OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	Inquest into the death of Matthew John Liddell
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR /03 2271
DELIVERED ON:	20 June 2007
DELIVERED AT:	Brisbane
HEARING DATE(s):	26 June 2006, 20, 21 and 22 November 2006
FINDINGS OF:	CA Clements, Deputy State Coroner
CATCHWORDS:	**CORONERS: Inquest; hanging death of young man receiving psychiatric care in hospital; procedure for observation of patients; procedure for assessment of suicide risk.**

REPRESENTATION:

Counsel:

Assisting:	Mr S J Hamlyn-Harris
Toowong Private Hospital:	Ms M J Burns, instructed by DLA Phillips Fox
Department of Defence and Department of Veteran's Affairs:	Mr G Kalimnios, instructed by Australian Government Solicitor
Jennifer Therese Hickey:	Mr G Rebetzke, solicitor, Roberts and Kane
Dr Geoffrey Rees:	Mr H McKay instructed by United Medical Protection

CORONERS FINDINGS AND DECISION

Introduction

1. This is the inquest into the death and circumstances of death of Matthew John Liddell, who was born on 18 September, 1974. Mr Liddell died on 24 November 2003 at the Royal Brisbane Hospital.

2. At about 1.05 am on Sunday 23 November 2003, he was found by a nurse in the bathroom of his room at the Toowong Private Hospital, where he was a patient receiving treatment for a mental illness, with a ligature made of a shoelace around his neck and connected to a shower tap.

3. Nursing staff immediately rendered medical assistance until the ambulance arrived at 1.23 am. Medical assistance then continued by ambulance officers together with nursing staff and an intensive care paramedic who arrived shortly after the ambulance officers.

4. Mr Liddell was transported to the Royal Brisbane Hospital and arrived there at 2.04 am on 23 November 2003. He was placed in intensive care and was ventilated until 11.15 am on Monday 24 November 2003 when life support was discontinued. A certificate was issued stating that life was extinct at 11.33 am on 24 November 2003.

5. Matthew Liddell had joined the Royal Australian Navy in 1993. In 1998, he was serving on the HMAS Westralia at the time of a fire in the engine room resulting in the death of four others. As a result of his experiences at that time, he had been suffering from severe post-traumatic stress disorder and depression, and had been under psychiatric care.

6. A Board of Final Medical Survey recommended that Mr Liddell be discharged from naval service as medically unfit and he was discharged on 28 May 2000. This medical board considered Mr Liddell's post traumatic stress disorder and also the continuing effects of a fractured right tibia he suffered in July 1998 and complaints of chest pain but it is apparent from relevant documentation that his post traumatic stress disorder was predominantly the basis of his discharge on medical grounds.

Coroners Act 1958 applies

7. The inquest was conducted pursuant to section 26 of the *Coroners Act 1958* ("the Act") because Mr Liddell's death occurred before 1 December 2003, the date on which the *Coroners Act 2003* was proclaimed. It is therefore a "pre-commencement death" within the terms of section 100 of the latter Act, and the provisions of the *Coroners Act 1958* are preserved

and continue to apply in relation to the inquest. I must deliver my findings pursuant to the provisions of that Act. I do so, reserving the right to revise these reasons should the need or the necessity arise.

8. The purpose of this inquest, as of any inquest under the Act, is to establish, as far as practicable –

- the fact that a person has died:
- the identity of the deceased person;
- whether any person should be charged with any of those offences referred to in section 24 of the Act;
- where, when and in what circumstances the deceased came by their death.

9. A coroner's inquest is an investigation by inquisition in which no one has a right to be heard. It is not inclusive of adversary litigation. Nevertheless, the rules of natural justice and procedural fairness are applicable. Application of these rules will depend on the particular circumstances of the case in question.

10. In making my findings I am not permitted, under the Act, to express any opinion on any matter which is outside the scope of this inquest, except in the form of a rider or recommendation.

11. The findings I make here are not to be framed in any way which may determine or influence any question or issue of liability in any other place or which might suggest that any person should be found guilty or otherwise in any other proceedings.

12. It has been very hard for Matthew Liddell's family to come to terms with losing him in these tragic circumstances. I express my sympathy and condolences, and that of the Court, to his family and friends in their sad loss.

SUMMARY OF THE EVIDENCE

Psychiatric treatment - Dr Rees

13. Matthew Liddell was a patient of Dr Geoffrey Rees, psychiatrist from 18 May 2000, after being referred by Dr David Crompton, until his death on 24 November 2003. Dr Rees's opinion was that Matthew suffered from post traumatic stress disorder and major depression as a result of his involvement in the Westralia disaster in May 1998. He initially saw Matthew on a sporadic basis, but then saw him approximately once a month during the first half of 2003. In April 2003, Dr Rees prescribed anti-depressant medication.

14. In May 2003, Matthew Liddell was discharged from the Navy on medical grounds and then went on a pension from the Navy due to his condition.

15. Dr Rees next saw Matthew on 11 June 2003. Matthew told him that although Dr Rees had prescribed the anti-depressant medication six weeks earlier in April, he had not started taking it because funding for medication was not immediately available from the Military Compensation and Rehabilitation Service (MCRS). Dr Rees wrote to the MCRS to rectify the situation.

16. On 9 September 2003, Dr Rees saw Mr Liddell again for the purpose of preparing a report that had been requested by the MCRS. In a report dated 11 September 2003, Dr Rees said that Matthew continued to report a significant symptom burden from his post traumatic stress disorder with nightmares about the Westralia tragedy and other military and naval themes on a nightly basis. He considered that Matthew had yet to gain the full benefit of psychiatric treatment and was not fit to return to work or to a vocational rehabilitation program although he believed that Matthew would be employable in the long term.

17. Dr Rees said that despite Mr Liddell's keenness to return to the work environment and his interest in seeking a rehabilitation program in the field of motor mechanics, Dr Rees had grave concerns that he was not currently fit to do so. He noted an earlier attempt at a motor mechanics apprenticeship that Matthew undertook with the Eagers Car Company which ended with him being dismissed as a result of altercations with colleagues. He was concerned that the same sort of contentious work situation might occur again. Dr Rees asked that Matthew be reassessed in a further 6 months time when his fitness to enter a vocational rehabilitation program might be more appropriate.

18. In his report of 11 September 2003, Dr Rees also pointed out that Mr Liddell's financial situation was extremely parlous in that he was receiving about $400 per week of which $180 was spent on rent:

> "In this context, it is extremely important that this man is able to have ready access to suitable psychiatric medications at a subsidised price. Mr Liddell has unfortunately forgone his anxiolytic anti-depressant medication Citalopram as a result of his poverty and I understand that MCRS is able to assist in this by setting up an account at a local chemist so that he may be able to obtain this medication free or at suitable discount."
>
> I understand that Mr Liddell has approached MCRS regards this but due to changes of staff and misunderstandings, so far he has received no satisfaction in this regard. Certainly I believe

that this would enhance his clinical progress significantly and make this man's burden of anger and frustration somewhat less.

His current medications remain Citalopram 20 mg mane and Temazepam 10 mg nocte alternating every second week with Zopiclone 7.5 mg nocte."

