at the Coroners Court of Victoria sitting at Melbourne

find that the identity of the deceased was ELAINE ELIZABETH SYKES

born on 9 August 1953

and the death occurred on 10 November 2011

at the railway line between Chandler Road level crossing and Noble Park Station, VIC 3174

from:

1 (a) MULTIPLE INJURIES SUSTAINED IN COLLISION WITH TRAIN (PEDESTRIAN)

in the following circumstances:

1. An inquest into the death of Ms Sykes was held on 25 May 2015, pursuant to section 52(1) of the *Coroners Act 2008* (Vic) ('the Act'). At approximately 7.23am on 10 November 2011 Ms Sykes was struck by a Metro train, between Chandler Road level crossing and Noble Park railway station, and sustained fatal injuries.

BACKGROUND AND CIRCUMSTANCES

2. Ms Sykes was born on 9 August 1953 and was 58 years of age at the time of her death. She resided on her own at Dandenong North, and is survived by her sons, Dean and Craig, with whom she shared close and loving relationships. She has been described as a good mother and lovely person, who would do anything for everyone.[2]

3. Ms Sykes had a documented medical history of hearing impairment to the right ear (2007), Meniere's disease (right, 2007), hypercholesterolaemia (2007), Transient Ischaemic Attack (2008), haemochromatosis (2009), urinary tract infection, colitis and Acute Renal Failure. Prior to admission to Dandenong Hospital on 25 August 2011, Ms Sykes had no previous mental health history.[3]

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[2] Statement of Sharon Broughton, dated 8 February 2012, Coronial brief, 9.

[3] North Dandenong Medical Centre medical records of Elaine Sykes, Coronial brief, 81; Statement of Dr Llina Tzolova, consultant psychiatrist at Southern Health, dated 3 April 2012, Coronial brief, 14 (Exhibit B).

4. Ms Sykes had a very good relationship with her sons and former husband, and would visit them two to three times a week. Approximately four months prior to her death, Ms Sykes mental and physical health began to deteriorate. Her physical appearance worsened, she had lost a significant amount of weight and was reporting to her family that her mind 'wasn't right', that she could not focus on anything and that nothing seemed or felt real. She began to struggle with everyday chores, could not shower and gave her keys to her son Dean Sykes ('Dean'), due to concerns that she should not be driving. In the month prior to Ms Sykes being admitted to Dandenong Hospital, the Sykes family twice attempted to have Ms Sykes medically reviewed. Assessments were conducted by Ambulance Victoria paramedics, and tests were conducted at Dandenong Hospital, both of which appeared normal. In the week prior to Ms Sykes admission to Dandenong Hospital, Dean became concerned about his mother's welfare, as she had not drank or eaten for at least five days. With the assistance of Ms Sykes friend Sharon Broughton, Ms Sykes was admitted to Dandenong Hospital on 25 August 2011. [4]

5. Upon admission to hospital, Ms Sykes was initially admitted under the medical team with acute renal failure for rehydration and treatment of per rectum bleeding. Medical consultation was sought from gastroenterology, neurology and psychiatric teams. Blood tests, urine tests and a CT scan of the brain were normal.[5] On 30 August Ms Sykes was recommended to receive involuntary psychiatric treatment, which was confirmed on 31 August, at which time Ms Sykes was considered to be severely depressed and presenting a significant risk to herself, in the context of refusing treatment. On 1 September Ms Sykes was transferred to the mental health service and was admitted to the Acacia Mental Health Unit 1. A short time after admission Ms Sykes was transferred to the surgical unit for investigation of rectal bleeding and colitis. On 7 September Ms Sykes was reviewed by a Clinical Liaison Team consultant psychiatrist and was discharged from involuntary patient status, as she was cooperative and accepting of treatment. She was transferred back to the mental health service on 16 September.[6]

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[4] Statement of Dean Sykes, dated 22 November 2011, Coronial brief, 4-5 (Exhibit A).

[5] Southern Health Mental Health Services Discharge Summary, dated 2 November 2011, Coronial brief, 147; Statement of Dr Llina Tzolova, above n 3, 14.

[6] Statement of Dr Llina Tzolova, consultant psychiatrist at Southern Health, dated 5 December 2012, Coronial brief, 15a (Exhibit C).

6. During her psychiatric admission at the Acacia Mental Health Unit 1, Ms Sykes was under the care of consultant psychiatrist Dr Llina Tzolova. In her role, Dr Tzolova would supervise the treatment of her patients, assess the patients on admission and discharge, review them on a weekly basis, or more frequently when necessary, and lead clinical review with the multidisciplinary team in discussing and updating each patient's management plan.[7] Dr Tzolova reported that during the first weeks of admission Ms Sykes frequently expressed negative themes and needed constant prompts to shower, use the toilet, eat and drink, stating 'my mind is not right'. As at 19 September Dr Tzolova thought that Ms Sykes' presentation may have reflected possible early dementia due to haemochromatosis. Consequently, a referral was arranged for Ms Sykes to be assessed by a specialist clinic at Royal Melbourne Hospital, additional background was obtained from Ms Sykes general practitioner and a family meeting was requested.[8]

7. A family meeting was held with Dean, Dean's girlfriend, Ms Sykes former husband Owen Sykes and Dr Parkhurst on 22 September. The hospital was informed by the family that in the previous 12 months Ms Sykes had not been depressed, did not appear to have low mood, had no psychiatric history and had no family history of dementia. She had not been eating or drinking for approximately 5 days, and she was described as a very different person in those weeks than she had been before. Ms Sykes family was informed of the clinical care and management, the intention to conduct further cognitive assessment and the possible diagnoses of depression and early dementia, secondary to haemochromatosis.[9]

8. Over the following days Ms Sykes reported that her sleep was not disturbed and her energy levels were improving. She required only minimal assistance with daily care and her appetite had improved. She expressed concern about her ability to cope at home, but expressed hope for the future. On several occasions during admission Ms Sykes described anxiety and fear, but could not explain the rationale, often stating 'it is not going to work'. She indicated feeling helpless and that she could not do a thing about it, consistently denied suicidal thoughts, was frustrated by her feelings and demonstrated a significant degree of

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[7] Statement of Dr Llina Tzolova, above n 3, 14.

