



MAGISTRATES COURT of TASMANIA CORONIAL DIVISION



In the Inquest into the Death of Liam Peter Mead

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

Ruling on Evidence

- 1 Liam Mead died on 7 March 2017. I am conducting an inquest into his death.
- 2 On the evidence to date, it is open to find the following circumstances surrounding his death.
- 3 Liam was a teenager when he died. He had experienced deterioration in his level of function in late 2016. That deterioration was associated with a disagreement with his parents about his use of electronic devices, an injury playing soccer, and the end of his relationship with his girlfriend. Liam was treated by a psychiatrist, Dr. Jason Westwater, in December 2016 and January 2017. He spent some time as an inpatient in the Wyndham Clinic Private Hospital in Victoria in January 2017. He was admitted as an inpatient to the Albert Road Clinic on the 13 February 2017. He was discharged from that clinic on the 5 March 2017, two days before his death.
- 4 One of those issues identified for inquiry at the inquest was the adequacy of adolescent psychiatric services in Tasmania.
- 5 In that regard, evidence has been received from a paediatrician, Dr Anagha Jayakar, about services available in Tasmania for youths and adolescents suffering a mental illness including those who are to be treated as inpatients. The effect of that evidence is, in part, that adolescents with a mental illness who are to be treated as inpatients are presently treated either on general paediatric wards or in adult psychiatric wards. Both of those settings have disadvantages. In addition, there has been evidence about possible advantages to the availability of inpatient care and treatment after discharge which is geographically close to the adolescent patient's family and social supports.

The Evidence Objected To

- 6 It is proposed to call Professor Patrick McGorry, Professor of Youth Mental Health at the University of Melbourne and the Executive Director of Orygen, the National Centre of Excellence in Youth Mental Health. He has provided a report dated 22 May 2019. In that report he says as follows:

“The final area I have been asked to comment on is in relation to adolescent and youth mental health care generally. My colleagues and I have been involved in the design and construction of a system of youth mental health care ranging from primary care through to specialist and tertiary mental health care including inpatient care over the past 2-3 decades. The kind of care required depends completely on the complexity, severity and persistence of the particular condition and the nature of that condition. Hospitalisation is generally only required for the management of risk provided there are intensive community mental health services available. There are also some occasions when inpatient care as therapeutic intervention itself is indicated but our private and public mental health systems tend to offer intensive care only in an inpatient setting. Outpatient forms of care are relatively hard to access, particularly quality care, and when available they are rarely of the frequency, intensity and skill to produce optimal outcomes. There are a range of reasons for this which relate to funding, workforce and geographical considerations. In Liam’s case, to access more intensive more intensive [sic] and skilled care he was forced to travel interstate, which lead [sic] to a dislocation of his care so that the links to his inpatient care and outpatient care were not have been [sic] as smooth as they might have been. Having said that, even in the same city in Melbourne, this is a major issue on many occasions.

There are major problems associated in placing young people with mental illness in poorly designed facilities, particularly if they are mixed with adults in adult psychiatric units or in general paediatric units which are designed for children with medical illnesses. Purpose-built facilities are essential, and this also applies to outpatient and community-based services such as headspace and other youth friendly environments. Young people to feel comfortable and [sic] must be in a culturally appropriate space which is safe for them.

As mentioned above, it is a significant problem if young people are treated in inpatient care in facilities in geographically remote from their family and friends. In this case, Liam’s parents made significant efforts to spend time with him in Melbourne and he had other relatives in Melbourne too, but he was certainly cut off from friends and other supports. Online connection helps to maintain links with friends and other, nevertheless this is still a potential problem.

I am acutely aware that the situation for quality youth mental health care in the state of Tasmania leaves a great deal to be desired. This does not only apply to the lack of dedicated inpatient facilities, but also to appropriate youth friendly community-based services, apart from a small number of headspace centres. In terms of specialist mental health care for high risk and complex patients with persistent serious mental illnesses, such as Liam suffered from, the level of expertise available is decidedly thin on the ground. Tasmania is particularly weak in this regard when compared with other Australian states though the latter are a long way from optimal at this stage. Australia has made significant progress in recent years in building a primary care system of care for young people with emerging mental disorders namely headspace, but this is not backed up by specialised forms and levels of care for young people with more complex and serious problems. There is an urgent need for a comprehensive youth mental health plan in the Tasmanian health system, which would range from acute and tertiary inpatient beds through sub-acute, stepdown residential units, mobile home treatment teams, assertive community treatment teams, and skilled multi-disciplinary linked to

headspace centre, primary care options and schools. This would be a major reform strategy, but until this actually occurs, preventable suicides and widespread disability caused by mental illness in young people will continue to be a major health problem.