Admission to Toowong Private Hospital

19. On 8 November 2003, Dr Rees was contacted by Matthew's family who were concerned about his state of mind. In consultation with them, Dr Rees arranged for Matthew to be transported by ambulance from his parents' home near Tin Can Bay, via Gympie Hospital, to the Toowong Private Hospital and admitted for treatment. At that stage, Matthew had presented showing suicidal intentions after separating from his de facto wife, who had filed a domestic violence order against him which was concerning him greatly. Dr Rees was informed that Matthew had ceased his anti-depressant medication about one month before this admission, at the time of the separation from his de facto wife. He also reported missing greatly his baby daughter, Imogen, as a result of the domestic violence order. Imogen was born in May 2003.

20. The Toowong Private Hospital is a 54 bed acute psychiatric facility. It is not a secure unit, and doors are not locked.

21. In hospital, Matthew continued under the care of Dr Geoffrey Rees. Dr Rees visited him on almost a daily basis and again started him on an anti-depressant. After he showed signs of improvement, Dr Rees approved him going on weekend leave into the care of his sister Michelle Campbell, who lived at Crestmead and had visited Matthew during the time that he was in the Toowong Private Hospital.

22. The first weekend leave was overnight from Saturday 15 November 2003 until the evening of Sunday 16 November 2003. This had apparently gone well, and on his return to the hospital Matthew was noted to be interacting well with nursing staff and told them that he had had a good leave and was feeling very relaxed.

23. Dr Rees last saw Matthew on Thursday 20 November 2003. On that date he presented as much improved and not suicidal, but still having nightmares. He was still on his medication. He remained angry with his de facto wife over the loss of access to his daughter. Week-end leave was again approved, from Friday 21 November 2003 to Sunday 23 November 2003.

24. On Friday 21 November 2003, a member of the nursing staff told Matthew that Dr Rees would be at the hospital at 7.30pm to see him, but Matthew

said he would not be there as he was leaving for weekend leave with his sister at 7.00pm. Dr Rees was contacted and had agreed that he would then see Matthew on the following Monday. Matthew left the hospital in the company of his sister at 7.00pm.

Early return from leave

25. On the afternoon of Saturday 22 November 2003, Michelle Campbell brought Matthew back to the hospital early at his request.

26. Earlier that day, Ms Campbell had observed Matthew's condition to deteriorate while he was in her care at her home. He appeared very withdrawn and pre-occupied with the police investigation into the alleged breach of the domestic violence order. On the Saturday morning, he spoke by telephone from Michelle Campbell's home with a police officer in Tin Can Bay and after that became very withdrawn and depressed and in the afternoon asked to be taken back to the hospital instead of waiting until Sunday night. He also spoke on the telephone to Dr Rees, who attempted to reassure him.

27. Dr Rees's evidence was that on the Saturday morning, Matthew telephoned him to express concern that police wished to interview him regarding the domestic violence order. Matthew was concerned that he might be imprisoned without a bail hearing. Dr Rees reassured him that this could not happen, and that in any case he remained a patient of the Toowong Private Hospital and no interview would occur until Dr Rees said that he was well enough.

28. Ms Campbell drove Matthew back from her home at Crestmead, dropping him off at the Toowong Private Hospital about 3 pm. After waiting for him to go inside, she returned home, but she continued to worry about the behaviour she had observed in him during the day. At 7.09 pm she telephoned the hospital to inform them of her concerns and spoke to a female nurse on duty, told her that Matthew was depressed and asked her to make sure they watched him and kept an eye on him. Ms Campbell says that the nurse laughed and said that Matthew was happy and watching the football. She felt reassured by this.

29. At about 8.03pm, Michelle Campbell received a text message on her mobile phone from Matthew, expressing hostility towards his former de facto.

Evidence of the nursing staff

Registered Nurse Hickey

30. Registered nurse Jennifer Therese Hickey was working on an afternoon shift on 22 November 2003 from 3.00pm until 9.30pm. She was in the nurses' station at the hospital when Matthew returned from weekend leave and recalled that he appeared angry and distressed.

31. The nurse in charge of the afternoon shift, registered nurse Liz Fountain, received Matthew when he arrived. Because Matthew had come back early from weekend leave, he had not been allocated to any particular nurse's list for that shift. Ms Fountain then allocated Matthew to Ms Hickey's patient list. Matthew was informed of that fact, and he then went to his room.

32. Ms Hickey engaged Matthew in a one to one conversation shortly after he had arrived back at the hospital. Matthew "ventilated" the issues which had led to his return to hospital and his feelings of anger towards his former de facto and family. Ms Hickey estimated that this conversation would have gone on for about 35-45 minutes. Initially, Matthew was quite hostile and dismissive of her, although physically calm and not outwardly aggressive. It took some time before she was able to develop rapport with him in order to discuss the stressors he was experiencing which had led to his return to the hospital. He identified as key stressors a domestic violence order that his ex-partner had taken out against him which he felt was unfair, and conflict in his relationship with his family members and in particular his sister, although Ms Hickey was unable to recall actual details of this conflict.

33. Ms Hickey also made the following note in Matthew's hospital chart in relation to this conversation:

> "Homicidal + suicidal thoughts. Reports feeling safe in hosp.
> Resistive to reframing events or negative thinking patterns."

34. Ms Hickey recalled Matthew telling her that part of the reason he had come back to hospital was that he felt safe in the environment there. She carried out a risk assessment, which involved asking a number of questions to explore his level of risk. By the end of their conversation, Matthew was a lot less angry and she felt she had gained some rapport with him.

35. Ms Hickey added a further note in the hospital chart, which she thought would have been towards the latter part of the shift, in which she recorded that he was settled in the unit, socialising with co-patients and was reactive and interactive. In evidence, Ms Hickey explained that Matthew was socialising with co-patients in the courtyard, and she observed him to

interact with everyone who was watching the World Cup Rugby match that evening. Although she did not specifically recall, Ms Hickey believed that in accordance with her usual practice, she would have relayed the information on Matthew's medical chart to night shift nurses Carol Austin and Jenny Hanley at handover before her shift ended at 9.30pm.

36. Ms Hickey said that the hospital had now introduced a form to be completed as a risk assessment tool, which was now used particularly when a patient was admitted. The form guided nursing staff through a number of issues in relation to risk assessment. It was not in use in November 2003, but Ms Hickey said that it contained the key issues of risk assessment that she would cover without the tool. Her approach to risk assessment had not fundamentally changed with the introduction of the form. Ms Hickey said that this method of risk assessment had been part of the core practice she had used for some fifteen years, and she had used it thoroughly with Matthew after his early return from leave.

37. On the night of 22 November 2003, there were 32 patients and three registered nurses on duty on the night shift. Level 1 registered nurse Carol Ann Austin and Level 1 registered nurse Jenice Irene Hanley were each working a ten hour shift starting at 8.45pm. Another Level 1 registered nurse, Tricia Gaye Simpson, commenced work at 10.30pm on an eight hour shift. Ms Hanley was the allocated nurse in charge that night.

Registered Nurse Austin

38. Ms Austin started work at 8.45pm. There was a hand over from the afternoon shift nurses to the night shift nurses from about 8.45pm until about 9.30pm. Ms Austin could not specifically recall the handover, but she was aware that Matthew Liddell had returned early from weekend leave earlier in the day, and remembered being told at some stage that he had been angry and distressed when he came back to the hospital. As a result, she made a conscious decision to keep an eye on him during the evening. From her experience patients frequently come back early from leave and that in itself is not cause for concern. Ms Austin had not had much contact with Matthew Liddell before that evening, but could remember one occasion a few nights before when she gave him his medication at night. On that occasion, he spoke to her about a domestic violence order his partner had taken out against him and was quite angry about that.