[8] Statement of Dr Llina Tzolova, above n 6, 15b.

[9] North Dandenong Clinic medical records of Elaine Sykes, dated 22 September 2011.

insight. By 29 September it was identified that Ms Sykes deficits were in memory and executive function.[10]

9. On 3 October a family meeting was held with Dean, a social worker, an occupational therapist, a nurse and Dr Parkhurst. At this stage Ms Sykes was expressing a strong desire to be discharged. During the meeting the family was informed that Ms Sykes was independent with living activities, was eating all meals, was alert and orientated, was having an occupational therapy assessment and some cooking lessons, but was still demonstrating some short term memory issues and problems with executive function. Treating clinicians informed that possible diagnoses included dementia, depression and a question of prolonged delirium.[11] Treating clinicians held concerns that Ms Sykes was demonstrating minimal insight into her cognitive difficulties. Ms Sykes progress and deficits were discussed with Dean at the meeting and a detailed discussion took place regarding possible discharge destinations, including returning home, Supported Residential Services ('SRS') or Aged Care Assessment Service ('ACAS') placement. During a further review of Ms Sykes on 5 October, subject to a second opinion, it was considered appropriate to continue discharge planning on the basis that Ms Sykes would return to her home. Although Ms Sykes still evinced cognitive impairment, on 7 October her health state continued to show improvement and she expressed hope for the future and getting back to normal.[12]

10. On 19 October a clinical review was undertaken which showed significant improvement. Ms Sykes was demonstrating independence in self-care and improvement in planning and problem solving. It was anticipated to discharge Ms Sykes on 21 October, subject to liaison with Dean and ongoing review. On 20 October Dean was contacted by treating clinicians and stated that he was not happy for his mother to be discharged home, as he did not think she was well enough. On 21 October Dean called Dr Parkhurst and informed that he would be unable to support his mother at home for the next two weeks due to work and study commitments, and because he needed time to return the state of his mother's house to how it was before she was admitted to hospital; before he and his girlfriend had moved in. Ms Sykes was reported to be very distressed that she was unable to go home. A meeting was arranged with Dean on 24 October, which he failed to attend. He contacted the hospital on

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[10] Ibid.

[11] North Dandenong Clinic medical records of Elaine Sykes, dated 3 October 2011.

[12] Statement of Dr Llina Tzolova, above n 6, 15c.

25 October requesting to speak to his mother's doctor, and was informed that his mother was ready for discharge and to call the ward the following day. When Dean did not phone the hospital, a further meeting was arranged for 27 October, which Dean attended. Treating clinicians discussed with Dean that his mother was thought to be ready for discharge home by the treating team, and Dean was informed that referrals had been made for neuropsychology and neuropsychiatry assessments which would be undertaken on an outpatient basis. It was reiterated that Ms Sykes was now independent in self-care, had no current demonstration of depressive symptoms or suicidal ideation, and had demonstrated an ability to act safely, and successfully complete tasks, such as cooking and shopping, without difficulty. Treating clinicians also discussed supports put in place by occupational therapists with respect to daily routine. It was reported that Dean expressed concerns that his mother would be unable to care for herself at home, and that he felt she was suicidal and would 'sit in a corner and die at home'. Dr Parkhurst informed Dean that his mother had not expressed any such thoughts or depressive symptoms, and reiterated that she was enthusiastic about returning home. The notes record:

> Dean stating unable to support Elaine at home. Currently he has exams, has lost his job and thinking of moving to WA soon. Helping her is out of the question. Elaine's other son is not willing to help. Dean wanting alternate discharge destination. Best place for her is a SRS.[13]

11. Staff stated that they would consider the matters raised by Dean and would speak to him the following day. Four attempts were made to contact Dean. On 28 October Dr Parkhurst spoke to Dean about the possibility of SRS placement. Ms Sykes felt that her son may not understand how much it costs to reside in SRS accommodation. On 2 November Dean had a telephone conversation with a social worker, who discussed the plan to discharge Ms Sykes. Dean informed that the next few days was not a good time to discharge his mother, due to a lot of plans going on. He was informed that this was not a reason to delay discharge. Dean stated that he needed time to move his belongings out of the house and advised that he could not live with his mother and that hospital staff had to accept this. He stated that he felt his mother would not cope and would sit on the lounge chair and die. The medical notes report that the social worker explained that the occupational therapist completed a thorough assessment and felt that Ms Sykes had the skills to live at home and did not require alternative housing, and that Dean stated that he would not let her live in one of those places

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[13] Ibid.

anyway due to them being over $300 per week.[14] Discussions took place with Ms Sykes, who stated that she wanted to be discharged, did not want to go to Prevention And Recovery Care Services ('PARCS') and that if she was not discharged by staff to her son that she would discharge herself.[15] In the afternoon on 2 November a family meeting was held with treating clinicians, Dean, Dean's girlfriend and Ms Sykes. They discussed the improvements made and that Ms Sykes was ready for discharge. They also raised that the likely diagnosis is a mood disorder secondary to a medical condition, discussed ongoing haemochromatosis management and Royal Melbourne Hospital ('RMH') follow-up. Medical information was provided to Dean, although he stated that he did not want to know anything about it. Details of Ms Sykes current medications were also provided to Dean, and he was given contact details for the psychiatric triage service ('PTS') and RMH neuropsychiatry, and was advised to contact PTS or Ms Sykes' general practitioner if he had any concerns about his mother's mental state. A detailed discharge summary was prepared and forwarded to Ms Sykes' general practitioner on 2 November[16] and Ms Sykes was discharged at 2.10pm in the company of Dean. During the family meeting it was observed that Dean was caring and supportive, rather than hostile, toward his mother. He informed that he would be staying with her for a few days. Dr Tzolova reported that at this stage treating clinicians decided that CATT involvement was not required.[17]

