MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Jordan Thomas Kirkwood

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is Jordan Thomas Kirkwood ('Mr Kirkwood');

b) Mr Kirkwood died in the circumstances set out in this finding;

c) Mr Kirkwood's cause of death was hypoxic brain injury following asphyxia due to hanging; and

d) Mr Kirkwood died on 30 April 2019 at the Royal Hobart Hospital (RHH), Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mr Kirkwood's death. The evidence includes:

- The Police Report of Death for the Coroner;
- RHH Death Report to Coroner;
- Affidavits establishing identity and life extinct;
- Affidavit of the Forensic Pathologist, Dr Donald Ritchey;
- Forensic Science Service Tasmania toxicological and analytical report;
- Affidavit of Constable Oliver Smith;
- Affidavit of Detective Constable Elise Clark;
- Affidavit of Sergeant Roy Cummings;
- Affidavit of Senior Constable Elise Allen;
- Affidavit of Peter Hooker, Tasmania police (rank not stated);
- Affidavit of Ms Kalila Hapka;
- Affidavits of Mrs Louise Kirkwood;
- Affidavit of Mr Paul Kirkwood;
- Affidavit of Ms Allanah Kirkwood;

- Affidavit of Mr Joshua Woods;
- Affidavit of Ms Laura Woods;
- Affidavit of Senior Constable Paul Hyland;
- Medical records of the Tasmanian Health Service (THS) Mental Health Hospital in the Home (MHHITH) program with respect to Mr Kirkwood;
- Letters from the consultant psychiatrist, Dr Honor Pennington, with respect to the MHHITH program;
- Medical records of the THS Alcohol and Drugs Service (ADS) with respect to Mr Kirkwood;
- Medical records of the Augusta Road Medical Centre with respect to Mr Kirkwood;
- Medical records of the Royal Hobart Hospital (RHH) with respect to Mr Kirkwood;
- Root Cause Analysis (RCA) report of the THS;
- Report of the forensic psychiatrist Dr Ian Sale;
- Letter of Professor Brett McDermott Statewide Specialty Director, Child and Adolescent Mental Health Service (CAMHS);
- Response to draft findings received from THS; and
- Forensic and photographic evidence.

Background

1. Mr Kirkwood was born in Hobart, Tasmania on 12 December 1999 to Louise and Paul Kirkwood. He was the younger brother of Allanah Kirkwood. At the time of his death, Mr Kirkwood was 19 years of age.

2. Mr Kirkwood grew up in Hobart and resided with his family in Montrose. In 2009, the family moved to West Moonah, where Mr Kirkwood lived until his death. He attended primary school at St Therese's Catholic School and high school at Sacred Heart College. Mr Kirkwood completed grade 11 at Guildford Young College before completing a carpentry qualification through TAFE. He was then employed for a short time at Baker's Delight and at Kings Towing before commencing a carpentry apprenticeship. Mr Kirkwood's first carpentry apprenticeship placement ceased after several months because the business he worked for experienced financial hardship. He commenced a second carpentry apprenticeship placement with Southern Building in mid-2018. Mr Kirkwood was described as a proficient and motivated worker.

3. Mr Kirkwood was very social and had many friends both at school and after he left school. He played football for the North Hobart Football Club up until the under 18

level in which year he received the 'Most Improved Player' award. He then ceased playing football and started going to the gym regularly. He also took up Thai boxing. His father says his son liked car and boat racing and he enjoyed going fishing and shooting with his father. Mr Kirkwood was the cousin of Joshua Woods and Laura Woods whose mother is Mrs Kirkwood's sister. Both families have always been close. Mr Woods is a police officer and Ms Woods is a paramedic. They both assisted Mr Kirkwood when his mental health symptoms became manifest.

4. Mr Kirkwood was in a relationship with Kalila Hapka ('Ms Hapka') from early 2018 until early 2019. The pair met at Sacred Heart College in 2015 and were friends for several years before commencing a relationship. During their relationship, Mr Kirkwood and Ms Hapka spent much of their time together and would stay at each other's houses. When Ms Hapka started sleeping at Mr Kirkwood's house more often she says she realised *"things might not be completely okay with him."* He spent a lot of time in bed and seemed to have lost his motivation. She says all he wanted to do was to sleep, eat and party. This included taking party drugs briefly but she says he stopped after she expressed her disapproval. However, he did not cease smoking marijuana. This led to difficulties in their relationship which resulted in them taking a break from the relationship from time to time. Despite this they remained in touch during March and April 2019 when Mr Kirkwood's mental health deteriorated.

Medical history

5. I have examined Mr Kirkwood's medical records. They are substantial for one so young. His physical health was generally good. He did have some health issues throughout his childhood and into adulthood, but these conditions were successfully treated. On 24 February 2006, Mr Kirkwood had dental surgery to remove two anterior maxillary supernumerary teeth. On 29 September 2009, he had an appendectomy after presenting to the RHH with a perforated appendix. He remained an inpatient until 5 October 2009 when he was discharged. He was readmitted on 7 October 2009 and remained an inpatient until 15 October 2009 because he required treatment for a post appendectomy abscess. In June 2014 and March 2016, Mr Kirkwood had corneal surgeries for the treatment of keratoconus, a condition which affects the cornea of the eye. On 14 October 2018, Mr Kirkwood was taken to the RHH emergency department (ED) by ambulance after being pushed and hitting his head on a stone wall and then concrete which rendered him unconscious. He had been out drinking alcohol. His Glasgow Coma Score was initially 10 and it fell to 7 en route to hospital He was assessed, and a CT of the head and cervical spine were

undertaken. Fortunately, no obvious brain haemorrhage or cervical spine fracture was detected. No abnormalities or fractures were detected by x-rays of the left shoulder and left hip. The plan was to discharge Mr Kirkwood into the care of his mother but while he was dressing, he fell on the ground. He did not lose consciousness, but he sustained a 1 cm laceration above the left eyebrow and a small haematoma. The wound was treated and he was kept in the ED until he was more mobile. He was placed under spine precautions and he was monitored until he was considered fit to be discharged. Mr Kirkwood did not require ongoing treatment and this incident was not reported to, or investigated by, Tasmania Police.

6. Mr Kirkwood's first recorded mental health difficulty occurred in September 2016 following the breakdown, a few months before, of his first serious relationship. He was in grade 11 at Guildford Young College at the time. Mr Kirkwood told his mother how he was feeling and he attended a general practitioner (GP) appointment with her on 26 September 2016. The history was his relationship break up was the trigger but not the only feature. He had been depressed for about 2 months. The night before he had put a belt around his neck in an attempt to kill himself but he stopped; he was not sure why. He admitted to planning to hang himself in the garage and he knew which rope to use. Mr Kirkwood's GP referred him to the RHH Department of Emergency Medicine (DEM) for psychiatric assessment and management of *"major depression with suicidal intent"*. His GP believed Mr Kirkwood was at high risk of harming himself. He attended the DEM and was diagnosed with the first episode of a *"non-melancholic depression with anxious features"*. In addition he was thought to have suicidal ideation which was secondary to feeling overwhelmed by worsening mood and hopeless thoughts which were triggered by his relationship break up and perpetuated by social withdrawal and interpersonal conflict with his family, the fact he did not like school and lifestyle factors such as diet and exercise. Mr Kirkwood was discharged into Mrs Kirkwood's care with a plan for treatment from his GP by way of the formulation of a mental health care plan and referral to a psychologist for cognitive behaviour therapy. He was also to see the school counsellor, who he had seen twice in the last week, while waiting to see his GP. In addition he was to concentrate on improving his diet, exercising and having social contact. He could return to the DEM if needs be and medication would be considered if the doctor's recommendations were insufficient. He saw his GP on 27 September 2016 and he saw a psychologist the next day. He saw the psychologist approximately 6 to 8 times and he seemed to be improving. Mr Kirkwood next presented to his GP with difficulties on 21 March 2018 when he attended with his mother who was concerned about him being isolated from the family and lacking motivation. The history was this had occurred because the building

firm he had commenced his apprenticeship with, and which he was enjoying, had gone out of business. His low mood improved when he secured his apprenticeship with the second building firm.

7. On 23 January 2019, Mr Kirkwood attended a GP appointment in the company of Ms Hapka. The notes suggest he requested some advice about his issues with drugs and alcohol. Mrs Kirkwood had originally booked this appointment for her son because her view was he *"had started to struggle again"*. She had expected him to come away with a mental health plan. The GP's notes make no reference to any mental health difficulties. They detail his consumption of alcohol and drugs. The history provided was Mr Kirkwood was consuming 7-9 standard drinks on four or more days per week. He also reported using a large amount of cannabis almost daily and other drugs occasionally. The *"various help available"* was explained to Mr Kirkwood and documentation was printed and provided. The GP encouraged Mr Kirkwood to contact ADS and the notes record that he would keep contacting them until he received a positive response. It appears Mrs Kirkwood contacted ADS and obtained an appointment.