39. Ms Austin said that she and Ms Hanley had been working night duty for about five or six years together and, once the handover was completed, they liked to circulate among the patients and keep an eye on them and in particular on any patients who may have been distressed during the previous shift.

40. That evening, she saw Matthew in one of the two TV rooms watching the Rugby World Cup grand final with other patients. She said there was a lot of camaraderie in the room and she particularly noticed Matthew's demeanour which she described as "very … cheerful, very relaxed … no tension evident in him, quite happy looking". That was nearly at the end of the football match. After the football, she noticed Matthew go out into the courtyard from the TV room and estimated that he would have been there for a couple of hours at least, and she was able to inconspicuously keep an eye on him. The courtyard was just outside the door of the nurses' station. Matthew seemed quite calm and was not displaying any anger or tension that she could see. He was with a female patient and seemed quite natural and calm and quite relaxed with her. They appeared to be talking with each other, with no signs of agitation from him.

41. At about 12.30am, Matthew and the other patient he had been talking to came in from the courtyard together to get their medication before going to bed. Ms Austin first gave the female patient her medication at the medication room. Matthew waited a few steps behind her, and after she left, Ms Austin asked him "Do you want your sleepers?". He "light-heartedly shrugged" and said "alright, yeah." or "whatever", and took the tablets in front of her. Ms Austin described his demeanour at that time as "contented and calm and cheerful, but not overly elated … not at all unhappy". She did not sense any tension about him and thought that the patient he had been speaking to had helped him with the issues that were concerning him earlier in the day.

42. Matthew took his tablets in front of Ms Austin and then walked off in the direction of his room. His room was number 13, which was about two-thirds of the way down the corridor, and it would take him a minute or two to get there. Ms Austin estimated that Matthew went to his room at about 12.40am.

43. Ms Austin explained that routine hourly observations of patients in their rooms commenced from 11.00pm. There were three nurses on duty and as there were three corridors, they each took one corridor on the observation rounds. That night Ms Austin was checking the corridor of rooms that included Matthew's room.

44. She started the observations at 1.00am. When she got to Matthew's room, room 13, the lights were still on in the room and she could see that his room mate, Pete, was sitting in bed listening to music on his headphones. Of the two beds, Matthew's was the bed closest to the door. She noticed that it was dishevelled and had a packet of "Starbursts" and a packet of cigarettes on it. She asked Peter, "Where's Matt?". He said that Matthew was in the shower and then added, almost as an afterthought, that Matthew had been in the shower "for a fair while". She then knocked on the bathroom door but there was no response. She called Matthew's

name and again had no response. She then opened the door and called again. She could see Matthew sitting slumped on the floor, but could not see all of him because the shower curtain was between them. The shower was on and she thought that Matthew must have fallen asleep in the shower. She again called his name in order to try to wake him, but when she received no answer, she pulled back the curtain and saw that Matthew was sitting naked on the shower floor with his back against the wall of the shower where the taps were. She then saw the ligature around his neck and immediately pressed the emergency buzzer on the wall of the bathroom.

45. Ms Austin then turned the shower off, closed the door and told Pete not to go in. She ran out of the room towards the nurses' station and at that stage met Jenny Hanley who was running towards her in response to the alarm. They both raced into the nurses' station, where Jenny grabbed the ligature knife (a special emergency knife which will not cut skin) and threw it to Ms Austin.

46. Ms Austin then ran back to Matthew's room. She could see that his bottom was slightly off the floor. She could also see that he had used his boot laces to make a ligature which was attached tightly to the tap and tied with a slip knot, with his weight pulling it tight. The taps in the shower were arranged vertically, and the ligature had been tied to the top tap, which she estimated to be about three and a half feet off the ground.

47. She cut the bootlace with the ligature knife and supported Matthew's body down to the floor. She then turned him over and thumped him on the back and shouted his name. She could see that he was not yet blue. She turned him over onto his back and began mouth to mouth resuscitation. Jenny Hanley had followed her into the room and simultaneously started cardiac compressions. Matthew's lungs were inflating. Tricia Simpson arrived and took over the compressions so that Jenny Hanley could return to the nurses' station to telephone the ambulance, the Director of Clinical Services and Matthew's psychiatrist, Dr Rees.

48. The nurses continued performing cardio pulmonary resuscitation (CPR) on Matthew for about twenty minutes until ambulance officers arrived and took over. When the ambulance officers arrived, they asked the nurses to keep going with the CPR while they got their equipment set up. Ms Austin noticed that Matthew still had good colour, indicating that blood must have been flowing, and his lungs were also inflating. Although she kept trying to feel for a pulse, it was difficult to detect. The ambulance officers used a defibrillator and, after connecting Matthew up to their machines, were able to detect a pulse. They transported him to the Royal Brisbane Hospital.

49. Ms Austin later spoke to Matthew's room mate, Pete, who told her that Matthew had had a conversation with him and had even helped him to

untangle his earphones before going to the shower. Pete had not picked up anything odd or concerning about Matthew's behaviour. Afterwards, Pete said that he realised Matthew did not take a towel or pyjamas to the bathroom with him. Pete was annoyed that he had not spotted that earlier.

50. When Ms Austin found Matthew in the shower, it was 1.05am. She estimated that it was at about 12.40pm that she had last seen Matthew when he left the nurses' station after taking his medication. Ms Austin said that she initially watched Matthew closely that night, but could find no indication that he was suicidal or even depressed.

51. Ms Austin said that if a relative or friend telephoned about the safety of a patient, she would pass this on to the nurse in charge and probably document it, but there was no set telephone procedure. She said that a family member who telephones to speak to a patient might be put through straight away, but often it was necessary to go and look for the patient, and occasionally it happened that a nurse would say to the family member that she could not find the patient at the moment and ask if they could call back. That could happen if the patient had gone to the shop or was in a more secluded area of the hospital.

Registered Nurse Simpson

52. Level 1 Registered Nurse Tricia Gaye Simpson worked the eight hour night shift which commenced at 10.30pm on Saturday, 22 November 2003. Because nurses Jenny Hanley and Carol Austin were both working the longer ten hour shift which had started at 8.45pm, she received a handover from them when she started work. She was told that Matthew had come back from leave early that afternoon and was given some information about the circumstances. Ms Simpson said that if any patient came back early from leave, she would probably have called their doctor to be on the safe side, to inform the doctor that this had occurred.

53. She did not recall specifically observing Matthew that evening, but did recall that during the evening, Ms Hanley and Ms Austin had discussed the fact that Matthew was watching a football game on television with other patients and was not isolating himself or appearing depressed.

54. Ms Simpson said that she commenced doing observation rounds at approximately 1.00am on 23 November 2003 in one of the three wings of the hospital. She had almost completed the round of her wing, in which everyone appeared to be asleep, when she heard the emergency alarm ring, and by looking at a display screen which hangs from the ceiling in each of the wings she could see that the emergency was in room 13. She then hurried to room 13 and on arrival, saw that Carol Austin and Jenny Hanley were performing CPR on Matthew on the bathroom floor of his

room. She then took over from Jenny Hanley so that she could call the ambulance and make other necessary telephone calls. She did chest compressions while Ms Austin was performing mouth to mouth resuscitation. They continued to resuscitate Matthew during the period of about 20 minutes until the ambulance arrived, and while the ambulance officers set up their equipment. Although they could not detect a pulse, the ambulance officers were able to do so once their equipment was hooked up. Once Matthew was connected to their machines, the ambulance officers took over his management and transported him to the Royal Brisbane Hospital.