12. Dr Tzolova reported that at the time of discharge Ms Sykes physical and mental health problems had been addressed. Her colitis and urinary tract infection had been treated, she did not display symptoms of her other chronic diseases, her weight had increased from 38.8kg to 46.6kg, her depressive symptoms had improved and her cognitive impairment decreased from 11/30 to 27/30 on MMSE, with residual deficits in memory and executive function, for which she was referred for further assessment and diagnostic clarification. Prior to discharge Ms Sykes was assessed as low risk, as had been her rating for six weeks prior to discharge. She had no depressive symptoms, delusions, perceptual disturbances, suicidal thoughts or thoughts of harm to others. She was oriented and requested to be discharged. Given that prior to the last family meeting treating clinicians believed Ms Sykes had limited family support, Ms Sykes was offered a continuation of live in direct care in

[14] North Dandenong Clinic medical records of Elaine Sykes, dated 2 November 2011.

[15] North Dandenong Clinic medical records of Elaine Sykes, 234.

[16] North Dandenong Clinic medical records of Elaine Sykes, Coronial brief, 147.

[17] Statement of Dr Llina Tzolova, above n 6, 15c-15d.

step-down unit PARCS and temporary placement in a SRS, however both Ms Sykes and Dean declined. She was discharged with Aspirin 110mg, Betahistine 16mg, Atorvastatine 10mg, Cholecalciferol 1000iu and mirtazapine 30mg.[18]

13. On 31 October an Occupational Therapy Living Skills Assessment was conducted which demonstrated that Ms Sykes had the skills and ability to live independently. In order to assist with daily activities, Ms Sykes was provided with medication management and daily routine plans. A post-discharge follow-up call was made to Ms Sykes by an occupational therapist, with no reported issues or change in mental state, and Ms Sykes was reminded about her general practitioner appointment.[19] Ms Sykes did not attend upon her general practitioner between the date of discharge and her death.[20]

14. Ms Sykes returned home with Dean, and he stayed with her until 6 November. He reported that when Ms Sykes was at home she was really confused, agitated and unsure about a lot of things. As soon as she returned home she pulled everything out of the cupboards and re-arranged things, but could not remember where everything went. Dean stated that his mother 'pretty much went through the whole house and tried to do the same thing' which was 'really weird' and out of character for her. Dean and his girlfriend provided Ms Sykes meals, and after eating she would become upset and state that she should not have eaten it. On 6 November Dean and his mother went food shopping and Ms Sykes became distressed and upset by the products Dean was placing in the trolley, stating 'that's dangerous' and 'you're playing with my life here'. When Dean took her home she had a 'bit of a tantrum' as he had moved her car, and he told her to call if she needed anything. That evening Dean moved back to his fathers residence.[21]

15. On 8 November Ms Sykes rang Dean and informed that she got her car fixed and wanted him to come around and look at the radio and TV in the car. Dean stated that he would look at it the following day, however due to work commitments he forgot. On 10 November

[18] Ibid 15d-15e; Supplementary statement of Dr Llina Tzolova, consultant psychiatrist at Southern Health, dated 5 October 2013, Coronial brief, 15f (Exhibit D); Statement of Constable Deborah Reavley, dated 22 May 2012, Coronial brief, 28.

[19] Statement of Dr Llina Tzolova, above n 6, 15d-15e; Medical notes of Occupational Therapist (Exhibit E).

[20] Letter of Dr John Bialyiew, General Practitioner at North Dandenong Clinic, Coronial brief, 29-30.

[21] Statement of Dean Sykes, above n 4, 7.

Dean observed his mother's car parked near his home and found her car keys between the door and flyscreen, which he presumed was so that he could look at the car.[22]

16. At approximately 7.23am on 10 November 2011 Ms Sykes was struck by a Metro train, between Chandler Road level crossing and Noble Park railway station, and sustained fatal injuries.

THE COLLISION

17. Metro Trains Senior Investigator Laurie Lacorcia reported that at approximately 7.23am on 10 November 2011 the 08:18 hours Dandenong to Flinders Street Comeng train, Describer No 4648, was travelling generally west when leading carriage 375M struck a female 100 metres east of Noble Park Station.

18. Personnel records indicate that Train Driver Anthony Ralph was appropriately qualified and medically fit to operate an electric train. He was not on any medication at the time of the collision, and reported that he had a good night's sleep the previous night and felt well rested. Train Driver Ralph reported that the train traversed the Chandler Road level crossing and a subsequent bridge over the creek as it made its way toward Noble Park Station. The weather was fine and visibility was clear. He estimates that the train was travelling at approximately 70-80km/h at the time. As the train neared the station Train Driver Ralph slightly reduced the speed of the train, in readiness to stop at the station. At this location the running line is flanked by grass embankments which contain scattered trees and shrubs, and is fenced off on both sides. Train Driver Ralph reported that it was at this time that he observed a person come out from behind the bushes on the left hand side, approximately 100m from the train, and walk on an angle toward the railway track, with their back to the train. Train Driver Ralph assumed the person was taking a short cut across the tracks and immediately sounded the whistle and applied the brake to full service. Train Driver Ralph then observed the person turn around, look at the train and continue onto the railway track, where the person then stopped in the middle of the track, turned to face the train and remained in that position, before the train made contact with Ms Sykes. Train Driver Ralph stated that while under emergency braking, the train continued to travel and came to a stand