8. Mr Kirkwood discussed his cannabis use with his mother and Ms Hapka and resolved to stop. On 25 January 2019, Mr Kirkwood attended an intake appointment at ADS with Ms Hapka. He was then placed on a waiting list. On 4 February 2019, Mrs Kirkwood contacted ADS by phone. She reported Mr Kirkwood had smashed his phone over the weekend because she believed he had attempted to cease cannabis use and this caused him to become overly irritable and so he consumed alcohol to compensate. He had argued with Ms Hapka who indicated she did not wish to continue the relationship and he threatened to self-harm in response. Mrs Kirkwood was advised by ADS to seek a GP mental health plan for her son and she was provided with the Mental Health Helpline contact information. The GP's notes indicate an appointment was made on 5 February 2019 however Mr Kirkwood did not attend. A subsequent ADS appointment was made for Mr Kirkwood for 6 February 2019 and Mr Kirkwood attended that appointment with Ms Hapka. Mr Kirkwood attended a subsequent appointment at the ADS with his mother and girlfriend on 20 February 2019. He told the same social worker he had not used cannabis. His mother indicated that she was very proud of him and that she had noticed an increase in his engagement and motivation. He also reported on an incident whereby he punched an unknown male while out drinking to excess with Ms Hapka. His next scheduled appointment was 27 February 2019 but he was unable to attend because he was working late. He attended the rescheduled appointment with his mother on 6 March 2019. He

reported he had remained abstinent, and he had been physically active and regularly going to the gym. He did not attend his next scheduled appointment on 28 March 2019 and attempts to contact him on that day, and his mother on 4 April 2019, failed. ADS therefore wrote to Mr Kirkwood on 4 April 2019 requesting he reschedule an appointment in the next 14 days. He did not do so. A note dated 11 April 2019 indicates that in response to attempts by ADS to contact Mrs Kirkwood she had responded by message *"that the past few weeks have been rough."* Given Mr Kirkwood ceased engaging with ADS his file was closed.

Mental Health 'Hospital in the Home' Program ('MHHITH')

9. The MHHITH Program commenced on 25 March 2019. This program is described in documentation provided to my office as an initiative led by the office of the Chief Psychiatrist in partnership with Statewide Mental Health Services (SMHS) which is a division of the Department of Health operated by the State Government. Prior to the program's commencement the Chief Psychiatrist delivered information sessions in December 2018 at which the concept was introduced and then in February and March 2019 he delivered further information sessions which outlined the operational service model. Frequently asked questions arising from the forums in 2018 were published on the SMHS intranet in January 2019 and a staff newsletter later that month provided an update on its organisational structure. In early February 2019 a change proposal was sent to all mental health services staff and unions. On 19 August 2019 a staff communiqué with respect to the program was sent via email to all staff which included links to the program's webpage and service brochure. Those pages can no longer be accessed and in fact an internet search found no trace of this program apart from a press release from the then Minister for Mental Health and Wellbeing of 11 September 2019.

10. According to Dr Pennington this program was to *"provide evidence – based intensive input into a person's home for those suffering with an acute illness. The service is specifically designed to care for people who would otherwise be managed in an acute inpatient setting …"* She goes on to advise the unit is staffed by medical, nursing, allied health professionals and peer/case management workers. It operates between the hours of 07:00 AM and 10:30 PM with overnight calls directed to the acute mental health unit at the RHH. The post consultation draft model of care dated January 2019 suggested it was a service which was *"a 12 bed Mental Health Hospital in the Home Unit "* where care would be provided on an intensive basis for up to 14 days. It was designed as an option to replace admission or an extended stay in hospital. MHHITH clients would

remain living at home while receiving home visits (sometimes twice daily) and phone check-ins from medical staff. Dr Pennington has advised the program continues to offer care to a maximum of 12 individuals at any one time and it augments inpatient mental health service provision.

11. Home visits were conducted by members of the team, depending on the planned intervention, for example, medical supervision, medical review, care planning, psychosocial support, or therapeutic interventions. The services provided included:

- A comprehensive assessment process;
- Consumer participation in the development of their own care and safety plan; and
- Active and intensive treatment in the community by the MHHITH team.

The program involved managing clients according to different levels of care similar to the category system used for inpatients. They were as follows:

- Care Level 1 – home visit twice per day;
- Care Level 2 – home visit daily;
- Care Level 3 – home visit on alternate days with a phone call on alternate days; and
- Care Level 4 – home visit every three days with phone calls on the other days.

Care plans were developed in consultation with the patient and their family/carer. A safety plan was also developed with the patient and their family/carer. The patient retained a copy of their safety plan so it could be enacted if required. Initially, each patient in MHHITH was to be seen at least daily face-to-face and contacted on at least 10 occasions in total each week. Additional contacts may be via telephone or other technology facilitating remote visual contact. Dr Pennington advised remote visual contact does not constitute face-to-face contact.

12. At the date of implementation, the eligibility criteria for admission to the MHHITH program required that participants must:

- Be aged between 18 and 65 years;
- Reside within 40 kilometres of the Hobart CBD;
- Reside in an environment that supports the safe and effective operation of the MHHITH service. This means that they live in accommodation that is suitable for home visits and that does not pose a high risk to staff or to the patient;

- Be referred from the RHH ED, MHIU, Adult Community Mental Health Team (ACMHT), or from a GP where shared care arrangements exist within an ACMH Service;
- Be currently experiencing an acute phase of mental illness;
- Not present an imminent risk of harm to self or others requiring in-patient care;
- Be likely to benefit from up to 14 days of intensive treatment;
- Agree to be involved in decisions about their treatment; and
- Have sufficient family or carer support available (even if not directly involved in daily care).

Importantly, Dr Pennington says individuals experiencing active suicidal ideation may be considered suitable to continue with home-based treatment if they have *"capacity to make decisions regarding their care, express a preference for this setting, are able to engage in their own care and have supportive family and/or friends."*

13. Dr Pennington advised that a transfer to hospital based care would result if there was a deterioration in a person's mental state with loss of capacity or ability to engage in treatment, or if there was a requirement for a more contained environment. A transfer might also occur if care supports became overwhelmed or were no longer able to provide support.

14. The records disclose Mr Kirkwood was transferred to the MHHITH unit on or about 3 April 2019 that is approximately 1 week after it commenced operation. He was the 5th person referred to the unit.

History Leading to Admission to MHHITH

15. It is evident Mr Kirkwood experienced a significant and serious decline in his mental health which began in early 2019. Between 20 March and 30 April 2019 Mr Kirkwood's mental health deteriorated significantly and this led to a number of presentations to the RHH DEM.

16. On 20 March 2019, Mr Kirkwood presented to the RHH DEM with Mrs Kirkwood for a mental health review. The triage notes of the visit indicate Mr Kirkwood had recently experienced a relationship breakdown[1]. This, according to Mrs Kirkwood, had led him to smoke cannabis which triggered his depression. The RHH records

[1] I infer with Ms Hapka.

show that Mr Kirkwood did not wait to be seen by a doctor. He was triaged at 8:07 PM and he departed the hospital at 9:33 PM.

17. Mrs Kirkwood says in her statement she believed Mr Kirkwood was really suicidal for the first time on 26 March 2019 when he went to St Therese's School and he sent his family a message. They found him there and took him to the DEM. There is no entry in the records for this date but there is an entry of him attending a school on 2 April 2019 where he had attempted to hang himself from a tree or some soccer goalposts with some Velcro straps which broke. He had sent a message to his parents who found him wandering in the area and they took him to the DEM. He reported lateral neck pain but a subsequent x-ray did not find any injury. He was cleared from a physical point of view. Mr Kirkwood was psychiatrically assessed and admitted as a voluntary patient for a further risk assessment. That assessment was undertaken by a consultant Dr Giardini, a locum psychiatrist, who was accompanied by a registrar. Their assessment was referred to as a *"post— hanging attempt."* The file note refers to Mr Kirkwood having ceased using cannabis 10 days earlier and that he had been struggling with withdrawal symptoms since. His cannabis use had caused relationship difficulties with his girlfriend.

18. Mr Kirkwood disclosed at the time of the suicide attempt he intended to end his life. He had used velcro straps attached to a tree branch but these had broken. There had been no loss of consciousness. He had then spoken with his mother who had suggested he come to the hospital. He denied prior self-harm attempts or current suicidal ideation. The next part of the file note states: *"agreeable for plan to T/F to HITH."* The mental state examination appears to have been unremarkable. Mr Kirkwood was considered to have good insight. The clinical impression of the doctors was of a suicide attempt in the context of cannabis withdrawal. The plan was to transfer him to MHHITH. He was discharged on 3 April at 2:58 PM with a referral to that program.

Mr Kirkwood's Time on the MHHITH Program and the Circumstances of His Death

19. On 4 April 2019, Mr Kirkwood was visited at home by Dr Azri Mohammad, a registrar, and David Hanlon, a carer peer support worker, from the MHHITH program. They noted Mr Kirkwood had been referred from the DEM after a suicide attempt involving hanging, and this was considered to be primarily due to craving and withdrawal in relation to cannabis. He had been conflicted in having made a promise to his mother and he believed that he might as well die if he started smoking cannabis

again. He then walked to a school ground where he apparently found some thick velcro which he had tied to his chest and neck. He had then texted goodbye to his mother and attempted to hang himself, but the velcro broke.

20. Mr Kirkwood described his life as *"screwed"* if quitting cannabis did not solve his problems with his mood. When specifically asked later in the interview, Mr Kirkwood described his mood as being a *"three out of ten."* Dr Mohammad assessed there to be a moderate risk of harm to himself, but there was no risk to others. The formulation was a history of drug dependence and a depressed mood accompanied by guilt and self-blame over a period of a year.

21. Following Mr Kirkwood's admission to this program, he was visited regularly or contacted by phone by various members of the staff at the unit. At various times his parents were also spoken to. His care level was adjusted through the course of the admission and towards the final stages he was assigned a care level of 4 in which contact is modest. It appears from file notes there is no particular member of staff who was given a key role, or had more regular contact than other staff members with Mr Kirkwood or his family.