55. Ms Simpson also spoke that night with Matthew's psychiatrist, Dr Geoff Rees, after he arrived.

56. Ms Simpson said that Matthew's attempt to hang himself was a shock because she understood that he was not showing any signs for concern that evening. If a patient was considered a high risk patient they were normally put in the "special care" rooms closest to the nurses' station. In the past she had sat in a room with a patient doing one on one nursing because the patient was very high risk, but to her knowledge Matthew was not in that category.

57. Ms Simpson was aware, during her shift that night, that there had been an incident earlier on the Saturday – 22 November 2003 – involving a young female patient called Laura. She believed she had been informed of that on handover. She also expressed the opinion that the patients would all talk about an incident like that, although she did not hear them do so.

Registered Nurse Hanley

58. Level 1 Registered Nurse Jenice Hanley also worked the night shift on Saturday, 22 November 2003, commencing at 8.45pm. She was the allocated nurse in charge. As such she was responsible for the staff, patients, rostering for the next day and security for the night. At the start of the shift, she and Carol Austin who started at the same time had a handover with the nursing staff on the afternoon shift for about 45 minutes from about 8.45pm until 9.30pm. Registered Nurse Hickey gave the handover in relation to Matthew and told her that there had been some ongoing aggravation with Matthew's ex-partner, that he had come back early from leave and was angry in relation to the domestic violence order his ex-partner had taken out and about not being able to see his child. However, she was also advised that Matthew had now settled and his anger had diffused. Although she did not recall specifically being told to keep an eye on Matthew, she said that she would have instinctively done so because she was aware of the issues he was having. Ms Hanley had previously had only short conversations with Matthew Liddell, but they did

include conversations about difficulties he was having seeing his baby daughter.

59. Ms Hanley observed Matthew watching the World Cup Rugby final on television, and noticed that he seemed to be enjoying the football and socialising with the other patients. She regarded television events of that sort as useful to the nursing staff because they were able to be in the television room for extended periods and observe the patients unobtrusively. After the football was over, a large group of patients, including Matthew, sat out in the courtyard talking and there was a relatively buoyant atmosphere there. Matthew was very sociable.

60. Ms Hanley recalled that Matthew and a young female patient had a lengthy one on one conversation in the courtyard. Her recollection was that the female patient had some work experience with domestic disputes. Her recollection was that they talked for about an hour and the other patient seemed to allay his fears. From his body language, he appeared to be a lot calmer and appeared to Ms Hanley to be relaxed and brighter.

61. When Matthew then came in past the nurses' station with the other patient, he and Ms Hanley had a brief but pleasant exchange of words. She asked Matthew if he wanted his medication. He said "okay, yeah". He seemed in a good mood and very calm. He went to Carol Austin to collect his medication at the medication room and took the medication in front of Carol before walking back past the nurses' station and saying good night to Ms Hanley on his way to bed. His medication was Immovane, a hypnotic sleeping medication which usually works within half an hour of being taken.

62. Ms Hanley said that there was nothing in Matthew's demeanour which indicated to her that anything was untoward.

63. Ms Hanley was returning to the nurses' station from doing the 1.00am observation rounds, in which she had taken one of the three wings of the hospital, when the emergency alarm went off and she could see from the emergency alarm screen that the alarm had come from wing two. Lights outside each room also indicated in which room the emergency was. She immediately saw Carol Austin running towards the nurses' station from the opposite direction to her. Ms Austin said "Matthew's hung himself". Ms Hanley said that she was "stunned"; she and Ms Austin ran to the nurses' station where she got the ligature knife and gave it to Ms Austin. Ms Austin ran back to Matthew's room, while Ms Hanley got oxygen from the nurses' station and went to her assistance. When she arrived at the room, Carol Austin had cut the ligature around Matthew's neck and laid him flat on the bathroom floor. Ms Austin started unprotected mouth to mouth resuscitation, and Ms Hanley started chest compressions. Matthew had no vital signs. A short time later, registered nurse Tricia Simpson came in

response to the alarm and took over the compressions, while Ms Hanley went back to the nurses' station where she dialled 000 and got straight through to call the ambulance. She also telephoned the nurse on call, registered nurse Liz Fountain (the contact nurse who was the next level of authority). She also telephoned the then Director of Clinical Services, Jenelle Killick, and Matthew's psychiatrist, Dr Geoff Rees.

64. Ms Hanley met three ambulance crews who arrived after about twenty minutes, and directed them to Matthew's room.

65. Ms Hanley also said that in her experience it was not unusual for patients to return from leave upset. Leave was considered part of the treatment and an attempt to normalise the patient's lifestyle, but often for a number of reasons it does not work out. Ms Hanley said that there would need to be a significant event, however, for her to contact a patient's treating doctor if they returned early from leave. She would do so, however, if she was unable to settle the patient with their medication or by counselling.

66. Ms Hanley also referred to "dependency ratings" which are used primarily to prepare the next shift roster. A patient is automatically classified as "high" on admission, but their rating will change depending on ongoing assessment. She said that Matthew's rating on 22-23 November 2003 would have been "low" for him to have been permitted out on leave. Also, when she observed him, he did not warrant a "high" rating.

67. When asked how she would describe Matthew when he came to the nurses' station to get his medication before going to bed, Ms Hanley said that he was "lovely…he smiled and said goodnight on his way past". There was absolutely nothing in his demeanour indicating to her that anything was untoward with him.

68. Ms Hanley was aware that a new practice had been introduced where, if a patient was on escorted leave and came back early, the person they were with was supposed to sign them back in. If they had been on leave with a particular family member, that person would now be required to come into the hospital to report that they were bringing the patient back, and they would most likely speak to a nurse and explain why the patient was coming back early. She regarded feedback of that nature as useful because it would give the nursing staff a better overall picture of what had happened while the patient was on leave.

69. Ms Hanley said that the nurses did not confiscate shoelaces from patients unless they had a very, very good reason to because it would be humiliating for every patient who came into the hospital if every item that they might self-harm with was removed from them. It was also her experience that whatever might be taken away from patients, they were able to find an alternative.

Ambulance officers

70. Ambulance officers were dispatched to the hospital at 1.19 am, arriving at 1.23 am. When they arrived, they saw that CPR was being administered by two staff members. The ambulance officers continued CPR while waiting for an intensive care paramedic to arrive. As there was no spontaneous breathing, they continued ventilation. The intensive care paramedic arrived. Matthew Liddell's Glasgow Coma Score remained at 3 at all times. He was transported by ambulance to the Royal Brisbane Hospital, arriving there at 2.04 am, when ambulance officers handed his care over to hospital staff.

Dr Rees contacted

71. Dr Rees was contacted by hospital staff in the early hours of Sunday morning, 23 November 2003, advising him that Matthew had returned to the hospital from leave, had tried to hang himself, that the ambulance was on site and they were taking him to the Royal Brisbane Hospital. Dr Rees then contacted Matthew's family to advise them, telephoning Matthew's sister, Michelle Campbell at about 2 am.