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[22] Ibid.

approximately 70 metres beyond the point of impact. Train Driver Ralph then immediately contacted Metro train control to report the incident.[23]

19. Investigator Laurie Lacorcia reported that the maximum track speed in the location where the collision occurred is 80 km/h. The train data logger indicates that train 4648 was travelling at 68km/h when the train whistle was sounded, and was approximately 221 metres prior to coming to a stand, followed by a full service brake application one second later when travelling at a speed of 64km/h and approximately 183 metres prior to coming to a stand. The train was travelling at 58km/h when the emergency brake was activated. The report reveals that the train travelled 138 metres from the time of the emergency brake application to the time the train came to a stand. The headlights were activated on low beam, as per operational requirements. Based on measurements taken at the scene, the data logger reading suggests that the emergency brake application was made approximately 72.5 metres prior to the point of impact. The expected deceleration and maximum stopping distances formula for a Comeng train travelling at 58km/h and under emergency brake application in dry weather and on a level gradient is up to 169 metres. The train therefore came to a stand well within the maximum stopping distance. Had the brake been applied to the emergency position at the time of engaging the brake to the full service position the maximum stopping distance formula suggests that the train would have required up to 204 metres to come to a stand. Given the measurements taken at the scene, the collision would still have occurred.[24]

20. At approximately 8.30am on 10 November 2011 a preliminary breath test was conducted on Train Driver Ralph by Senior Constable Caroline Gillespie, which returned a negative result.[25]

POST-MORTEM INSPECTION AND REPORT

21. A post-mortem inspection and report was undertaken by Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine. Dr Lee reported that the post-mortem computed tomography scan and examination showed injuries consistent with the clinical history.

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[23] Statement of Train Driver Anthony Ralph, dated 31 January 2012, Coronial brief, 18-19.

[24] Metro Trains Melbourne Incident Report prepared by Senior Investigator Laurie Lacorcia, dated 14 February 2012, Coronial brief, 20-24.

[25] Statement of Senior Constable Caroline Gillespie, dated 23 March 2012, Coronial brief, 17; Metro Trains Melbourne Incident Report, above n 24, 21.

22. Toxicological analysis of blood did not detect alcohol or common drugs or poisons.

23. Dr Lee reported that the cause of death is 1(a) Multiple injuries sustained in collision with train (pedestrian).

PURPOSE OF THE CORONIAL INVESTIGATION

24. The primary purpose of the coronial investigation of a reportable death[26] is to ascertain, if possible, the identity of the deceased, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[27] An investigation is conducted pursuant to the *Coroners Act 2008* (Vic)[28] and the outcome of this part of my investigation is included in this finding.

25. Coroners are also empowered to report to the Attorney-General on a death they have investigated: the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[29] This is referred to as the 'prevention role' of the coroner.

26. It is not part of a coroners role to lay or apportion blame. As Calloway JA espoused in *Keown v Kahn* (1999) VR 69:

> In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was a breach of a recognised duty, but that is the only sense in which para. (e) mandates an inquiry into culpability. Adopting the principal recommendation of the Norris Report, Parliament expressly prohibited any statement that a person is or may be guilty of an offence. The reasons for that prohibition apply, with even greater force, to a finding of moral responsibility or some other form of blame: the proceeding is inquisitorial.[30]

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[26] Section 4 of the *Coroners Act 2008* (Vic) requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death includes all deaths that appear 'to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury. Mr Ogon's death falls within this definition.

[27] *Coroners Act 2008* (Vic) s 67.

[28] Hereafter referred to as 'the Act'.

[29] *Coroners Act 2008* (Vic) ss 72(1), 72(2) and 67(3).

[30] *Keown v Kahn* (1999) VR 69, 76.

27. Callaway JA observed that it is the coroners role to seek to establish the facts, set them out and for others, if they wish, to draw legal conclusions. An amendment to *Coroners Act 1985* (Vic) in 1999 repealed the obligation on a coroner to make a finding as to persons/other entities who 'contributed' to the death, due to the connotation that attached to that concept; a connotation of fault, blame or culpability. The 2008 Act similarly makes no reference to such an obligation. However, the removal of the obligation does not preclude a coroner from making a finding of contribution, in appropriate cases.

28. The *Briginshaw*[31] standard of proof is applicable to findings of fact in this Court. As Dixon J espoused:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proof, indefinite testimony or indirect inferences.[32]

THE EVIDENCE

29. This finding is based on all the investigation material comprising the coronial brief of evidence, all material obtained after the provision of the brief, the statements and evidence of those witnesses who appeared at the inquest and any documents tendered through them, other documents tendered through counsel, and submissions made by counsel.

30. The following witnesses gave *viva voce* evidence at the inquest:

    a) Dean Sykes, son of Ms Sykes; and

    b) Dr Llina Tzolova, Consultant Psychiatrist at Southern Health;

ISSUES INVESTIGATED AT INQUEST

31. At the commencement of the inquest, it was evident that most of the facts about Ms Sykes' death are known and without dispute, including her identity, the medical cause of her death and aspects of the circumstances of her death, including the place of her death.

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[31] *Briginshaw v Briginshaw* [1938] 60 CLR 33.

[32] *Briginshaw v Briginshaw* [1938] 60 CLR 33 [362]-[363].

32. There were issues identified regarding discharge planning that required further exploration at inquest, including:

a. The appropriateness of the decision to discharge Ms Sykes from hospital on 2 November 2011; and

b. The provision of community based support to Ms Sykes upon discharge from hospital.