22. Other than medication, which included an antidepressant, there was little other specific treatment except for non-specific counselling and support. There were references to a potential referral to other services or agencies such as Headspace or to a program which was run by Anglicare.

23. Towards the end of the admission, recommendations were made to Mr Kirkwood and/or his family to seek assistance in the private sector by requesting their GP to provide a mental health care plan which would enable referral to a clinical psychologist. It appears from the notes Mrs Kirkwood had misgivings about this proposal and this was in part due to what had occurred between the family and a GP during the previous January. The plan appears to have involved the Crisis Assessment and Treatment Team (CATT) providing interim support.

24. One day after Dr Mohammad's assessment, on 5 April 2019, Mr Kirkwood told his mother he was not feeling safe and he needed to go back to hospital due to his mental health. Mrs Kirkwood took him to the RHH and they arrived at approximately 10:30 PM. There was, in my view, not an unreasonable expectation on the part of Mr Kirkwood and his mother that there would be an awareness at the DEM of the MHHITH program which would allow for fast tracked assessment and potential admission. There was no such awareness. Mr Kirkwood became frustrated and said he

wanted to wait there on his own. Mrs Kirkwood respected this request, and left the hospital. Later Mrs Kirkwood called the DEM to confirm he had been admitted but they had no record of him. When she asked Mr Kirkwood where he actually was he expressed suicidal feelings. Police were notified at 12:57 AM on 6 April 2019 that Mr Kirkwood was unaccounted for and possibly suicidal. A police negotiator was authorised and called out. Police conducted telephone triangulations which indicated Mr Kirkwood was in the New Town or Moonah area. Mr Kirkwood was eventually located following contact with Ms Hapka. He told her he was at Sacred Heart College. Police arrived and conveyed him to the RHH in protective custody under the *Mental Health Act* 2013. When police re-attended the school grounds, they located a noose constructed from belts near to where Mr Kirkwood had been found. At the RHH, Mr Kirkwood was admitted. However, he was not assessed within the four-hour timeframe that the protective custody was in force. When the timeframe for protective custody lapsed, Mr Kirkwood agreed to remain voluntarily and await psychiatric assessment. He was assessed by a psychiatric registrar who proposed to admit Mr Kirkwood to the acute unit at the RHH however, later that same day he was reviewed by Dr Woo, a senior psychiatrist, who made some adjustments to medication arrangements and recommended a return to care by MHHITH.[2] The same day, the MHHITH team changed Mr Kirkwood's care level to Care Level 1, mandating home visits twice daily, in response to his sudden deterioration and suicide attempt.

25. On 24 April 2019, the MHHITH team called Mrs Kirkwood and advised they planned to assess and discharge Mr Kirkwood on 26 April 2019.

26. On 26 April 2019, a meeting of those in the MHHITH team resolved to discharge Mr Kirkwood on 29 April 2019. The full names of those members at this meeting is not recorded. No further home visits were scheduled for Mr Kirkwood and MHHITH personnel would be available for phone call support only up until the discharge date.

27. Upon review of witness affidavits, it is clear to me Mr Kirkwood was not consistently open about his mental health struggles with treating professionals, his friends, and his family. It was not uncommon for him to disclose information to one party but not to another. Sometimes, Mr Kirkwood would disclose information about an attempt to Ms Hapka or his family and this information would not be passed on, at all or in a timely manner, to the treatment team. This means that, in hindsight, no party had a clear and comprehensive understanding of Mr Kirkwood's history or his state of mind.

[2] The information about an assessment and admission recommendation made by a psychiatry registrar during the afternoon has been derived from the RCA report. These notes which should have been included in the DEM's record have been requested on 3 occasions but have not been forthcoming.

Ms Hapka says in her affidavit she is aware of two unreported[3] incidents when Mr Kirkwood attempted or threatened to take his own life. The first unreported incident occurred on an unknown date close to the beginning of Mr Kirkwood's involvement with MHHITH. Ms Hapka says Mr Kirkwood set up a rope in the garage of the family home after having unspecified issues with his family. He told her he intended to take his life, but that he was interrupted by his cousin who knocked on the door. Ms Hapka was at Mr Kirkwood's home the next day when he went into the garage to take the rope down so his family would not find it.

28. The second unreported incident occurred on 26 April 2019. Mr Kirkwood contacted Ms Hapka and, during a text message exchange, stated he had locked himself out of his car and that he was going to hang himself. Mr Kirkwood sent Ms Hapka photographs of a noose. Ms Hapka and Mr Kirkwood texted one another for some time. He eventually smashed a window so he could get back into the car and he went home. Ms Hapka says she does not know if Mr Kirkwood's parents knew about this incident.

29. Later on the 26 of April 2019 or in the early hours of 27 April 2019 Mr Kirkwood overdosed on a number of medications including antidepressants, diazepam, anti-inflammatory medications, paracetamol and methotrexate. The next morning, he drove part of the way to work before sending a text message to Mrs Kirkwood telling her to look under his bed. She located empty medication packets and tablets and told Mr Kirkwood to turn around and drive home. Mr Kirkwood told his parents, on his return home, that he wanted to go to bed and that he did not want to go to hospital. Mrs Kirkwood telephoned for an ambulance, and he was taken to hospital. Upon arrival at the RHH, he denied he took the medication with suicidal intent. Instead, he said he was having trouble sleeping and, concerned about having work the next day, took the medication to help him get to sleep. At least one of the MHHITH staff appears to have been doubtful about the reliability of this history[4]. It is also apparent from empty packaging Mr Kirkwood's parents found in Mr Kirkwood's bedroom and missing medication they knew he had, Mr Kirkwood significantly underreported the amount of medication he took. The records note Mr Kirkwood had an *"acute stress reaction"* and that *"his reported motivation [taking the medication to sleep] was very out of character."* Mr Kirkwood was medically assessed and was found to have no immediate biochemical disturbance. He was referred to his GP for follow-up blood testing.

[3] I refer to these as 'unreported incidents' because information of the attempts was not passed on to medical staff at the RHH (generally or to the MHHITH team) or to Tasmania Police.
[4] See the notes of Craig Doolan for 27 April 2019 at 20:39:46.

30. Mr Kirkwood was psychiatrically assessed by Dr Goh and although his notes suggest a thorough assessment was conducted some of his handwriting is difficult to read. His assessment includes discussions with Mr Kirkwood's parents. Dr Goh considered the overdose was either accidental or impulsive, and that it was qualitatively different to prior incidents of self-harm behaviour. Mr Kirkwood was discharged from the DEM, with advice to cease medication for a period. However, Dr Goh made a note that should Mr Kirkwood return to the DEM he would need to be admitted. Dr Goh's advice to Mr Kirkwood at discharge was thorough and included follow up by the CATT. It appears from the notes however the MHHITH program conducted the follow-up instead.

31. On the evening of 28 April 2019, Mr Kirkwood injured himself at home by cutting his neck while in the bath. While the RCA report says MHHITH staff were not informed of this incident, there is a reference to it in the retrospective file entry made on 30 April 2019 which detailed a home visit the previous day.

32. On 29 April 2019, Dr Honor Pennington and Belinda Freach conducted a home visit. Mr Kirkwood was at work with his father who had taken him to work and then worked with him in order to assist his son with his duties. Mr Kirkwood remained at work the whole day, although he informed MHHITH during a phone call earlier in the day that he was feeling very ill and might leave work early. Mr Kirkwood's father thought that his son was experiencing kidney pain related to the recent overdose. He says Mr Kirkwood spent any spare time during the day laying on the concrete at the work site and he complained about abdominal pain. Mr Kirkwood exchanged text messages with his cousin, Ms Woods, throughout the day. They discussed how Mr Kirkwood was and whether they wanted to go to the gym together after work. Mr Kirkwood also had a short text message exchange with Ms Hapka, who he had seen commenting on a Facebook meme in apparent reference to their breakup. The meme read, *"dating my last boyfriend was like being on the bachelor but not knowing I was on the bachelor."* Mr Kirkwood sent a screenshot of Ms Hapka's interaction with her friends under his post to her with the message, *"love this."* When Ms Hapka replied with the statement, *"but true,"* Mr Kirkwood sent a message stating that she was the love of his life and that he was sorry. Mr Kirkwood would later tell MHHITH staff that Ms Hapka had ended their relationship by this point.

33. That night, Dr Pennington arrived at the family home before Mr Kirkwood had returned home. She spoke to Mrs Kirkwood, who updated her about the recent suicide attempts, self-harm incidents, and hospitalisations including the neck injury that

happened the night before. When Mr Kirkwood arrived home from work at approximately 5:00 PM, he told the MHHITH team his relationship with Ms Hapka had ended for good. The MHHITH home visit notes (which were entered retrospectively, on 30 April after Mr Kirkwood's death) indicate Mr Kirkwood was visibly upset and *"teary."* However, he was also reported to be reflective on his relationship with Ms Hapka, that it was significant but unhealthy. He was hopeful of being able to adjust to the loss. He denied any thought or plan to self-harm. Dr Pennington noted Mr Kirkwood had normal thought form. The doctor also noted Mr Kirkwood, *"remains a risk of impulsive self-harm or suicidal behaviour but nil current acute concern and well supported by family who are aware of his sadness."* The MHHITH team advised they would delay his planned discharge from the program on 29 April but that he would be discharged to CATT in the next few days. Mr Kirkwood was to stay in the care of his parents and there would be no change to his current level of care. His medication was to remain unchanged and he would be linked with a private psychologist prior to discharge.