Subsequent events

72. When Michelle Campbell rang the Royal Brisbane Hospital at about 6 am to check on Matthew's condition, she was told that it was critical and that he was on life support. She and her parents called again at about 8.15 am. When she and Matthew's father went to the hospital later in the morning, they were informed that there was no hope of Matthew's survival, that he had sustained severe brain damage. The family unanimously decided that life support should be discontinued.

73. Matthew Liddell died after life support was terminated on 24 November 2003, and at 11.33 am that day, Dr Gregory Phillip Comadira, certified life to be extinct.

74. A post mortem examination certificate was issued by Dr Ong stating that the cause of death was:

    1. i. hypoxic encephalopathy
       ii. hanging

    2. coronary atherosclerosis

75. Police were notified on the afternoon of 24 November 2003 after Matthew Liddell died at the Royal Brisbane Hospital on 19 October 2003. An investigation was then carried out into the circumstances of his death, and

Plain Clothes Constable Marion Eatock of the Indooroopilly Police Station completed a Coronial Investigation Report.

Matthew Liddell's service in the navy

76. Matthew Liddell joined the Royal Australian Navy on 10 May 1993.

77. Group Captain Lambeth, the Director of the Directorate of Mental Health, Australian Defence Force and a psychiatrist, reviewed the records of the psychological and psychiatric assessments of Matthew Liddell held by the Department of Defence. Dr Lambeth has developed a special interest in post traumatic stress disorder together with anxiety disorders and depression in general, over approximately twenty years. He had not personally seen Mr Liddell, but was able to comment on the following aspects of his service in the navy. Dr Lambeth considered that there was no doubt that Mr Liddell had post traumatic stress disorder as a result of the accident on the Westralia.

78. Before the accident on the Westralia, Matthew had aspired to join either the SAS Regiment or to become a navy clearance diver. The assessments of his ability to perform as a clearance diver were positive.

79. An assessment by a psychologist, Heather Longworth, dated 3 November 1995, records the fact that Matthew had admitted to fabricating a complaint of asthma in an attempt to be taken off work on a submarine, had expressed difficulty in coping with the confinement onboard and had described being withdrawn from others, avoiding social contact, feeling less tolerant of others and being short tempered. The psychologist considered he had a tendency toward being over-controlled, obsessive, insecure, apprehensive and reserved. The material suggested that he had some difficulty in being in a closed environment in a submarine.

80. In another report, dated 2 September 1996, Ms Longworth said that Matthew had been interviewed and assessed as suitable for transfer to employment as a diver, and such a transfer was recommended. However, the transfer to the Clearance Diver Branch did not take place, apparently because there were shortages in the technical branch, where he was needed.

81. Mr Liddell joined the HMAS Westralia in January 1997. In a letter dated 24 May 1997, he sought a discharge from the Royal Australian Navy because:

> "I wish to pursue a career in the Special Air Service Regiment (SASR) and I believe I will not realise this goal if I remain employed in the RAN. I apply to change to the Clearance Diver Branch in order to bring me a step closer to serving with the SAS. However, my application was

> denied due to shortages in the Technical Branch. I am convinced my application to transfer directly to the SASR will be met with the same response."

82. On 14 July 1997, Lieutenant J P Booker of HMAS Westralia wrote to Captain M Lines of the Army Psychology section a letter of referral in connection with Mr Liddell's application to join the Special Air Service Regiment. In the letter, Lieutenant Booker said this:

> "AB Liddell is a fit, ambitious young man who seeks a military career with a degree of rigour and excitement. He is disappointed that his current employment in the RAN is neither as demanding or disciplined as he desires. AB Liddell applied for a Transfer of Branch to Clearance Diver as a step towards service in the SASR however, his application was not supported due to shortages in the Technical Branch. While this was a great disappointment to him, he has not let it show in his work and has continued to be a productive member of Cargo Section. It is an administrative quirk that he stands a greater chance of success in applying to transfer to another service than transferring to another branch within the RAN.
>
> … AB Liddell has no personal problems that I am aware of and has a good service record. I have no hesitation in recommending him for service in the SASR."

83. Mr Liddell had a time away from the HMAS Westralia after an injury to his left shoulder in February 1998, and returned to the ship on 4 May 1998.

The fire on the Westralia

84. HMAS Westralia is what is known as an underway replenishment ship – in simple terms, a large fuel tanker. A fire broke out in the engine room at about 11am on Tuesday 5 May 1998. At the time the Westralia was conducting trials eight nautical miles off Fremantle in Western Australia. The fire was extinguished at 12.35 in the afternoon. Four Royal Australian Navy personnel died as a result of the fire. They each died from acute smoke inhalation. The cause of the accident was investigated by a Board of Inquiry and by a West Australian Coronial Inquest. The fire was found to have started as a result of the failure of a flexible fuel hose providing a source of diesel fuel to an extremely hot engine exposed component.

85. Mr Liddell was on watch in the engine room at the time of the fire. He became aware of thick black smoke emanating from the base of the engine room. He then became involved in assisting to fight the fire and in

the evacuation of casualties from the engine room. Two of those who died were known to Mr Liddell, and one of these was a friend.

86. From a review of the files, Dr Lambeth said that there was a critical incident response following the accident, mounted extremely quickly and involving a psychological assessment and debriefing on approximately the day after the fire. This critical incident stress debriefing was based on something called the "Mitchell Model" which had been developed in the United States. It had now fallen into disfavour following a number of studies. Dr Lambeth said that following the establishment of the Australian Defence Force Mental Health Strategy in 2002, the Australian Centre for Post-Traumatic Mental Health was commissioned to come up with an evidence-based best practice method of critical incident response, which they have done. This had now been written up as a defence instruction, shortly to be ratified and circulated among all people in defence. Dr Lambeth said that the Australian Defence Force had a very close association with the Melbourne-based Australian Centre for Post Traumatic Mental Health, a preferred provider of expert evidence and assistance in developing training courses for the ADF.

87. Immediately after the fire, Matthew Liddell was taken to the St John of God Hospital at Murdoch, where he was examined, and it was considered at that hospital that he had emotional distress as well as some pharyngeal and ocular irritation. The observation of emotional distress was apparently made by the Director of Emergency Medication at the hospital, Dr Paul Mark. After two days in the St John of God Hospital, he was transferred to the Navy Hospital, HMAS Stirling, for a period of six days where he underwent further counselling.

88. The accident on the Westralia occurred in the confined area of the engine room. Dr Lambeth expressed the opinion that the fire would have acted upon a vulnerability in Matthew, given that he had already expressed some degree of fear or apprehension in closed spaces.

89. Helen Gavriel, psychologist of HMAS Stirling, saw Mr Liddell on 14 May 1998. She noted that he appeared to be "doing okay" and had said that he wanted to go back to the Westralia, saying he was not sure why but he would like to be involved in the process of fixing the ship up. He was keen to transfer to the Clearance Diver Branch and intended to do so in the near future. When she saw him again on 27 May 1998, he had been back on the Westralia for over a week, and reported that the first few days were difficult.

90. Another psychologist on HMAS Stirling, Joanna Douglas, saw Mr Liddell on 26 June 1998 and 3 July 1998 regarding his desire to transfer to Clearance Diver Branch and also with respect to his progress in recovering from the trauma of the HMAS Westralia fire. At that stage, Mr

Liddell was still seeking the transfer. Since the fire, he had successfully made several private dives as well as one with a Clearance Diver Branch team. In a report dated 8 July 1998, Ms Douglas said:

> "ABM team LIDDELL is still experiencing severe symptoms of stress response to trauma. These include sleep disturbance – lack of sleep and nightmares, intrusive thoughts, and feelings of distress in the ship's engine room. ABMT LIDDELL also states that feels unable to sail again as a stoker."