Decision to discharge Ms Sykes

Notification of intention to discharge Ms Sykes

33. Dean Sykes gave evidence that he was only aware that his mother was going to be discharged on 2 November 2011, after attending a meeting with treating clinicians on that day. However he conceded that the clinicians did indicate during a phone call earlier that day that his mother would 'more than likely' be discharged.[33]

34. Throughout his mother's admission Dean had, on multiple occasions, raised concerns about his mother being discharged. On 20 October he informed treating clinicians that he was not happy for his mother to be discharged home, as he did not think she was well enough. On 27 October it was reported in medical notes that during a family meeting Dean expressed concerns that his mother would be unable to care for herself at home, and that he felt she was suicidal and would 'sit in a corner and die at home'. On 2 November Dean again raised concerns with treating clinicians that he felt his mother would not cope and would sit on the lounge chair and die.

35. The comprehensive and contemporaneous medical records and notes demonstrate that treating clinicians engaged with Ms Sykes' family extensively, both over the phone and in person, in providing comprehensive updates on her clinical care and management, and discussing possible diagnoses, potential readiness for discharge and possible discharge destinations.[34] I am satisfied, after reviewing the evidence, that Ms Sykes' family was well informed about the real possibility of her being released on 2 November. There were a number of occasions where treating clinicians indicated that Ms Sykes was ready for discharge. As early as 3 October discharge planning was discussed between treating clinicians and Dean, including possible discharge destinations such as returning home,

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[33] Inquest transcript, 4-5.

[34] See Inquest finding, 5-7.

Supported Residential Services ('SRS') or Aged Care Assessment Service ('ACAS') placement. Towards the end of Ms Sykes' admission, treating clinicians were forthcoming in their communication to Dean that his mother was ready for discharge. This information was clearly articulated at a family meeting on 27 October, whereby treating clinicians discussed with Dean that his mother was thought to be ready for discharge home by the treating team, and informed that referrals had been made for neuropsychology and neuropsychiatry assessments, which would be undertaken on an outpatient basis. It was reiterated that Ms Sykes was now independent in self-care, had no current demonstration of depressive symptoms or suicidal ideation, and had demonstrated an ability to act safely, and successfully complete tasks, such as cooking and shopping, without difficulty. Treating clinicians also discussed supports put in place by occupational therapists with respect to daily routine. Nonetheless, after Dean raised concerns that he believed his mother was suicidal and held concerns that she would 'sit in a corner and die at home' the treating clinicians listened to his concerns, informed that they would consider them overnight and contact him the following day, attempted to do so (albeit unsuccessfully) until 28 October and continued to keep Ms Sykes in their care until 2 November. On this basis, I am satisfied that Ms Sykes readiness for discharge was clearly communicated to the Sykes family, in a timely and appropriate manner leading up to 2 November.

Decision to discharge Ms Sykes

36. Dean had, on a number of occasions, clearly articulated his concerns that his mother may be suicidal or would not cope and sit in her house and die. It is important to note that concerns about inability to cope and concerns about suicidality are entirely separate matters for consideration.

37. Dr Tzolova gave evidence that Ms Sykes was assessed for risk three times a day.[35] Prior to discharge Ms Sykes was assessed as low risk, as had been her rating for six weeks prior to discharge. At the time of discharge Ms Sykes physical and mental health problems had been addressed. Her colitis and urinary tract infection had been treated, she did not display symptoms of her other chronic diseases, her weight had increased from 38.8kg to 46.6kg, her depressive symptoms had improved and her cognitive impairment decreased from 11/30 to 27/30 on MMSE, with residual deficits in memory and executive function, for which she was referred for further assessment and diagnostic clarification. She had no depressive

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[35] Inquest transcript, 54.

symptoms, delusions, perceptual disturbances, suicidal thoughts or thoughts of harm to others. She was oriented and requested to be discharged.[36]

38. Dr Tzolova stated that she did not ever see evidence that Ms Sykes would intentionally take her own life, and said that it was not a concern at all for treating clinicians in the short-term, as Ms Sykes always denied suicidal thoughts, did not have behavioural traits of a person who wanted to manipulate with aspects such as not taking medication and hiding it to overdose, was quite compliant with treatment, talked about the future when discussing her discharge plan and appeared future focused. Examples of Ms Sykes having future focus included being concerned about the cost of SRS and how she would be able to afford it, and completing her tax return.[37] Dr Tzolova gave evidence that an expectation of whether Ms Sykes was intending, or was developing a plan, to end her own life was very far from her mind. Dr Tzolova stated that the risk was low and there was no 'acute risk', 'we didn't think about the risk at all'.[38] Dr Tzolova did not get a sense that Dean believed his mother would intentionally end her own life; she believed that he expected that his mother would deteriorate the same way that happened previously, 'just gradually, not – neglecting herself and as a result, worsening her conditions'.[39] On 2 December during the pre-discharge meeting treating clinicians informed Dean that the likely diagnosis is a mood disorder secondary to a medical condition. At Inquest, Dr Tzolova stated that in order to provide a pure psychiatric diagnosis clinicians have to exclude that the condition is due to any other medical conditions, and that this was the reason their diagnosis was secondary to medical conditions:

> We are suspecting depression and also we are thinking that it could be early signs of dementia, quite often depression or psychosis could be early sign of dementia and that's – kind of that was prompting us to think about the long-term what we can do for [Ms Sykes]. We didn't have concerns about current episodes. No risk, improvement in mental state, managing, so the concern was longer term.[40]

39. In explaining that there was no acute risk and that the concern was longer term, Dr Tzolova gave evidence that:

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[36] Statement of Dr Llina Tzolova, above n 6, 15d; Supplementary statement of Dr Llina Tzolova, above n 18, 15f.

[37] Inquest transcript 56, 60.

[38] Inquest transcript, 47, 59.

[39] Inquest transcript, 65-6.

[40] Inquest transcript, 58-9.