34. The same night, after the MHHITH team left, Mr Kirkwood ate dinner at home with his parents. He then told his mother he was going to the shop to buy cigarettes. He left the house at approximately 6:45 PM and he and his mother were in contact via text message and while he was out he advised he was going for a drive. At 7:33 PM, Mr Kirkwood sent a text message to Ms Hapka indicating he loved her and that he was *"sorry."* He sent another at 7:40 PM which said *"good bye"* and that he loved her. Soon after, at 7:41 PM, Mr Kirkwood sent a very lengthy message to Mrs Kirkwood indicating he was suicidal and that he had already attempted to end his life with a stanley knife, but that this was unsuccessful. Mr Kirkwood's text indicated he was intent on suicide and that he was going to buy a heavy-duty rope from Bunnings. The message contained details about where his father's car could be located and that he could be found on a nearby property behind a water tank. Mr Kirkwood warned his mother that his family should not go looking for him, and they should let police find him. Mrs Kirkwood was unable to contact her son after this text message.

35. Immediately after receiving the message, Mrs Kirkwood told Mr Paul Kirkwood and their daughter, Ms Kirkwood, about it. Mr Paul Kirkwood left the house immediately to look for his son. Ms Kirkwood contacted her cousin, Mr Wood, who left his house to look for Mr Kirkwood. Various members of the family and Ms Hapka were making unsuccessful attempts to contact Mr Kirkwood via phone and message.

36. At 7:45 PM Mr Wood called Radio Dispatch Services and outlined the situation. He also called his sister, Ms Woods, directly. Ms Woods was working on-duty as a paramedic at the time and she relayed a message to the southern operations centre of Ambulance Tasmania and indicated she would join the search. Police units were tasked to search for Mr Kirkwood at 8:00 PM. A number of police units were despatched to look for Mr Kirkwood. The first of those arrived at where Mr Kirkwood was believed to be at approximately 8:04 PM. Ms Woods and her work colleague, paramedic Ms Stephanie Buell, arrived shortly after police. Mr Woods arrived shortly after them. Mr Paul Kirkwood was already on the scene and he was searching the area. At 8:10 PM Mrs Kirkwood notified MHHITH by phone Mr Kirkwood had run away and that she had called police.

37. Upon arrival, Ms Woods had already been forwarded Mr Kirkwood's final message by Mrs Kirkwood. She informed police that, according to the message, he would likely be located behind some nearby water tanks. Ms Woods and Ms Buell located Mr Kirkwood at 8:30 PM fully suspended from a tree. Ms Woods alerted other searchers and began to prepare her resuscitation equipment. Police retrieved Mr Kirkwood from the tree but he was unresponsive. Ms Woods called for additional ambulance by radio and asked her brother, Mr Woods, to wait for them by the road. Ms Woods and Ms Buell commenced resuscitation efforts. Mr Kirkwood was found to be in asystolic cardiac arrest. Ms Woods administered intravenous adrenaline. The paramedics were assisted by firemen from the Glenorchy Fire Station. The firemen had been tasked by police to attend in order to gain access to the Tolosa Street fire trails prior to Mr Kirkwood being located. Resuscitation efforts consisted of compression, the administration of adrenaline, and the use of a CPR bag. Mr Kirkwood was also defibrillated. The paramedics used equipment to prevent aggravating any possible spinal injuries. After recovering a pulse and after approximately 50 minutes of treatment Mr Kirkwood was considered stable enough to transport to hospital. Ms Woods stepped away from the resuscitation attempts upon the arrival of paramedics Michael Webber and Cameron Banks. Additional paramedics, Paul Stevenson and Phillip Krushka, also arrived to assist.

38. Mr Kirkwood was transported to the RHH DEM by ambulance. He arrived at 9:59 PM and was moved to the resuscitation area. Mr Kirkwood's immediate family and Ms Woods arrived at the hospital before him and waited while he was being treated. They were joined by other extended family over the next two hours.

39. Mr Kirkwood did not meaningfully stabilise while at the hospital. He had poor ventilation and he was hypotensive. He was administered further intravenous adrenaline. Staff conducted a CT scan of his brain and this indicated diffuse cerebral oedema. Mr Kirkwood was transferred to the Intensive Care Unit shortly before 1:00 AM on 30 April 2019. He arrested shortly after his arrival and CPR was commenced along with an adrenaline infusion. Mr Kirkwood arrested again and could not be revived.

Investigations

40. At 9:20 PM while Mr Kirkwood was being treated at the scene, Detective Constable Clark and Constable Mizzi from the Criminal Investigation Branch arrived. Detective Constable Clark examined and assessed the scene and concluded there were no suspicious circumstances[5]. Forensics officer Constable Paul Hyland arrived at 9:30 PM and examined the scene. He took measurements and photographs. He assessed the hanging point and the car Mr Kirkwood had driven to Tolosa Street. Constable Hyland found there were no suspicious circumstances necessitating further forensic examination. Police could not identify any witnesses to the incident. The area in which Mr Kirkwood was found is approximately 100 metres from the nearest houses and it is not clearly visible from the road. It was already dark when he sent the final message to Mrs Kirkwood and the area is not illuminated by street lights or within view of known CCTV cameras. Subsequently police obtained affidavits from Mr Kirkwood's family.

41. Police seized the rope and Mr Kirkwood's mobile phone from the scene. The phone data was downloaded and further examination of this material showed Mr Kirkwood had made extensive use of the 'Notes' application. Identical text of almost all of the last text message to Mrs Kirkwood is contained in the notes application. Other entries also provide insight into Mr Kirkwood's frame of mind as they include a number of recorded and unrecorded suicide attempts or incidents. There is an entry at 10:49 PM on 2 April 2019 referencing an earlier attempt and a similar message was sent to Ms Hapka on this date via SMS. There are also screenshots recorded in the Camera application that show Mr Kirkwood investigated methods of suicide on 24 and 28 April. On 26 April 2019, there is a screenshot of a location ping showing Mr Kirkwood at the western end of Tolosa Street, a photograph of a noose on the ground, and a photograph of a smashed car window. This evidence is consistent with

[5] By no suspicious circumstances I mean the officers concerned found nothing at the scene to suggest any other person was involved in Mr Kirkwood's death and what they found was consistent with him having suicided.

the details provided by Ms Hapka of the incident referred to in paragraph 28. There is also an apparent suicide note, addressed to Ms Hapka, in the Notes application dated 26 April 2019. On 27 April 2019, Mr Kirkwood took a photo of a very large quantity of pills on a table. The location tag on the photo shows that Mr Kirkwood probably took this photo at the family home. This photo likely depicts the medication Mr Kirkwood took on 27 April 2019, leading to the overdose referred to in paragraph 29. There is a Notes application entry from this same night indicating the overdose was an attempted suicide, contrary to what Mr Kirkwood later told Dr Goh. The note also makes reference to *"under the… bed"* where his parents later located medication packets after the overdose. There are images depicting the incident on 28 April 2019. At 11:25 AM on 29 April 2019, there is a screenshot of a Bunnings product page for a Grunt 12mm x 10m high strength rope, which is consistent with the rope found at the scene. This screenshot indicates Mr Kirkwood was likely contemplating suicide as early as 11:25 AM on 29 April 2019 and prior to the MHHITH home visit when he told Dr Pennington he was not feeling suicidal.

42. The State Forensic Pathologist, Dr Donald Ritchey, performed a post-mortem examination on 30 April 2019. Dr Ritchey found Mr Kirkwood's cause of death was global hypoxic brain injury following asphyxia due to hanging. Mr Kirkwood's death was significantly contributed to by his depression and previous suicide attempts. Dr Ritchey noted ligature marks on Mr Kirkwood's neck consistent with hanging. The severity and pattern of the injuries indicates they were caused when Mr Kirkwood placed a noose around his neck and jumped from a tree branch. This is the method of suicide that is outlined in various notes, internet searches, and messages made by Mr Kirkwood. Dr Ritchey also noted Mr Kirkwood had superficial injuries on both sides of his neck consistent with self-inflicted cutting. These injuries were very superficial and are consistent with the incident described in paragraph 31. I accept these opinions of Dr Ritchey which are set out in his affidavit.

43. A toxicology report was prepared by Mr Neil McLachlan-Troup, a forensic scientist at Forensic Science Service Tasmania. The report indicates the following substances were present in Mr Kirkwood's blood sample:

- Caffeine;
- Nicotine/cotinine;
- Fluoxetine (at a concentration of 0.21mg/L);
- Norfluoxetine (a metabolite of fluoxetine);
- Diazepam (at a concentration of 0.04mg/L); and

- Nordiazepam and tamezapam (both being metabolites of diazepam).

Fluoxetine is an anti-depressant serotonin inhibiter which was prescribed to Mr Kirkwood and the reported concentration indicates that it was, if taken alone, within the therapeutic range. Diazepam is a benzodiazepine sedative and it was also a prescribed medication for Mr Kirkwood. He was prescribed both these medications for concurrent use by MHHITH practitioners. The concentration of diazepam is also within the therapeutic range. The report indicates no alcohol or metabolites associated with illicit drug use were found.

Review of the MHHITH Program

44. Due to the circumstances of Mr Kirkwood's death, I commissioned a review of Mr Kirkwood's medical treatment and, in particular, whether he should have been placed on the MHHITH program. That review was conducted by the very experienced forensic and consultant psychiatrist Dr Ian Sale.