91. Ms Douglas considered that continuing to be on the ship was prolonging Mr Liddell's distress. He had requested a loan posting to Clearance Diver Team 4 to enable him to gain work experience in his chosen area and to work away from the HMAS Westralia. Ms Douglas recommended that the loan posting be treated as urgent because of his ongoing distress whilst he was required to work on HMAS Westralia.

92. In a further report dated 20 November 1998, Joanna Douglas noted that the loan posting to a clearance diving team had been arranged, but before taking up the loan posting Matthew broke his leg while playing soccer as part of the ship's team. Ms Douglas said that his continued high level of trauma symptoms raised concerns for his recovery, and consequently he was assessed for post traumatic stress disorder according to the Davidson's Structured Interview Schedule. His scores on the assessment satisfied the criteria for post traumatic stress disorder, and as flashbacks and dreams featured strongly in his symptoms, he was referred to Mr Christopher Lee, a clinical psychiatrist in Perth, for treatment with eye-movement desensitising and processing. This treatment, known as Eye Movement Desensitisation and Reprocessing or EMDR, is frequently used for post traumatic stress disorder. Mr Lee confirmed that his symptoms met the criteria for that condition.

93. Ms Douglas concluded her report as follows:

> "Subsequent to treatment, Mr Lee assessed ABMT LIDDELL's symptoms as falling within the normal range and treatment has, therefore, been discontinued. This does not mean, however, that ABMT LIDDELL is symptom free and in his final report Mr Lee notes that some avoidance symptoms, particularly, persist. In evidence of this, when ABMT LIDDELL was classified as Medical Category 5 following recovery from his broken leg he contacted Psychology in a distressed state and reported feeling highly apprehensive of re-joining HMAS WESTRALIA and unable to sail again as a stoker.

> …ABMT LIDDELL believes his psychological and emotional recovery to be progressing normally at present. The exceptions to this, however, are his specific avoidance symptoms which, as they are limited, seem more practical to accept rather than attempt a probably lengthy and possibly unsuccessful, treatment program. In all other areas ABMT LIDDELL presents as highly motivated to recover and pursue his desire to become a CD."

94. On 7 January 1999, Commander AH Johnston of HMAS Stirling requested the approval of a compassionate posting of Mr Liddell to HMAS Penguin, a naval hospital, at the first available opportunity. The letter includes the following paragraph:

> "The primary reason for the request is that since his involvement in the fire onboard HMAS WESTRALIA 5 May 98, AB Liddell has required ongoing psychological and medical support due to suffering severe post-traumatic stress which necessitated using outside specialist psychological treatment. The Navy Psychologist has now reported that although this was discontinued in Oct 98 some of the symptoms persist. The psychologist further reported that symptoms in the area of stress avoidance have persisted and related to a sufferer experiencing severe distress or dysfunction when encountering situations which act as reminders of the traumatic experience. In AB Liddell's case the strongest triggers of distress are HMAS WESTRALIA itself and any shipboard engine room. The psychologist further reported that the sailor has for some time expressed a wish to be posted from STIRLING in order to remove himself from constant reminders of the fire. He recently suffered a setback and experienced increased levels of post-traumatic stress in anticipation of the release of the WESTRALIA BOI findings in Dec 98. On medical advice he was sent immediately on leave."

95. Mr Liddell was posted to HMAS Penguin on 14 March 1999. According to a minute from Lieutenant Anderson of HMAS Penguin, dated 11 May 1999, Mr Liddell was again requesting a transfer of branch to the clearance diver category. It appears that his efforts to become a clearance diver at that time were unsuccessful because there were no vacancies in the clearance diver category.

96. On 14 June 1999 Mr Liddell was posted to HMAS Geraldton, but after five weeks, he was posted to the HMAS Coonawarra on 20 July 1999.

97. The posting to the HMAS Geraldton was described as a “crash posting” meaning a posting that had come about suddenly, where there was an urgent need to be met.

98. Matthew Liddell’s mother, Mrs Dulcie Liddell said that when Matthew was on the HMAS Geraldton he was employed in the engine room. Although there was no confirmatory evidence of that, it appears that Mrs Liddell obtained that information from Matthew himself. In addition, when Dr Harvey Whiteford assessed him later in 1999, he told Dr Whiteford that in the first week of his assignment to HMAS Geraldton, there was an accident in the engine room which resulted in a marked exacerbation of his symptoms.

99. The records did indicate that Matthew was not happy serving at sea on HMAS Geraldton and his morale was thought to be low. Dr Lambeth considered that this might have been reflective of depression as part of the post traumatic stress disorder.

100. The material indicated a breakdown in communication in that the commanding officer of HMAS Geraldton was not informed and was unaware that Mr Liddell was undergoing psychological assessment. A minute dated 20 July 1999 from the commanding officer, Lieutenant Commander P L Orchard, notes that Mr Liddell had been landed at HMAS Coonawarra following an incident which appears to have occurred in July, involving an verbal altercation with Mr Liddell’s immediate supervisor, and says this about his time on the Geraldton:

> “During the period in which he was embarked Liddell portrayed a shy, reserved person who, as a result of his time on WESTRALIA, was not happy serving at sea. It was unknown by myself, until the day of his departure, that he was still undergoing psychological assessment at PENGUIN prior to posting to GERALDTON. This information was gained from the sailor’s mother.
>
> Several members of my ship’s company had raised concerns about Liddell’s attitude and often strange comments he was heard to say. On a number of occasions I counselled the sailor to investigate his general morale and wellbeing. I had no reason to support some of the comments raised by my team.
>
> On Liddell’s departure and whilst packing the remainder of his kit the enclosed items were found [referring to some handwritten material by Matthew Liddell] … [this] reflects some of the comments previously mentioned and heard by

> my team. It appears to have been written by a very disturbed mind."

101. The handwritten material by Matthew Liddell was not found until after he had been landed following the incident with his immediate supervisor.

102. On 28 July 1999, after 8 days on the HMAS Coonawarra, Mr Liddell was transferred back to HMAS Penguin.

103. In a minute dated 3 August 1999, a navy consultant clinical psychologist, S J O'Brien, notes that Mr Liddell was required to answer a charge or charges amounting to prejudicial behaviour in relation to the verbal altercation with his immediate superior. The minute goes on to say:

> "SMN LIDDELL is well known to the psychology section and had been diagnosed by a consultant psychologist in WA following his exposure to the fire on board WESTRALIA incident, as meeting the diagnostic criteria for Post Traumatic Stress Disorder (PTSD). This condition is described in the literature as a 'disorder of arousal' based upon a large body of evidence suggesting that the disorder has a physiological component of neurological hypersensitivity; that is, a lowered threshold for emotional excitation or arousal. My own clinical experience verifies high arousal, 'short fused' acting out behaviour amongst PTSD patients.
>
> When seen by me on a self referred basis on 28 July 1999, in describing the incident that brought him to notice SMN LIDDELL described how he '… went bananas' and 'fell off my tree' during a discussion with his superior.
>
> Given the persistent features of increased arousal associated with the condition it is quite feasible that SMN LIDDELL'S behaviour at the time of the alleged incident could in part be a symptom manifestation. Whilst not entirely relieving the member of personal responsibility there does appear to be mitigating circumstances."