> With transient ischaemic attacks, [Ms Sykes] had atrophy of the brain with these mini-strokes she had and haemochromatosis we were expecting that she'll develop dementia and it was a matter of time. Again it's hypothesis our working diagnosis but we wanted to make sure that we connect her early with the services who could provide support for these people...[41]

40. Prior to discharge a comprehensive assessment was undertaken by an occupational therapist, in the context of intensive involvement and a thorough assessment of Ms Sykes capacity to look after herself at home.[42] She had demonstrated an ability to act safely and successfully complete tasks, such as cooking, shopping and crossing roads without difficulty. The occupational therapist consequently formed the view that Ms Sykes had the skills to live at home.

41. Dean gave evidence that on the date of discharge he asked his mother's treating clinicians what to do if his mother had another outburst, or if the same thing happens how he would get her re-admitted and he was informed 'take her to your local [general practitioner] and go from there'. He stated that there was no discussion about who was going to manage his mother once she was discharged, stating 'I think... they wanted me to be a full time carer for her which at the present time I was a fourth year apprentice, I had my exams, working seven days a week, it was just out of the question for me to be a full time carer which I did state to them'.[43] Dean stated that he was given no other information in relation to CATT teams or other services, and was not made aware of visits to other hospitals or testing.[44]

42. It appears from the comprehensive medical notes of the family meeting on 2 November, and the discharge summary, that discharge planning as to medical appointments, medication provided to Ms Sykes and her Centrelink application was discussed with Dean. Dr Tzolova gave evidence that although she did not see Dean receive a psychiatric triage service ('PTS') card that usually treating clinicians hand a PTS card, which lists the PTS number if there are any concerns or change to agreed care plans, or the PTS phone number to the patients or the family.[45] I acknowledge however, that this may well have been a stressful, confusing and

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[41] Inquest transcript, 43.

[42] The nature of the involvement between Ms Sykes and the occupational therapist and the assessment by the occupational therapist will be discussed in further detail later in this finding

[43] Inquest transcript, 8.

[44] Inquest transcript, 8-9.

[45] Inquest transcript, 67.

overwhelming experience for Dean, and that receiving this information orally may have been difficult to remember at the time and to recall at inquest. Dr Tzolova acknowledged at inquest that after hearing Dean's evidence he may not have understood everything about the diagnosis and what treating clinicians were trying to do, and stated that maybe if it was written down it would help.[46]

43. Ms Sykes had been admitted to the Acacia Unit for a total of 47 days. Dr Tzolova stated that this was much longer than usual for an inpatient stay, as it was a very complex case involving medical conditions such as acute renal failure, haemochromatosis and delirium, a psychiatric presentation which was not clear as to whether it was depression or dementia, and social issues.[47] Dr Tzolova stated that mental health services are required to treat a patient in the least restrictive manner possible. Even if she was troubled about Ms Sykes going home, Dr Tzolova stated that she could not have made Ms Sykes an involuntary patient on a Community Treatment Order as she did not meet the criteria under the *Mental Health Act 1986* (Vic); she was aware of her condition, she was accepting of treatment and she was willing to continue to accept treatment. Dr Tzolova gave evidence that clinicians had to negotiate quite often with Ms Sykes to stay a little bit longer, 'a few more days, a few more days' but that if she wanted to discharge herself, clinicians could not do anything, as she was a voluntary patient. Dr Tzolova formed the view that if Ms Sykes had not been discharged on 2 November, she would have discharged herself.[48]

44. I accept the evidence of Dr Tzolova that Ms Sykes was a voluntary patient who could self-discharge at any stage, due to not meeting the criteria under the *Mental Health Act*. I accept that assessments of Ms Sykes' physical and mental health demonstrated that she was ready for discharge and was a consistently 'low risk' in the six weeks leading up to discharge, and that she had stayed as an inpatient for a longer than usual period of 47 days. I appreciate that it would have been inappropriate, and contrary to the provisions of the *Mental Health Act* in relation to treating a patient in the least restrictive manner, to hold Ms Sykes as an inpatient against her will, as she was a voluntary patient who was compliant and assessed as low risk. I further accept that while Ms Sykes was a voluntary patient in the Acacia Unit, outside the concerns raised by Dean, there was no evidence to suggest that Ms Sykes had suicidal

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[46] Inquest transcript, 51.

[47] Inquest transcript, 56-7.

[48] Inquest transcript, 63-4.

ideations or intent, and that consequently at no stage did Ms Sykes' treating clinicians consider Ms Sykes at risk of taking her own life. On this basis, the decision to discharge appears reasonable and appropriate.

Provision of community based support to Ms Sykes post-discharge

45. Prior to discharge, a comprehensive assessment of Ms Sykes capacity to independently look after herself at home was undertaken by an occupational therapist. At Inquest, Dr Tzolova gave evidence that this was a special assessment tool that allows the occupational therapist to assess if people are able to live independently. Upon review of the evidence, the assessment appears to be thorough and comprehensive. Ms Sykes appears to have attended occupational therapy group programs on 4, 10, 14, 18, 19 and 20 October and engaged in activities such a walking to the shops, buying groceries, addressing road safety issues, participating in sports and cooking, with 'nil issues'. Ms Sykes had demonstrated an ability to act safely, and successfully complete tasks without difficulty. The occupational therapist consequently formed the view that Ms Sykes had the skills to live at home.