45. Regarding the history leading to admission to MHHITH, Dr Sale reviewed all the clinical records obtained by me including those which relate to the incident on 2 April 2019 and the psychiatric assessment by Dr Giardini, who was accompanied by a registrar. Dr Sale says Mr Kirkwood's mental state appears to have been unremarkable, that he denied current suicidal ideation, and that he was considered to have good insight. The clinical impression of the doctors was of a suicide attempt in the context of cannabis withdrawal and the plan was to transfer Mr Kirkwood to the MHHITH program. Dr Sale concludes:

> *"From this file note it appears the decision to transfer to MHHITH might have already been made. The assessment appears to have been somewhat cursory, and there is no indication that there were any discussions with Mr Kirkwood's parents. It would seem unlikely that Dr Giardini made the decision to transfer given that he was a locum and would probably not have been familiar with the intake criteria for this new service. It is possible that there are other records relevant to this contact, e.g., the initial assessment by an Emergency Department doctor, an assessment by a Psychiatric Emergency Nurse (PEN)."*

46. On 4 April 2019, Mr Kirkwood was visited at home by Dr Azri Mohammad (a registrar) and Mr David Hanlon (a carer peer support worker). The details of this visit have been outlined in paragraphs 19 and 20. On this day, Mr Kirkwood was assessed as eligible for the MHHITH program and he was admitted as a patient to that program. Following his admission, Dr Sale notes the following:

> Mr Kirkwood *"was visited regularly or contacted by phone by various members of the staff of the unit. At various times his parents were also spoken with. His care level was adjusted through the course of the admission and towards the final stages he was assigned a care level of 4 in which contact is modest. It is apparent from the file notes that there appears to be no particular member of staff who was given a key role, or had more regular contact with Mr Kirkwood or his family.*

In an affidavit provided in the course of this investigation, Mrs Kirkwood raised concerns about the number of MHHITH staff that her son interacted with. She estimated Mr Kirkwood had contact with 28 different MHHITH staff members in the month of April 2019[6]. Mrs Kirkwood states that *"he [Mr Kirkwood] would not have felt that he could confide in a stranger."* Mrs Kirkwood believes her son would have benefitted from working more closely with select practitioners because he would have felt more comfortable to share his feelings. I agree with Mrs Kirkwood that the constant staff changeover during Mr Kirkwood's treatment is a concern, particularly because much of the staff interaction with Mr Kirkwood then had to involve repeated introductions and the retelling of history already within the knowledge of the unit. Valuable time was lost when Mr Kirkwood could have been building rapport with a select number of staff and he could also have been receiving counselling and support. Dr Sale continues:

> *"Other than medication, which included an anti-depressant, there was little other specific treatment other than non-specific counselling and support. There were references to a potential referral to other services or agencies such as Headspace, or to a program run by Anglicare (ASAP).*
>
> *Towards the end of admission, there were also recommendations to Mr Kirkwood and/or his family to seek assistance in the private sector by requesting their general practitioner to provide a Mental Health Care Plan, thus allowing for referral to a clinical psychologist. It was apparent that Mr Kirkwood's mother had misgivings about the proposal, in part a legacy of what had occurred between the Kirkwoods and a general practitioner during the previous January. The plan appears to have involved a CATT team to provide interim support."*

Regarding this, Dr Sale concludes:

[6] The MHHITH notes reveal there were at least 28 people from that unit alone who had something to do with Mr Kirkwood's care in April 2019.

> *"There are some practical difficulties involved with this plan. In particular, in my experience, it would be very difficult to obtain a quick appointment with a private clinical psychologist. There would likely have been a significant gap between the discharge from MHHITH to when a psychologist could provide more focussed psychological treatment."*

This view is corroborated by Mrs Kirkwood who says that on 29 April 2019 she tried to make an appointment with a psychologist but *"everywhere I called said it would be 3 months."*

I note Mr Kirkwood's planned discharged from the MHHITH program, due to occur on 29 April 2019, was pushed back following his hospital admission for the overdose on 27 April 2019. However, the family were advised at the home visit on 29 April that *"HITH will delay discharge at the present moment, but that the referral to CATT will go ahead soon."* This means that discharge from MHHITH was imminent despite the overdose on 27 April 2019 and the incident in the bath on 28 April 2019. I consider that, given MHHITH's knowledge of these incidents, it was not appropriate to discharge Mr Kirkwood from the program with vague advice to contact a private psychologist.

47. During the 26 day period that Mr Kirkwood was involved with MHHITH, there were further incidents of self-harm ideation or behaviour as outlined above. Regarding these, Dr Sale says:

> *"On 5 April 2019, Mr Kirkwood had become distressed and had sought assistance at the Emergency Department. There may have been some belief on the part of Mr Kirkwood and his parents that there would be an awareness at the Emergency Department of the MHHITH program, allowing for fast-tracked assessment and potential admission. There was no such awareness, and growing inpatient, Mr Kirkwood had left and after a lengthy walk had turned up at a construction site with the apparent intention of hanging himself with a belt. His location was identified through his phone and he was retrieved by police and returned to RHH for further assessment. There he was assessed by a psychiatric registrar (name not known) who proposed to admit Mr Kirkwood to the acute unit at the Royal Hobart Hospital. However, later on the same day Mr Kirkwood was reviewed by Dr Woo, a senior psychiatrist, who made some adjustments to medication arrangements and recommended a return to care by MHHITH.*

Dr Sale continues:

> *On 27 April there was an overdose of multiple medications… Mr Kirkwood claimed that this was an accidental overdose and that it was his intention to try and get to sleep. At least one of the MHHITH staff (Doolan) appears to have been doubtful about the reliability of this history… Dr Goh made what appears to be a thorough assessment, but unfortunately his handwriting is difficult to read… Dr Goh considered that the overdose was either accidental or impulsive, and that it was qualitatively different to prior incidents of self-harm behaviour. Mr Kirkwood was discharged from the Emergency Department… However, Dr Goh made a note that should Mr Kirkwood return to the ED, he would need to be admitted.*

On 28 April 2019 the incident in the bath tub occurred. Had Mr Kirkwood presented to the ED following this, it is probable he would have been admitted given Dr Goh's advice.

48. Dr Sale finds that much of Mr Kirkwood's treatment plan proceeded on the basis his mental health problems were attributed to cannabis use and cravings to resume use after cessation. This attribution appears, from the note, to have been accepted by some staff. However, following the incident on 5 April 2019, Mr Kirkwood disclosed to MHHITH staff he had experienced feelings of being a burden, he had let people down, and he saw his future as hopeless. He revealed he had been sad or depressed for a period of approximately six months and this led to him increasing his use of cannabis. In other words, his difficulties with cannabis use, and his anguish over this, may have been a consequence rather than the cause of Mr Kirkwood's problems. This information displaces the attribution that cannabis use was the only, or predominant cause, of Mr Kirkwood's depression.

49. Following Mr Kirkwood's death the THS conducted a RCA and prepared a report. In summary, the RCA panel found:

- The MHHITH team had commenced rapidly at a time when it was not fully equipped with a documentation suite[7]. However, the program was considered to be adequately staffed.
- There were problems with record-keeping, e.g., the MHHITH were unaware of Mr Kirkwood's earlier involvement with ADS and the Digital Medical Record (DMR) of Mr Kirkwood's file was problematic in that it was not necessarily in chronological order and some information was missing.

[7] Importantly in this case there was no documentation requiring an assessment of the home environment specific to minimising items of self-harm. The then assessment process only identified dangers which could impact staff. The panel found Mr Kirkwood's family and relevant others could have been educated on items for removal and safe keeping. The family were spoken to by MHHITH staff about the safe keeping of medications but only after the overdose and after 2 hanging attempts.

- During his time with MHHITH, Mr Kirkwood received no focused therapy or counselling directed at underlying issues, particularly the relationship problems with his girlfriend.
- Despite the MHHITH Model of Care stating clients should not be admitted if they present an imminent risk of harm to self or others, Mr Kirkwood was admitted to MHHITH and he remained on that program despite there being at least 3 further reported incidents. The RCA report says this situation should have triggered a review of the safety of home treatment.
- The MHHITH Model of Care envisaged an admission of up to 14 days but Mr Kirkwood's time with the service was extended to 26 days, until he died.
- Mr Kirkwood's mental state had been deteriorating and, at the time of discharge, he was not well enough to move to less intensive care.
- Cannabis was not a contributing factor to Mr Kirkwood's suicide, although he was estimated by the panel to have been a previously heavy user.
- Mr Kirkwood's true thoughts and intentions were not consistent with what he reported, and that clinical decisions would have been better made if they had reflected his behaviour and actions rather than his verbal responses.
- The failure to attempt to involve Ms Hapka in Mr Kirkwood's care or to speak with her was criticised. As the panel says *"[w]ithout the girlfriend being interviewed, the full complexity of the relationship issues will never be known. The final suicide attempt seemed to be precipitated based on the events of the night before, when the client and the girlfriend had brief contact, but there is no documentation detailing what transpired."*
- Mr Kirkwood was prescribed an SSRI anti-depressant (fluoxetine) that is controversial in adolescent depression because of the potential of an increased risk of suicide. Nonetheless, the panel concluded the specific choice of medications while controversial was sound.

50. Dr Sale agrees with the panel's conclusion that Mr Kirkwood's risk of self-harm should have precluded him being admitted to the MHHITH program in the first place. Dr Sale goes on to add:

Mr Kirkwood was largely unknown to Mental Health Services. Many case presentations involve previously known patients whose illness episodes in the past are documented and understood. The exclusion criterion concerning risk of self-harm is an obvious need in a care arrangement where there is inevitably less supervision. Other than the risk of self-harm or death for the patient such an outcome would likely be harmful to family and carers who have been placed in a position of responsibility.