104. On 21 December, psychiatrist Dr Harvey Whiteford, assessed Matthew Liddell for a firm of solicitors acting for him, and wrote a report of the same date, in which he expressed this opinion:

> "Matthew Liddell is a 25 year old single man, employed in the Royal Australian Navy, who has not worked since August 1999. He was exposed to particularly traumatic events whilst involved in a fatal fire aboard the HMAS Westralia in May 1998. Immediately following this, he

> developed symptoms of post traumatic stress disorder, which have continued to be severe and disabling, despite inpatient and outpatient psychological and psychiatric treatment, redeployment and vocational rehabilitation.
>
> Mental state examination on Tuesday 21 December 1999, revealed evidence of clinically significant anxiety and depressive symptoms consistent with a diagnosis of post traumatic stress disorder.
>
> … In my opinion, there is a direct causal link between the HMAS Westralia fire and the development of your client's post traumatic stress disorder."

105. Dr Whiteford considered that Matthew was permanently incapacitated from returning to employment in the military, but expected that with appropriate retraining and psychiatric treatment and support, he might be able to undertake some part-time civilian employment at an undefined time in the future. He assessed Matthew's disability at 30% under ComCare Table 5.1. He expected that there would be some improvement in this level of disability with the passage of time but considered that he would have a degree of permanent psychiatric disability which was unlikely to decrease below 20% even with optimal ongoing treatment.

106. Dr Whiteford believed that Mr Liddell had an element of "survivor guilt" because he believed his friend who died in the fire on the Westralia was carrying out duties which, in normal circumstances, would have been assigned to him that day. Mr Liddell described himself to Dr Whiteford as being "in shock" immediately after the fire.

107. Mr Liddell told Dr Whiteford that he believed that the EMDR treatment he had received from psychologist Christopher Lee had assisted him especially with his sleep disturbance. Dr Whiteford observed that the psychological reports on file indicated an initial improvement in symptoms of anxiety, hypervigilance, sleep disturbance and intrusive recollections of the incident. Mr Liddell said that over the following nine months, he was trying to be posted away from Perth. He told Dr Whiteford his sleep pattern deteriorated with intrusive nightmares, the content of which included memories of the actual incident, and seeing dead bodies lying on the floor of the engine room:

> "Further symptoms included irritability with difficulties in impulse control and frustration tolerance, which had contributed to episodes of physical conflict, including whilst driving a motor vehicle. He also reported difficulties with attention and concentration and short term memories. Mr Liddell reports difficulties in confined spaces and pervasive

> restlessness. He does not report any persistent flashbacks of the incident. There have been periods of depression with suicidal ideation but not specific intent. His energy level is low, as is his libido. He is more socially isolated and describes himself as only having two close friends. Previously, he was described as outgoing, with many friends. The statement of Mr Liddell's mother confirms these opinions and also expresses the opinion that Mr Liddell's self care has deteriorated."

108. It appears that Mr Liddell told Dr Whiteford that he was being trained for the clearance diving branch in April 1999 but problems with his right lower leg, which he had fractured some six weeks after the fire on the Westralia, resulted in him being unable to continue.

109. Mr Liddell told Dr Whiteford that, after being assigned to HMAS Geraldton in June 1999, his symptoms were exacerbated by an accident in the engine room. He said that after being removed from HMAS Geraldton after approximately five weeks, he came to Brisbane for two weeks recreation leave in August 1999, but as a result of his symptoms was admitted to the Second Field Hospital at Enoggera on 5 September 1999.

110. Matthew Liddell was referred by Dr Ash, a general practitioner at the Military Hospital, Enoggera Army Barracks, to psychiatrist, Dr David Crompton. After four or five days in the military hospital he was admitted to the day program for combat related post traumatic stress disorder at the Toowong Private Hospital under Dr Crompton's supervision. This program consisted of attendance four days a week for six weeks, followed by one day a week for six weeks.

111. On 2 December 1999, Dr Crompton wrote to Dr Ash expressing this opinion:

> "Mr Liddell has developed Post Traumatic Stress Disorder in the context of exposure to the incident on the Westralia.
>
> In considering his situation, I have formed the opinion that Mr Liddell will not be able to continue to work in the Navy. This decision is based on his concentration, irritability, motivation, intrusive thoughts and mood disturbance."

112. Dr Crompton referred Mr Liddell to Dr Geoffrey Rees, psychiatrist, who took over his care from 18 May 2000, shortly before he was discharged from the Army on 28 May 2000.

OTHER MATTERS

Investigation into the incident by the Toowong Private Hospital

113. Ms Janelle Killick was the Director of Clinical Services at the Toowong Private Hospital from 1999 until 2006. She conducted an internal investigation into the incident of 23 November 2003, and also assisted the hospital's workplace health and safety officer who undertook the investigation of the incident shortly after it occurred and liaised with the Division of Workplace Health and Safety.

114. Ms Killick said that leave is considered part of the therapeutic treatment of patients. From her investigation, and review of the clinical notes, when Matthew Liddell returned early from leave on 22 November 2003, there were no clinical indicators to warrant an escalation of intervention other than what occurred.

115. Dr Harvey Whiteford is currently the Kratzmann Professor of Psychiatry and Population Health at the University of Queensland, has clinical rooms at the Toowong Private Hospital and visits there two days per week when he sees patients.

116. Dr Whiteford expressed the view that when a patient returns early from leave, it was a matter for the nurse assessing the patient to decide whether clinical intervention was necessary. He would expect the nurse to contact the patient's treating psychiatrist if such intervention was not successful. He regarded the clinical intervention as appropriate in the particular circumstances of Matthew Liddell's return from leave, and thought it reasonable in those circumstances not to call the treating psychiatrist.

117. Considering that after Matthew Liddell's return to the hospital, he had been observed to be stable for some six to eight hours, Dr Whiteford did not consider that there was any reason to put Mr Liddell on regular observations after that time.

Protocol when a patient returns early from leave

118. In November 2003 there was no specific procedure in place for contacting a patient's psychiatrist if the patient returned early from weekend leave.

119. Ms Christine Gee is the Chief Executive of the Toowong Private Hospital and Chairman of the Psychiatric Sub-Committee of the Australian Private Hospital's Association (APHA). She said that as a result of the sub-committee's concern regarding coronial inquests in Western Australia, the APHA had sought legal opinion and made recommendations to support risk management with regard to patient leave and absconding patients within member hospitals. Consequently, in about February 2006, the

hospital had amended its written leave policy, which included requirements with respect to carers providing escort to patients on leave:

> "The requirements of care etc are explained to the carer. The carer must sign the patient back in to the hospital upon their return. The carer is also required to advise of any concerns they may have in relation to the patient and the leave experience. This essentially forces a formal documented review of the leave. If the carer fails to sign the patient in, and the patient is just "dropped off", the carer would be called to follow up and the documentation noted accordingly."

120. This is a very desirable improvement in the practice which applied at the hospital in November 2003.

121. The Director of Clinical Services at the hospital, Ms Killick, expressed the opinion that if a patient returned early from weekend leave on most occasions, she would have expected the nurse to telephone the psychiatrist, but it would depend on the presentation of the patient.