46. Dr Tzolova gave evidence that the first and most preferential option was for Ms Sykes to reside at PARCS post-discharge, where a patient would reside for an average length of three weeks, or four weeks if there were concerns. Dr Tzolova stated that clinicians attempted to urge Ms Sykes to accept referral to PARCS, as it was a 24-hour step-down unit that would reinforce living activities such as shopping, going out, planning and taking medications. She stated that it would be helpful for someone such as Ms Sykes, as staff monitor the residents daily functioning and observe behaviour such as if the patient has initiated tasks and eaten without prompting, and if staff have any concerns they meet with the family and urge for SRS or returning back to hospital. However, as the medical records note, Ms Sykes and Dean refused the offer and Dr Tzolova acknowledged that to reside at PARCS the patient has to agree and cannot be forced to reside there.[49]

47. The next preference of the treating clinicians was SRS, if Ms Sykes did not have adequate family support. Dr Tzolova gave evidence that during Ms Sykes admission an application was made to Centrelink for Ms Sykes to become a recipient of the disability support pension, as the pension covers the cost of SRS accommodation, which is inclusive of food,

[49] Inquest transcript, 35, 42-4.

medication management and utilities. Again, Ms Sykes and Dean refused the offer of SRS, due to the cost associated with residing there.[50]

48. Dr Tzolova gave evidence that Ms Sykes residing at home with the support of her family was preferential to CATT involvement. She stated that CATT follow-up is usually five to seven days post-discharge and is completed by phone or in person. She stated that they have a snapshot and have 15 minutes assessing the patient based on the patients responses. Dr Tzolova also stated that although CATT clinicians are 'very, very experienced' they are different people every day, as opposed to family.[51] Dr Tzolova was pleased that Dean offered to stay with his mother for a few days, as family are around for a lot longer than CATT. Dr Tzolova stated:

> CATT…don't have the baseline. I mean the baseline will be discharge and they see if there is any deterioration in mental state but they can't assess the functioning that much, they have to ask the patient and she has to tell them, 'yes, I had lunch, I had dinner, I cooked or I washed the dishes' but it's based on her report. While the family is there they can say, 'yeah she had lunch but we had to prompt her. We had to put the plate in front of her and encourage, so it's a huge difference…because the family knows the person.[52]

49. Ms Sykes was also offered a referral to the Eastern Region Mental Health Services (ERMHS). This is a service which supports people with a mental illness by staff assisting their clients with daily activities, such as shopping and appointments. She was also offered a referral to Meals on Wheels. However, Ms Sykes refused these referrals, which was her right.[53]

50. Dr Tzolova stated that referrals were also made to the RMH for neuropsychology and neuropsychiatry assessments, as there are specialists in that field at RMH and they have a network referring people with cognitive deficits to dementia services, which provides access to placement.[54] Dr Tzolova stated that their long-term management plan was to be followed by the neuropsychiatric unit at RMH because they have access to a lot of accommodation and supports for people with cognitive deficits.[55] Unfortunately, it appears that the

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[50] Inquest transcript, 43.

[51] Inquest transcript, 39, 62.

[52] Inquest transcript, 39, 62.

[53] Inquest transcript, 36.

[54] Inquest transcript, 43-4, 58.

[55] Inquest transcript, 35.

appointment was booked for the week after Ms Sykes had passed away.[56] An Aged Care Assessment Service ('ACAS') assessment was also considered, as one facility accepted patients under the age of 65. At Inquest Dr Tzolova stated, 'but again [ACAS] was planned for the future because if we kind of put this in motion in a few months they'll accept [Ms Sykes] in Royal Melbourne to be in their caseload and their case so they'll be looking after Ms Sykes and they'll be providing services we can't provide'.[57]

51. Guardianship was not considered by Ms Sykes treating clinicians. Dr Tzolova stated that she has employed guardianship only a few times and in circumstances where the persons have grossly impaired executive function and the family interests are in conflict, their interests are not in the interests of the patient, or there is no family;[58] none of which circumstances apply in this matter.

52. Dr Tzolova gave evidence that treating clinicians decided CATT involvement was not required.[59] Dr Tzolova stated that CATT involvement was initially considered, as treating clinicians were concerned about Ms Sykes family support, were questioning Dean's motives, as he was not responding to their calls and was asking them to lie, and they were unsure if they could rely on him. However after meeting with Dean, Dr Tzolova stated that it appeared that Dean was a very caring person and not someone who would neglect his mother. She acknowledged that he had a lot on his plate during that time and that was the reason he was avoiding calls or not being able to come all the time. Dr Tzolova stated that the CATT team could step in if Dean was not there to at least have a snapshot everyday. However if Dean was there, there was no need for CATT, because the information and feedback they could get from him is much more available and correct compared with the snapshot provided by CATT.[60] When asked what was going to happen after two or three days when treating clinicians knew Dean was leaving, Dr Tzolova stated:

> Basically, if someone is not well and can't manage [sic], in the – after discharge, in the next three or four days, they'll have a relapse, they'll stop eating or drinking. If they are pretending – because Mr Sykes concern was that Ms Sykes was presenting in a certain

[56] Inquest transcript, 36, 81.

[57] Inquest transcript, 58.

[58] Inquest transcript, 71.

[59] Supplementary statement of Dr Llina Tzolova, consultant psychiatrist at Southern Health, dated 5 October 2013, Coronial brief, 15f.

[60] Inquest transcript, 45-6.

> ways…to be discharged and that's the reason we were thinking it will be very helpful because if he's working long hours, not at home and if she's really unwell and just presenting well, then she could deteriorate and he could bring her in the hospital.[61]

53. Dr Tzolova gave evidence that if Dean was not there and Ms Sykes did not have family support, 'I would have definitely given her a choice, you stay in hospital, you go to PARCS until I'm sure that everything is fine but again it's – if she says no that's a big, big challenge'.[62]

54. At inquest, Dr Tzolova agreed that in hindsight, knowing Dean would be gone in a couple of days, and knowing he had expressed concerns about his ability to care for his mother and her capability to survive in the home, treating clinicians could have at the very least provided support whether it be ERMHS or CATT, to ensure everything is okay, and that if everything was okay in two, three four weeks that they would review it again.[63] I accept that in relation to ERMHS the patient has to agree and cannot be forced to accept their services, however the same cannot be said for CATT services.