51. Dr Sale makes the following further points with respect to Mr Kirkwood's care:

Mr Kirkwood was a late adolescent male. Manifestations of mental disorder, including depression, are significantly influenced by age. It is apparent that he was unforthcoming and at times misleading about the difficulties he was experiencing. The RCA team commented that more note should have been taken of what he did rather than what he said. I agree.

The disclosures Mr Kirkwood made after the incident occurring on 5 April 2019, together with the contents of the suicide note, point to a profoundly depressed young man who saw his situation as without hope, who believed that he was a burden to others, and who was consumed by feelings of self-blame. In my opinion, and obviously this is a retrospective view, he likely needed intensive treatment in an in-patient setting.

The RCA report refers to the prescription of fluoxetine as "controversial". This comment reflects significant concerns that arose in the past when it became apparent that clinical trials managed by some pharmaceutical companies had been less than transparent about adverse effects of SSRI antidepressants such as paroxetine. This concern was particularly in relation to suicidal ideation and aggressive behaviour. In 2004, the United States FDA issued a warning about suicidal thoughts and behaviour in young people prescribed SSRI antidepressants. This risk appears to be minimal in older age groups.

For a clinician, it is a matter of judgment whether to prescribe SSRIs to children and adolescents, but if they do, it would be essential to warn of this specific risk, and continue to be observant for this possibility as treatment proceeds. Mr Kirkwood was told about the side effects of this agent, but I was unable to determine from the documentation provided as to whether this particular risk had been covered with him...

The RCA team was critical of the MHHITH for failing to provide more focused psychological treatment. Obviously when a two-week engagement is envisaged, there are limits to what can be done in this area. However, brief psychotherapy can be of benefit, and is probably perceived as being more meaningful to both the patient and his family.

Following on from the above, there was no particular member of the MHHITH team who was designated as Mr Kirkwood's key case worker. This limited anyone being able to develop a longitudinal view of his mental state. Having a designated worker would also enhance prospects for the development of rapport and trust, which in turn might have allowed for Mr Kirkwood to be more forthcoming about the difficulties he was experiencing.

52. Finally, Dr Sale says while the initial decision to transfer Mr Kirkwood to MHHITH can be questioned, there were two further occasions when the safety of this course could have been reviewed. First, following the incident on 5 April 2019 in which there was suicidal ideation and intent. The initial assessment at the RHH DEM recommended admission to the acute unit. Dr Woo reviewed Mr Kirkwood a few hours later and favoured continued management by MHHITH. Dr Sale says in respect of Dr Woo *"[a]s a senior psychiatrist with the Tasmanian Health Service, it is likely that he would have been familiar with the MHHITH model of care, and in particular that a patient not present an imminent risk of harm to self. The MHHITH team might also have considered whether a second potential self-harm incident after a short interval might reflect an unacceptable level of risk."* The second opportunity for review arose on 27 April 2019 when Dr Goh assessed Mr Kirkwood following the polypharmacy overdose. Dr Sale says *"Dr Goh appears to have accepted the patient's claim that this was accidental, which in all the circumstances was distinctly improbable. Again, the MHHITH team might also have given thought as to whether their plan to proceed towards discharge and a lesser level of care was in Mr Kirkwood's interests."*

53. Dr Sale is eminently qualified to provide these opinions and I accept them without reservation**.**

54. The RCA makes a number of recommendations which have been agreed to by those with the power to implement change and the report suggests they were to be completed by 15 March 2020. I agree with each and every one of them. I am unaware as to whether these recommendations have been implemented. The recommendations are as follows:

- The MHHITH documentation requires completion and endorsement within the next 3 months and it is to be made widely available;
- Entry into the record must reflect what service is being provided rather than an individual consultant's name;
- The orientation program of MHHITH is to provide a comprehensive education session of the Digital Medical Record documentation processes;
- The MHHITH services admission criteria are to be revised to provide greater guidance on admission suitability for clients who have made recent self-harm and/or suicide attempts;
- MHHITH is to consider access and availability for psychological intervention where it is clinically indicated and it is either to provide those interventions or to refer patients to services that can provide that treatment; and

- Where consent is provided MHHITH is to ensure the involvement of significant others in the provision of collateral information.

Availability and Adequacy of Mental Health Services in Tasmania for Young Adults

55. It is my understanding that at the time of Mr Kirkwood's death there was no mental health service in this State for young adults. As the RCA panel noted, in some parts of Australia, including Victoria, patients under the age of 25 years have access to a specialist youth mental health service for that age group. This enables age-group specific assessments and treatment to be provided.

56. If Mr Kirkwood was to be treated as an inpatient in Tasmania he would have been admitted to the RHH. The option for treating him may have involved him being hospitalised in an adult psychiatric ward. It is unlikely, given his age, he would have been hospitalised in a paediatric ward but if he was that ward does not specialise in adolescent mental health. It was found by Coroner Stanton in the Inquest into the Death of AZ [2022] TASCD 60 that neither of these options are appropriate for adolescents or young adults. All of the professional medical experts in that case agreed that treating young people in hospital wards that are not specifically designed for adolescent psychiatric care is less than ideal.

57. This unsatisfactory state of affairs existed despite the fact that in 2015, Coroner McTaggart in her decision in [2015] TASCD 298, 299, 300, 301, 302, 303 made a number of recommendations relating to the establishment of a dedicated inpatient unit for adolescents or young persons, as well as the creation of other positions and facilities aimed at suicide prevention. The recommendations Coroner McTaggart made which are relevant to this case included:

    i) The design and establishment of a dedicated inpatient unit for adolescents or young persons between the ages of 12 and 25 years, including treatment for those suffering from an acute state of mental illness or suicidality;

    ii) Consideration be given to the establishment of a multi-disciplinary facility for young persons suffering from an acute state of mental illness or suicidality, such facility to have a comprehensive through-care and after-care model to provide ongoing community–based risk management;

iii) The establishment of state-wide positions of suicide prevention co-ordinators to provide necessary outreach between discharge from hospital and entry into appropriate services to assist with a streamlined approach to discharge planning, collaboration between service providers and continuity of care; and

iv) Hospitals offering emergency medicine consider developing and implementing a suicide risk assessment tool, to be applied consistently on a state-wide basis where suicidal risk assessment is required.

58. At the time of Mr Kirkwood's death those recommendations had not been implemented. If they had been there might have been no need for the MHHITH program or at least his admission to that program. Earlier last year the Office of the Coroner sought information from the THS with respect to the implementation of Coroner McTaggart's recommendations. As to the 4 recommendations set out in paragraph 57 above, the respective answers to each recommendation of Professor Brett McDermott who is the Statewide Specialty Director of the Child and Adolescent Mental Health Service (CAMHS) are as follows:

i) The recent redevelopment of the RHH included a new 16 bed adolescent inpatient unit which is managed through the Paediatric Ward. This unit opened in 2020 and delivers an integrated model of care whereby mental health patients and paediatric, medical and surgical patients are supported in the one unit. Stage 3 of the RHH Site Masterplan Review 2020-2050 recommended the redevelopment of the Repatriation Hospital site as a campus of the RHH. The plan includes the creation of a new dedicated adolescent mental health inpatient and outpatient facility. I note in the information provided to this office no timeframe has been placed upon the provision of this facility;

ii) Two new "Safe Havens" are to be commissioned within Tasmania with the first to open in 2022 – 23 and the second in 2023 – 24. The lower age of entry is 16 years. These facilities are in the community and are an alternative to attending hospital. The services are safe, welcoming and homelike, they provide therapeutic and clinical support and have an embedded worker model, a person can self-refer and they are open to the public from 8:00 AM and 10:00 PM;

iii) Most people who require assistance from CAMHS and who attend emergency departments and/or are admitted to inpatient units are suicidal. Rather than

creating suicide coordinators for 80% of the ED/admitted cohort, a more robust approach of suicide prevention and proactive follow-up should be considered for all CAMHS cases. He says this approach is being undertaken. Consistent with this, a new seven-day post discharge clinic has been established by CAMHS-South to ensure this national KPI is met and suicidal youth are proactively followed up, monitored and reviewed prior to service allocation and entry. A similar undertaking is planned for the North and North-west CAMHS services; and

iv) This recommendation is underway with a state-wide rollout of the "Connecting with People" suicide assessment and intervention program. See https://nspa.org.uk/member/connecting–with–people–website/

Response by THS and Discussion

59. My draft findings were forwarded to the THS and comment was invited from that organisation and from Dr Woo and Dr Goh. A very detailed response was received from Dr Ben Elijah who is the Executive Director Medical Services Statewide Mental Health Services. Nothing was received separately from Dr Woo and Dr Goh. Dr Elijah's response indicates Dr Woo, Dr Bourke and Dr Giardini provided him with clinical assessments with respect to Mr Kirkwood's care. He outlined each doctors', and his, clinical experience and their familiarity with the MHHITH program and Hospital in the Home programs elsewhere in Australia. Dr Bourke became involved owing to the absence, on leave, of Dr Pennington as she was acting in Dr Pennington's position. In addition to this response, and after a further request for records I also received, despite previous requests for records I thought were missing, the following:

1. Psychiatric Emergency Nurse assessment notes of Ms Healy dated 3 April 2019;

2. TraK ED notes detailing an assessment by Ms Healy dated 6 April 2019; and

3. Emergency Department notes including an assessment by Ms Healy dated 6 April 2019.

In addition I was advised *"The reference to an amendment is in relation to an entry in the RCA. The RCA states that on 6/4/19 at 1518 hrs "the client was reviewed by the registrar who recommended admission to the inpatient unit". However, Mr Kirkwood was not reviewed by a Mental Health Practitioner at 1518 hrs. The DMR indicates that at 1518 hrs Mr Craig Doolan (MHHITH) had a telephone conversation with Dr Woo, however he was not reviewed by a Mental Health Registrar or Consultant at 1518 hrs."*

60. Comments were provided with respect to Mr Kirkwood's initial presentation to the ED on 3 April 2019. I was informed of the 3 consultant psychiatrists who treated Mr Kirkwood, namely Dr Woo, Dr Giardini and Dr Pennington, none were interviewed as part of the RCA process. Comments were also provided with respect to the RCA and in particular the statements in that report:
    1. That there were 3 suicide attempts while on MHHITH and this should have triggered a review of the safety of home treatment; and
    2. The panel considered clinical decisions could have been reflective of Mr Kirkwood's behaviour and actions rather than his verbal responses.