In conclusion, Liam's death was a terrible tragedy, which is heartrending on any reading of the material that has been made available to me. What is particularly disturbing in his young age and potential, which will never now be fulfilled and the long-term grief that his parents will suffer. It does not seem to me that his death could have been reasonably predicted at the time that it occurred, apart from general heightened risk immediately post discharge in someone that is suffering from an only partially remitted depressive illness with known suicidal risk. However, it is quite possible that if the inpatient unit had been located in Tasmania and there was very active daily outreach follow up for him following discharge with better engagement of the patient with the same treating team that the outcome might have been different."

- 7 Counsel for the Tasmanian Health Service, Mr Paul Turner SC, objects to that evidence in particular the evidence which addresses the adequacy of adolescent psychiatric services in Tasmania. He does so on the basis that that issue does not fall within the proper confines of the inquest. In particular, it is submitted that all of the services engaged for Liam's care were private services. No public health services were engaged. There is therefore no cause to consider the adequacy of such services.
- 8 For the reasons which follow I consider that the scope of the inquiry originally articulated is too broad. However, the scope of the inquest can be appropriately limited. Even with such limitation, the evidence of Professor McGorry is relevant and will be admitted.

Findings To Be Made

- 9 The starting point is s 28 of the *Coroners Act* 1995. That section provides as follows:

Findings, &c., of coroner investigating a death

"(1) A coroner investigating a death must find, if possible –

- (a) the identity of the deceased; and
- (b) how death occurred; and
- (c) the cause of death; and
- (d) when and where death occurred; and
- (e) the particulars needed to register the death under the [Births, Deaths and Marriages Registration Act 1999](#) .
- (f)

(2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

(3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

(4) A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.

(5) If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that

person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care.”

- 10 Evidence relevant to findings about how Liam’s death occurred and the cause or causes of his death is admissible.
- 11 The obligation to find how death occurred refers to the means or mechanism by which Liam died and extends to the circumstances attending the death. That is, I am required to find by what means and in what circumstances the death occurred *Re The State Coroner; ex parte Minister for Health* (2009) 38 WAR 553 per Buss JA at [42]. That decision is in respect of s25 of the *Coroners Act* 1996 (WA) which is relevantly identical to the s28 of the *Coroners Act* 1995 (Tas) in terms of the duty to make findings.
- 12 Further, in *Attorney General v Copper Mines of Tasmania Pty Ltd* [2019] TASSC 4 the Full Court of the Supreme Court of Tasmania considered the admission of expert opinion evidence. Blow CJ (at [39] with whom Pearce J and Marshall AJ agreed at [48] and [50] respectively) referred with approval to *Preece v West* [2012] VSC 327, (2012) 40 VR 521 where Maxwell P and Harper JA said that an expansive or inclusive approach to the investigation was appropriate. Although *Attorney General v Copper Mines of Tasmania Pty Ltd* dealt principally with the duty to afford procedural fairness to an interested party the observations about the broad nature of the inquiry are apposite.
- 13 A circumstance attending Liam’s death is that he had been treated for mental illness at an inpatient clinic in Victoria. On the evidence it is open to conclude there are disadvantages to such treatment occurring away from Liam’s family and social supports. He was discharged from that interstate mental health facility two days before his death when it might be concluded there was an increased risk of suicide. There is evidence that he had expressed suicidal thoughts on many occasions leading up to his death. It will be necessary to determine whether or not Liam took his own life. But if it was concluded that he had done so, the nature and availability of mental health services for adolescents to treat any mental health problem such as Liam was treated for, and managing the risk of suicide for adolescents with expressed suicidal thoughts such as Liam, are clearly circumstances surrounding his death. That includes considering what inpatient services are available and what treatment is available post discharge. Such matters are properly within the scope of the inquiry. The evidence of Professor McGorry is relevant to those matters.
- 14 The cause of Liam’s death is a question of fact which must be determined by applying common sense to the facts of the case. It is not limited to direct natural and probable causes, proximate in time or real effective causes or a material contribution. The question of causation is not limited by causes that are reasonably foreseeable. Neither is the mere satisfaction of the but-for test sufficient although it is a useful negative criteria: *Re The State Coroner; ex parte Minister for Health*, above, per Buss JA at [44] and [45] referring to *W R B Transport v Chivell* [1998] 201 LSJS 102 [20]-[21] per Lander J.
- 15 In this case, Professor McGorry’s evidence is that it is quite possible the outcome might have been different if the inpatient unit had been located in Tasmania and there was very active daily outreach follow up with the same treating team with better engagement following

discharge. The availability and adequacy of services which would address that possibility is a matter of relevance. It may well be that, in so far as possibility alone is raised, that would, in the end, be an insufficient basis for a finding that any unavailability or inadequacy in such services was a cause of death. But that does not prevent it from being an appropriate matter of inquiry to assess the strength of that possibility and whether it might be as firm as a likelihood. Combined with other evidence it might be that evidence would enable a finding of causation to be made. That is an appropriate matter for consideration and the evidence of Professor McGorry is relevant to causation in that way.