122. Dr Rees said it was commonplace for nursing staff to contact him if necessary at the weekend with concerns about a patient, and if he had been contacted after Matthew's early return from leave, it was his standard practice to come in. Although he would have liked to have been called, Dr Rees said it was "a reasonable call" in the circumstances for the nursing staff not to have done so.

123. The evidence is that Matthew was assessed on a one-to-one basis by a suitably qualified member of the nursing staff and his presentation was not such as to suggest that Dr Rees should have been called. Rather, that was a matter for the discretion of the nursing staff. It cannot reasonably be said that they were wrong not to call Dr Rees in the circumstances. Matthew was observed after his return and throughout the evening, and when he went to bed there was nothing about his presentation to suggest a risk of suicide. If Dr Rees had been called, it seems unlikely that the approach to Matthew's care would have been any different. There is also nothing to suggest that, if Dr Rees had gone to the hospital, Matthew himself would have acted any differently. Dr Rees had spoken to him by telephone that morning and had attempted to reassure him about the matters that were concerning him.

Documentation of telephone calls to patients

124. Mr Liddell's sister, Michelle Campbell said that she telephoned the hospital on the evening of 22 November 2003 at 7.09pm. No record has

been found of that phone call, and none of the nurses who gave evidence could recall such a call.

125. The Director of Clinical Services, Ms Killick, gave evidence that she spoke to each of the nurses on duty at that time in relation to whether they took a telephone call from Ms Campbell, but none of them recalled speaking to her. Ms Killick said that if Michelle had expressed more than just concern, she would have expected that something would have been written down in the medical record, or that Ms Hickey or the nurse in charge would have been told. She suggested, however, that nurses received many calls a day and they are not necessarily documented.

126. The Chief Executive Officer of the hospital, Ms Gee, said that the volume of telephone calls meant that it was administratively too burdensome for all calls to be documented, and whether that was done was left to the professional discretion of the individual nurse.

127. The evidence indicates that it would not be reasonable to require all telephone calls to patients to be documented by nursing staff, given the widely varying nature of the calls. Inevitably, the question of whether or not to write details of a call in a patient's medical records is a matter to be decided in the discretion of the nurse who receives the call. Obviously, some calls will be sufficiently significant to a patient's care that they should be documented. However, Michelle Campbell's evidence of the telephone call she made to the hospital at 7.09pm on 22 November 2003 does not suggest that it was in that category.

Availability of means of suicide

128. Ms Killick said that during the years that she was Director of Clinical Services at the hospital, there were regular safety audits. Risks to patients were removed or minimised where possible. In particular, she said, the hanging point risks were minimised – for example, the taps in the showers are low taps for disabled persons, shower hoses are used instead of a fixed shower head, curtain rails in bathrooms and patient rooms will not support a patient's weight. Communications from relevant authorities such as the Australian Council on Health Care Standards and the National Council for Safety and Quality were followed in order to minimise and reduce risks. Ms Killick said, however, that it is not possible to rule out every possible risk. She said that in minimising the risk of suicide, there has to be a balance maintained with human dignity in a therapeutic environment.

129. It is not the normal practice of the Toowong Private Hospital to remove shoelaces from patients, although razors, tablets, occasionally belts and other potentially harmful implements are taken. Patient can be placed on

frequent visual observations if considered to be at risk of self harm, or if they are expressing severe distress, are agitated or behaving unusually.

130. As to the availability of the means of suicide, Dr Whiteford made this observation:

> "…I think trying to secure the whole hospital from points where someone could unfortunately take their life is virtually impossible. It's an open hospital. It has 54 beds. It's got a courtyard. It's got multiple areas which – for a vast majority of patients is a safe environment, but for a very small minority there are risks, and I don't think those risks can be removed, whether it's the shower taps… [or] other points in rooms or in the general courtyard of the hospital."

131. Dr Whiteford said, however, that there were two special care rooms, on either side of the nurses' station, which could be used if a patient was considered to be at significant risk. The Chief Executive Officer of the hospital, Ms Gee, said that these rooms could be used if a patient was assessed as requiring very frequent observation. If considered necessary, constant observation could also be provided where there is a nurse with the patient constantly.

CONCLUSION

132. Matthew Liddell developed post traumatic stress disorder and depression following his close involvement in the events on board the HMAS Westralia on 5 May 1998 in which four others died after a fire broke out in the engine room. This eventually led to his discharge from the Navy in May 2003 as medically unfit. Later that year his condition deteriorated significantly at a time of other stressful events in his life, particularly the separation from his de facto wife and baby daughter. These events appear to have precipitated his admission to the Toowong Private Hospital by ambulance from Tin Can Bay on 8 November 2003.

133. After Matthew's condition improved in hospital, his treating psychiatrist gave approval for him to have weekend leave with his sister. On the second of these weekend leaves, he became very distressed about the police investigation of domestic violence proceedings brought by his de facto wife, and on Saturday 22 November 2003, he returned early from weekend leave, and was observed by nursing staff to be initially quite angry. However, he appeared to settle down quite well in the ward. That evening he watched a football match on television and socialised with other patients. When he went to bed after midnight, he appeared to be

quite calm and cheerful, giving no indication that he might be considering suicide.

134. A short time later, a nurse doing the 1 am visual observation rounds found him hanging from a low shower tap in the bathroom area of his room, with a ligature made from a shoe lace attached to his neck. Despite all efforts by the nurses, ambulance officers and doctors to save his life, Mr Liddell did not recover, and died at the Royal Brisbane Hospital on 24 November 2003 shortly after life support was discontinued.

FINDINGS

135. I make the following findings –

(a) The identity of the deceased was Matthew John Liddell.

(b) His date of birth was 18 September 1974.

(c) His last known address was 2 Arkroyal Drive, Cooloola Cove, Queensland.

(d) At the time of death he was not employed but was in receipt of a Navy pension.

(e) The date of death was 24 November 2003.

(f) The place of death was the Royal Brisbane Hospital, Brisbane.

(g) The formal cause of death was:

1. i. hypoxic encephalopathy
   ii. hanging
2. coronary atherosclerosis

136. This court has jurisdiction in appropriate cases to commit for trial any person/s which the evidence shows may be charged with the offences mentioned in section 24 of the *Coroners Act 1958*. There is no evidence at all of the commission of such offences, and I therefore make the formal finding that the evidence is not sufficient to put any person or persons upon any trial. Therefore no person will be committed for trial.

RECOMMENDATIONS

137. Pursuant to section 43 of the Act, I have regard to recommendations which might be made by way of rider to the formal findings. I note the review and consideration given by the Towong Hospital after Matthew's death. In particular I note the improvement of communication that should

occur between family carers and hospital carers. The hospital has introduced a report to be completed by the family carers after a patient is returned to hospital after leave. The open and continuing communication between the family and friends of a person suffering depression and the risk of suicide, with the doctors and nurse involved in their care is essential to achieve optimal support and treatment. While it might seem that hospitals could improve physical safety for patients at risk by more onerous restrictions on personal items with which they might cause themselves harm, the reality is that it is impossible to remove all items and change the physical environment to eliminate all risk of suicide.

138. Finally I acknowledge the efforts of Matthew's mother, Dulcie Liddell, his sister Michelle Campbell and other family members who assisted with the inquest process by the provision of information and by attending the hearing.

139. Thank you to counsel appearing and assisting in this inquest. The inquest is now closed.

Chris Clements
Deputy State Coroner
20 June 2007