61. Issue and/or comment was also taken with various statements made in paragraphs 17, 22, 23, 24, 27, 33, 45, 46, 48, 50, 51, 52, 59[8], 60[9], and 61[10] of my draft findings. I have carefully taken into account the criticisms and/or comments made with respect to those paragraphs.

62. As to the recommendations in the RCA set out in paragraph 54 Dr Elijah's response advises:

    I. ***'The MHHITH documentation requires completion and endorsement within the next 3 months, and it is to be made widely available'***

    2. ***'Entry Into the 1PM record must reflect what service is being provided rather than an individual consultants name'***

    - The MHHITH document suite is now fully completed. All staff are trained in DMR, 1PM, HCS and Patient Flow Manager.

    - iPM is the Patient Administration System that captures the activity for a patient. DMR is the Digital Medical Record that captures the clinical documentation. The two systems are linked and allow for clinical entries to be identified under service tabs, for example, Alcohol and Drug Service.

    - The MHHITH Operational Manual - SMHS State-wide was also implemented in late 2021.

      Mental Health Hospital in the Home t MHHITH) Operational Manual · SMHS Statewide-Manual-20211025

[8] Now paragraph 74.
[9] Now paragraph 75.
[10] Now paragraph 76.

3. ***'The orientation program to MHHITH is to provide a comprehensive education session of the Digital Medical Record documentation process'***

- New members of the team are closely supported and orientated to the use of DMR when starting work with MHHITH, including the direct observation of colleagues using the DMR program;

- MHHITH now have a dedicated MHHITH e-tab for notes and staff are orientated to the use of this tab. Only one tab per admission is used so that all notes appear in chronological order

4. ***'The MHHITH services admission criteria is to be revised to provide greater guidance on admission suitability for clients who have made recent self-harm and/or suicide attempts'***

- On the day of Jordan's death, he was assessed by two senior clinicians. Based upon their assessment on DMR, they categorised him to be in the 'active' but not 'in danger and imminent' risk of suicide, as per the CWP model. The 'active' category reflects the nature of one's thoughts, for example they may be having difficulty generating positive future thoughts and increasing distress; their perception for the future may be that life is hard but they may still have some hope and appear able to cope with the emotional pain; they may even have conscious thoughts that entertain the idea of suicide but are not actively planning or preparing for this.

- On Jordan's assessment on 29 April, he was appropriately teary in the setting of his relationship break-down and the subsequent discussion about this, but able to make eye contact and engage well with staff. He spoke spontaneously and was reflective. Jordan was hopeful for the future and felt well supported by his parents. He denied any thoughts of suicide or self-harm and was able to safety plan with staff. He was future planning and help seeking.

- Someone who is clinically assessed to be an 'imminent risk' (as per the CWP), would not be managed with MHHITH. Some of the clinical indicators that would reflect this category include an individual being unable to be distracted by thoughts of suicide, extreme hopelessness, viewing suicide as the only option, planning (for suicide) is complete;

- All patients managed with MHHITH have their management plan and progress formally reviewed and discussed by the team twice per day at clinical handover (0830 and 1400). In addition to these, there are also regular multidisciplinary team meetings, so there is ample opportunity for the team to be alerted to a change in a patient's clinical presentation, in which their management plan will be amended accordingly if required.

- In the case of Jordan's assessment, he remained in the active category, hence the clinical decision to continue to monitor him in the community. This decision was made in collaboration with Jordan, his parents, and by senior clinicians, using the triangle of care model. Jordan and those who knew him best, his family, were all in agreement with this plan.

5. ***'MHHITH is to consider access and availability for psychological intervention where it is clinically indicated and it is either to provide those interventions or to refer patients to services that can provide that treatment'***

- MHHITH does not have a psychologist on staff, but even if it did, specific longer psychological interventions would not generally be commenced during an acute phase of illness. Specific psychological therapy would usually be delivered in the community when a patient is ready. In the acute phase of illness, treatment incorporates psychoeducation, setting expectations of what psychology is and why is (sic) might be beneficial, and getting patients ready and willing to engage in therapy (if clinically indicated).

6. ***'Where consent is provided MHHITH is to ensure the involvement of significant others in the provision of collateral information'***

- Common psychiatric practice is for patients to have one identified next of kin/carer (or in Jordan's case, close contact with both parents). It is not routine practice to be seek collateral from additional sources, unless there is a clear clinical indicator for the same, a client requests it and consent is provided. MHHITH staff had no way of knowing or predicting the communication that was transpiring between Jordan and his (ex) girlfriend Ms Hapka. Given the fluctuating state of their relationship throughout the course of his admission, it did not appear

she was a 'significant other' when Mr Kirkwood was so consistently supported by two very loving parents, with whom MHHITH had regular contact.

- In terms of engagement with Jordan, a 19 year old young male, who had previously experienced fleeting engagement with mental health services, and given the sometimes conflictual relationship he and Ms Hapka had, the team prioritised confidentiality and respecting Jordan's autonomy in directing his care. Had he requested for the team to reach out to Ms Hapka, this contact would have been made. In the absence of this request, his parents with whom he had a very close relationship with, were his identified Next of Kin.

63. In conclusion the response says completed suicide is not always predictable and it may only be in retrospect that conclusions can be drawn however these do not always fit with what was clinically evident during an episode of care. It is asserted, based on the assessments of 2 very experienced psychiatrists and a psychiatry registrar, that Mr Kirkwood was not an imminent risk when he was seen on 3 separate occasions in the ED. THS believe the best environment to treat him was within a service such as MHHITH which respected his autonomy with family support and the opportunity to work. It is asserted there was clear evidence he responded to this after the first few days and for about 3 weeks thereafter. His mental state clinically improved from 6 April to the MMHITH review on 29 April. It is said unfortunately the best clinical practice does not always prevent suicide however THS endeavours to make correct diagnoses based on sound assessment and practise patient centred, safe and empathetic care. Dr Elijah says *"[o]n the final review by the treating team it was not apparent during this interaction that* [Mr Kirkwood] *appeared to be minimising information. Rather, he appeared to be appropriately sad in relation to the ending of his relationship. He denied any thoughts or plans to harm himself and was able to engage appropriately in safety planning."*

64. I note the further records provided by Dr Elijah includes an assessment by Christine Healy RN, a Psychiatric Emergency Nurse (PEN), who consulted with Mr Kirkwood on 3 April 2019 following a self-harm incident. Her notes set out a detailed history and her observations. She says Mr Kirkwood's difficulties represented a situational crisis which was contributed to by a broken relationship and the cessation of regular cannabis use. She assessed risk as low for immediate self-harm. Her recommendation

was for admission to the Department of Psychiatry at the RHH. The next clinical contact was with Dr Giardini and a registrar, following which Mr Kirkwood's care was transferred to the recently 'opened' MHHITH program. While Dr Elijah says Dr Giardini was well-equipped to be able to make a decision to admit a person to MHHITH, it is unclear from the notes whether he actually admitted Mr Kirkwood to that program. I note Dr Giardini was a locum and MHHITH had only been running for 8 days.

65. The further documentation also clarifies what transpired on 5 and 6 April 2019. Mr Kirkwood attended the ED on the evening of 5 April with his mother. They had been unable to use the MHHITH telephone number as it had not been switched through. Unfortunately, ED staff knew nothing of the service and therefore the fast track care the Kirkwood's expected was not provided. Mr Kirkwood had to wait and during this period he persuaded his mother to go home after which he left the ED. After threatening suicide to his former girlfriend he was located by police at a construction site where he was found with a noose fashioned out of belts. He was returned to the ED under protective custody. At the ED he was seen again by Ms Healy who made a number of file entries until a hand over to a mental health nurse at 7.30am. The Protective Custody order expired without there being a formal assessment. It seems the next assessment was conducted by Dr Woo during the evening of 6 April. It appears the intention was to assess Mr Kirkwood that afternoon but he was not present and police again were asked to retrieve him. It seems likely Dr Woo had initially intended to admit Mr Kirkwood to the RHH, but later chose to return him to MHHITH care. Despite there being a number of requests made by my office pursuant to s59 of the Act there is still a period of around 12 hours (7.28am to 7.18pm) where there seems to be no file entries. Dr Elijah says the failure of the telephone service was of no consequence as Mr Kirkwood would still need to be processed through the ED in the usual way. It seems counter intuitive that when a MHHITH patient's condition deteriorates they cannot be moved seamlessly into an inpatient facility without having to be processed through the often trying and extremely busy ED environment with clinicians who are not familiar with their condition and course of treatment; a process that often takes several hours.