FINDINGS

55. I find that the identity of the deceased is Elaine Elizabeth Sykes.

56. I am satisfied, having considered all of the evidence before me, that no further investigation is required. I am satisfied that there is no evidence to suggest the involvement of any other person in this death.

57. I acknowledge the difficulty for health clinicians to manage and treat individuals with complex physical and mental health issues, as was present in this matter.

58. The evidence satisfies me that the medical management and care provided by Southern Health and Ms Sykes general practitioner was reasonable and appropriate in the circumstances, having regard to the complexities involved.

59. I am satisfied that Ms Sykes' readiness for discharge was clearly communicated to the Sykes family, in a timely and appropriate manner leading up to 2 November 2011.

60. The evidence satisfies me that the decision to discharge, made by treating clinicians at Southern Health, was reasonable and appropriate in the circumstances.

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[61] Inquest transcript, 46.

[62] Inquest transcript, 49.

[63] Inquest transcript, 49-50.

61. I find that the limited provision of community based support to Ms Sykes post-discharge was reasonable in the circumstances. Ms Sykes had unfortunately refused many support services offered to her, and as most services required the patient to agree to a referral, treating clinicians at Southern Health could not force Ms Sykes to accept the services offered. However, I find that referral to CATT would have been appropriate in the circumstances, given Dean's concerns about his ability to care for his mother and her capability to survive in her home.

62. I am satisfied that Ms Sykes intentionally took her own life. Ms Sykes appeared to be troubled with personal and health matters, despite the support she received from her family, and treating clinicians.

63. I find that Train Driver Ralph took all reasonably practicable steps to avoid the collision and that there was nothing that he could have done to prevent it. The speed of the train was within the prevailing track speed. The service and emergency brakes were applied appropriately and performed as designed. There were no other environmental factors which may have caused or contributed to the collision.

64. I accept and adopt the medical cause of death as identified by Dr Jacqueline Lee and find that Elaine Sykes died from multiple injuries sustained in collision with train (pedestrian).

COMMENTS

Pursuant to section 67(3) of the *Coroners Act 2008* (Vic), I make the following comments connected with the death:

1. At Inquest, Dr Tzolova gave evidence that treating clinicians decided CATT involvement was not required, as Dean was going to be living with Ms Sykes for a few days and the information and feedback they would get from him 'is much more available and correct compared to the snapshot with CATT'.[64] Dr Tzolova agreed that in hindsight, knowing Dean would be gone in a couple of days, and knowing he had expressed concerns about his ability to care for his mother and her capability to survive in the home, treating clinicians could have at the very least provided support to ensure everything was okay.[65] I accept that some services, such as ERMHS, PARCS and meals on wheels, require agreement from the patient before a referral can be made, and that the patient cannot be forced to accept such services. However, the same cannot be said for CATT services. CATT clinicians are very

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[64] Inquest transcript, 45-6.

[65] Inquest transcript, 49-50.

experienced in assessing patients post-discharge and identifying if there are any concerns that need to be monitored or addressed by treating clinicians. Although I make no recommendation in relation to this matter, in appropriate circumstances where family support is relied upon for post-discharge care and no support services are accepted by the patient, and the family raises concerns about their ability to care for the family member being discharged, or the patients ability to care for themselves, it may be prudent for CATT services to be provided. This would assist in monitoring and assessing the person discharged, and would create a safeguard and support for the person discharged, and their family.

2. I acknowledge that family members receiving information orally from treating clinicians upon discharge may find the discharge meeting stressful, confusing and overwhelming, consequently affecting their memory of what information was conveyed to them. At inquest, Dr Tzolova acknowledged that after hearing Dean's evidence she was of the view that he may not have understood everything about the diagnosis and what treating clinicians were trying to do, and stated that maybe if it was written down it would help.[66] On this basis, I have made two recommendations in relation to this issue.

RECOMMENDATIONS

Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendations connected with this death:

1. With the aim of minimising risk and preventing like deaths, I recommend that if a psychiatric inpatient is discharged home and their treating clinicians have an expectation that a family member will be involved in their care, the family member be provided with the hospital discharge summary, if consent is given by the patient.

2. With the aim of minimising risk and preventing like deaths, I recommend that if a psychiatric inpatient is discharged home and their treating clinicians have an expectation that a family member will be involved in their care, the family member be provided with a written document stating who to contact if they have any concerns, and what support services are available to the patient.

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[66] Inquest transcript, 51.

65. Pursuant to section 73(1) of the *Coroners Act 2008* (Vic), I order that this finding be published on the internet.

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

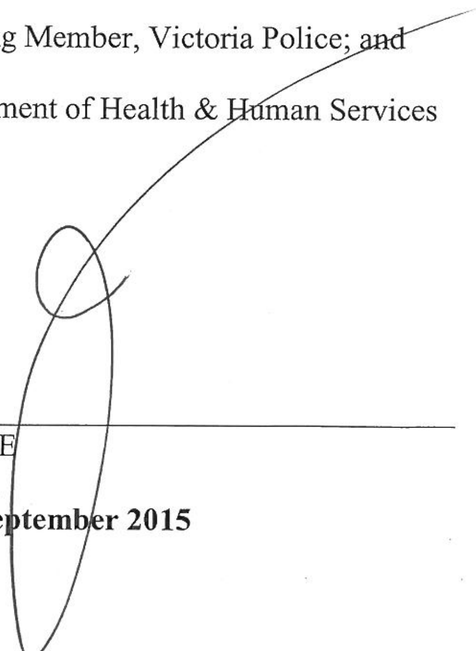
The family of Elaine Sykes;

Interested parties;

Investigating Member, Victoria Police; and

The Department of Health & Human Services

Signature:



JOHN OLLE
CORONER
Date: **24 September 2015**