Recommendations or Comments

- 16 It is well established that an inquest ought not be held solely to enable comments or recommendations to be made. The power to make such comments and recommendations is not free standing. The coroner has no power to conduct a roving commission of inquiry into any matter connected with the death. Indeed, the power to comment and make recommendations is subordinate and incidental to the power to make findings relating to how deaths occurred and their causes. The powers to comment and make recommendations arise as a consequence of the prime function to make findings about how death occurred and the cause of death: *Harmsworth v State Coroner* [1989] VR 989 per Nathan J at 996.
- 17 But once the inquest is held, although the limits on the power to comment are not easily defined, it is wide so long as it is connected with the death: *Commissioner of Police v Hallenstein* [1996] 2 VR 1 per Hedigan J at 7. Similarly recommendations must be made with respect to ways to prevent further deaths whenever appropriate. The reference to “further deaths” requires that the recommendations arise out of, or have some connection to, the findings in respect of this death. In *Attorney General v Copper Mines of Tasmania Pty Ltd* above, Blow CJ said that the duty to investigate the circumstances leading up to the death includes doing so with a view to making recommendations with respect to ways of preventing further deaths and other appropriate matters: at [45]. His Honour considered evidence admissible if it would assist in deciding whether it is appropriate to make recommendations with respect to ways of preventing further deaths or on some other matter.
- 18 The nature and availability of mental health services for adolescents in Liam’s situation are perhaps only relevant in the event of a finding that Liam took his own life. That is a matter about which it is not appropriate to make any determination or express a view about at this stage. But such a conclusion is clearly open on the evidence. In the event a finding was made to that effect, questions about the services available to treat the mental health condition creating the risk of suicide and services available to manage that risk, both as an inpatient and in the community after discharge as an inpatient, are in my view sufficiently related to this death to be considered circumstances surrounding his death in to which it is appropriate to inquire. They may also have a bearing on the cause of death.
- 19 Once the issue of the availability and adequacy of such services for that purpose is raised as a matter relevant to a finding about how death occurred or the cause of death, the court is not limited to evidence solely relevant to that finding. It is permissible to consider other evidence which addresses recommendations which might prevent such deaths in the future or comments on matters connected with Liam’s death. That evidence can extend beyond the circumstances of this particular death and look more broadly at matters which might be

relevant to recommendations arising out of findings about the circumstances of death. In my view that includes services which if they were available in Tasmania might have been utilised. The absence of such services is relevant to recommendations and comments which might be made arising out of those circumstances. It might be that no recommendations are necessary and no comment is appropriate. But the availability and adequacy of mental health services for adolescents might be an appropriate matter for comment or a matter about which recommendations with respect to ways of preventing further deaths are necessary, for example by providing inpatient and appropriate follow up treatment. The evidence of Professor McGorry is relevant to those matters.

- 20 For the above reasons I consider the evidence of Professor McGorry referred to above is relevant to the findings that need to be made. Even if not directly relevant to those findings it is relevant to comments and recommendations which might be appropriate and required as a result of findings about the circumstance and cause of Liam's death. If it was found that Liam took his own life then just as the nature and quality of the treatment and suicide risk management undertaken by those treating and caring for him including the Albert Road Clinic is relevant, so the absence of such services which might have had advantages for Liam's treatment and risk management are relevant. Indeed, in *Harmsworth v State Coroner* above, Nathan J considered the adequacy of prison facilities could be a matter of legitimate comment. In similar ways the adequacy of mental health services for adolescents like Liam could be a matter about which it is appropriate to comment.

Scope of the Inquiry and Conclusion

- 21 The articulation of the issue for inquiry is presently too broad because it extends to all adolescent mental health services generally. It is properly limited to the availability and adequacy of services to treat mental illness and manage the risk of suicide for adolescents such as Liam. Although expressed more broadly than that initially, it has never been intended to extend the scope of the inquiry beyond that. However, even on that basis the evidence of Professor McGorry is relevant. That does not involve an extended enquiry or roving royal commission of the sort criticised in the various decisions cited. I rule that the evidence objected to is to be admitted on the inquest.
- 22 In light of that ruling I understand that Mr Turner SC will seek to provide evidence from the Chief Psychiatrist. I expect that material will be able to be obtained in relatively short order and will convene a directions conference to allocate further hearing dates to take that evidence, conclude the evidence of Mr Mead and give directions about the timing and form of submissions.

Dated: 2 August 2019 at Launceston in the State of Tasmania

Ken Stanton
Coroner