66. Dr Sale is of the view Dr Elijah has downplayed the significance of Mr Kirkwood's first self-harm incident involving the use of velcro straps perhaps because common sense would suggest this was unlikely to be successful. Mr Kirkwood worked in the construction industry and would have had access to heavier duty forms of velcro. More importantly it is important to consider what Mr Kirkwood himself believed at

the time. Dr Sale says he has previously been involved in research concerning what people believe about the effectiveness of methods of suicide. In respect to medications, for example, there was a widespread belief in the community that objectively harmless agents would be lethal unless there was urgent medical intervention. Mr Kirkwood's second self-harm incident on April 5 is also downplayed because he had not used the noose he had set up, notwithstanding the method was one which was potentially highly lethal. In relation to the later medication overdose leading to an assessment by Dr Goh, it is unclear whether Dr Elijah agrees with Dr Goh's assessment. Dr Sale suggests the reference to matters such as Mr Kirkwood wishing to go to a party suggests perhaps a view that the behaviour was trivial.

67. Dr Elijah notes the concerns about multiple service providers being involved in Mr Kirkwood's care but suggests this as advantageous because it brings the patient into contact with different perspectives and skills. However, this may not be the perception of patients and families and is certainly not the experience of the Kirkwood family. With respect, this seems a service-centred view rather than a patient-centred attitude. It is probably a product of the nature of the organisation of the workforce at the RHH and the resources available to that hospital.

68. Dr Elijah refers to the use of the Connecting With People program (CWP) as part of the MHHITH treatment process. This is not mentioned in Mr Kirkwood's records but it was perhaps adopted later. As I understand it CWP is a program for skilling non-clinicians, e.g. work colleagues, about how to address and assist, and hopefully reduce the risk of self-harm. It is akin to a First Aid strategy. One would hope that in a specialised mental health service more sophisticated and individualised approaches remain in place.

69. As to ongoing care Dr Elijah says *"[a]n acute phase of illness is not the most appropriate time to commence longer-term therapy"*[11]. Dr Sale strongly disagrees. In his long experience he says while longer term treatment measures and the service provider(s) involved might only be involved as an introductory step, when in crisis and distressed there is no time that a patient and their carers/supports will be more receptive to the need for appropriate treatment. Having worked in both the public and private sectors for significant periods of time he says sadly the private and public sectors of mental health treatment are different countries with little understanding or familiarity with each other. Some specialist psychiatrists have experience of working in the private sector, e.g. Dr Woo, but he is the exception. Anyone working in the private sector

[11] Second paragraph on page 8 of Dr Elijah's response.

would know it would not be possible for Mr Kirkwood to be able to see a clinical psychologist or psychiatrist in a timely way. Waiting periods, particularly for more experienced clinicians, is several weeks, sometimes months. I too, from my many years of experience working in both personal injuries and workers compensation, know that this is so. Dr Sale says expecting a CATT to 'hold the fort' for more than a couple of weeks or so is impractical and unfair to the patient, their family, and those charged with the responsibility of providing care. If programs such as MHHITH expect to use referral to the private sector as a feasible management plan those that run that program must look at measures such as having practices on a retainer arrangement so as to ensure timely care.

70. Dr Elijah advises that the RCA recommendations concerning documents and file management have been completed. Surely this should have been completed well before the MHHITH commenced operation. Other RCA recommendations are not endorsed. The RCA panel is criticised for not interviewing medical staff involved (Giardini, Woo, Pennington but not Dr Goh). It is not for me to tell THS how to run their RCA process however one would have thought that in order for the RCA process to be robust, transparent and fair relevant witnesses need to be spoken to in order to obtain their version of events and/or perspective.

71. The issue concerning longer term treatment needs has been previously addressed. In relation to collateral information and there being a single next of kin[12] Dr Sale says that is simply wrong. Legally there is a designated 'next of kin' but it would be, in his view, ludicrous for clinicians not engaging with others for this reason.

72. Dr Sale says his overall impression is that while the Hospital in a Home concept is a worthy one in this instance it appears to have been rushed into action at a time when simple infrastructure issues such as the documentation suite and communication systems were incomplete or untested. He points out this was a new team and therefore it would have been prudent to accept only patients who had mental health problems that were well understood and reasonably predictable. This was a service in a 'shake down' phase where caution was warranted as service arrangements, relationships and procedure settled into place. He is of the view it was not the place for a virtually unknown young man with prominent self-harm ideation and behaviours. While he saw many service providers there was no coherent treatment and discharge plan, and his ongoing difficulties seem to have escaped attention. The plans for Mr Kirkwood's continuing care were unworkable. Dr Sale says more than three years

[12] Dr Elijah says *"[c]ommon psychiatric practice is for patients to have one identified next of kin/ carer".*

later, the THS response is discouraging. Other than fixing administrative issues such as documentation and file management there is no acknowledgement that they might have done better or that changes have been made. Dr Elijah at page 5 of his response refers to *"information that has come to light"*, but does not specify what this refers to, or how it came to light. There is no indication that whatever this information is, it was not sufficient to prompt any doubts on his part. At the very least, the arrangement for dealing with a deterioration in a MHHITH patient needs to be addressed.

73. Having considered all the evidence in this case including the very detailed and considered response by Dr Elijah I accept the opinions of Dr Sale.

Conclusions

74. I find that Mr Kirkwood should never have been admitted to the MHHITH program and on 5 April 2019 Mr Kirkwood received an inadequate level of care from the MHHITH service. First, Mrs Kirkwood attempted to call the MHHITH after-hours line after being told ED staff were not aware of the program. This line was not connected. Mrs Kirkwood was later advised the program, having only been in operation for 12 days at this time, had begun operating without the phone numbers being tested. ED staff should have been aware of the program and the after-hours line should have been operating from the date the MHHITH program commenced. This no doubt undermined Mrs Kirkwood's trust in the program and it directly contributed to Mr Kirkwood becoming frustrated and leaving the hospital where-after the incident detailed in paragraph 24 occurred. Second, Dr Woo's decision to return Mr Kirkwood to the MHHITH despite an earlier clinical decision to the contrary is very concerning. Following the incident in paragraph 24 Mr Kirkwood was not eligible for the program as he presented as an imminent risk of harm to himself.

75. As highlighted in paragraph 52, Dr Goh's assessment of Mr Kirkwood is problematic. I find Dr Goh's acceptance of Mr Kirkwood's excuse for the overdose was unreasonable given the documented history of self-harm and suicide attempts which were readily available to Dr Goh. Additionally, I find the MHHITH team were aware of the overdose and rightly doubted the reason given by Mr Kirkwood[13]. There is however no evidence this observation is then reviewed by the MHHITH team and whether it was considered in the decision which was subsequently made to discharge Mr Kirkwood from the MHHITH program. This very important observation is either missed or not acted upon appropriately. Following the polypharmacy overdose which

[13] See paragraph 29 and footnote 4.

is when Dr Goh assessed Mr Kirkwood he was not eligible for the MHHITH program as he again presented as an imminent risk of harm to himself.

76. It was substandard practice for the MHHITH team to develop a plan and treat Mr Kirkwood solely on assertions he made about events and his state of mind that he was not suicidal, particularly when those assertions were undermined by his subsequent actions to the contrary.

Comments and Recommendations

77. I **comment** that Mr Kirkwood should never have been placed on the MHHITH program when he was. Not only was that program not fully operational he did not meet all the eligibility criteria. I agree with Dr Sale and the RCA panel that the nature of Mr Kirkwood's mental health at the point of his admission to the program was such as to preclude his admission to that program. In my view he required intensive in-patient treatment. I accept his consent was required for such an admission, given there is no evidence that in early April 2019 he did not have capacity to make a decision about his own assessment and/or treatment under the *Mental Health Act* 2013, and accordingly he could not be detained involuntarily. That consent was however likely to be forthcoming given one of the eligibility criteria for the MHHITH program was an agreement to be involved in decisions about his treatment and Mrs Kirkwood's evidence that up until the evening of 29 April 2019 Mr Kirkwood *"had always been happy to seek help."*

78. I **comment** that there were at least two occasions, being those outlined by Dr Sale, when Mr Kirkwood's participation in the MHHITH program should have been reviewed and terminated. Had this occurred then it is likely Mr Kirkwood would have received in-patient care and treatment. Although it is not possible to speculate about whether the provision of inpatient care and treatment would have prevented Mr Kirkwood's death at some point in the future, what can be said is that common sense suggests his survival, at least in the short term, would have been assured.

79. I **recommend** the RCA's recommendations set out in paragraph 54 are implemented in full.

80. I **recommend** that in order for mental health patients to build trust and rapport with their treatment providers that the number of medical and allied staff be limited to as few staff as possible in order to avoid the difficulties highlighted in paragraph 46.

81. I **recommend** the responses to Coroner McTaggart's recommendations set out in paragraph 58 are finalised as soon as reasonably possible.

82. The circumstances of Mr Kirkwood's death are not such as to require me to make any further comments or recommendations pursuant to Section 28 of *the Coroners Act* 1995. Mr Kirkwood's death is profoundly sad but in my view it was regrettably foreseeable given the deficits in his care and treatment.

Acknowledgements

83. I extend my appreciation to investigating officer Constable Oliver Smith for his very thorough investigation and report.

84. I convey my sincere condolences to the family and loved ones of Jordan Kirkwood.

Dated: 19 May 2023 at Hobart in the State of Tasmania.

Robert Webster

Coroner