QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of John Edward Drane**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2014/148
DELIVERED ON:	15 June 2016
DELIVERED AT:	Brisbane
HEARING DATE(s):	15 April 2016, 23-25 May 2016
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, nursing home resident, immolation, burns, whether accidental or self-harm, risk assessments for smoking and/or self-harm, physical diseases as predictors of suicide in older adults, communication in concurrent investigations
REPRESENTATION:	
Counsel Assisting:	Ms M Jarvis
Counsel for Masonic Care Queensland:	Mr A Herbert i/b McCullough Robertson
Counsel for Metro North Hospital & Health Service (MNHHS):	Mr A Suthers i/b MNHHS

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Introduction

1. John Edward Drane was aged 75. He was a resident at the Masonic Care Queensland (MCQ) facility at 60 Wakefield Street, Sandgate. He had been diagnosed with bladder cancer in late 2013 and had two surgical procedures. In early January 2014, he started receiving chemotherapy and radiotherapy.

2. In the afternoon of 9 January 2014, he had returned from his second set of radiotherapy and first set of chemotherapy. He was wearing a chemotherapy infuser attached to a catheter inserted in his arm. He went to the smoking room set up at MCQ and was seen by cleaning staff to be smoking. Ten to fifteen minutes later he was seen to be sitting in a chair with his clothes from bottom to top on fire. The fire was extinguished by staff, with some difficulty. He was taken by ambulance to the Royal Brisbane Hospital Burns Unit, but died from his burns later that night.

3. Investigations commenced as to the cause of the fire involving the Queensland Police Service (QPS) and Queensland Fire and Emergency Service (QFES). Workplace Health and Safety Queensland (WHSQ) also investigated whether MCQ had fulfilled its obligations under workplace health and safety legislation. The conclusion of the QPS report provided to the coroner was that the fire occurred when a cigarette being smoked by Mr Drane dropped into his lap and ignited his clothing.

4. Concerns were reasonably raised by Mr Drane's family as to how such an event could occur in such a public environment. Issues were raised concerning whether appropriate risk assessments were conducted by MCQ regarding smoking by residents.

5. A decision to hold an inquest was made. At a pre-inquest hearing the following issues were determined:

    i. The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death.

    ii. The circumstances leading up to the death.

    iii. The appropriateness of the care provided to the deceased at the residential care facility; in particular, the identification, assessment and management of risks associated with the deceased's recent medical treatment and smoking behaviours.

    iv. Whether any additional risk management strategies should be implemented in facilities where elderly persons reside so as to ensure their safety in the event of a fire.

6. As will become evident, two weeks before the commencement of the inquest, an issue was raised in a report prepared by the QFES investigator as to whether the manner in which Mr Drane became alight was accidental or whether he had been deliberately set on fire, through either a third party or intentionally by himself. That report had not become available to the QPS or the coroner until the QFES investigator was informed an inquest was listed. This raised further issues as to the communication and exchange of information between QPS and QFES given their concurrent investigations.

7. The following witnesses were called to give evidence at the inquest:

- Detective Senior Constable Janelle WALSH
- Queensland Fire and Emergency Service (QFES) Investigator Greg JONES
- Sergeant Shane SCARINCI
- Ms Heather GAMBETTA, Domestic Assistant, employee of residential care facility
- Ms Isabel HUDSON, Registered Nurse, employee of residential care facility
- Ms Lynda JOHNSTON, Domestic Assistant, employee of residential care facility
- Dr Peter BALTHES, General Practitioner
- Dr Kieron BIGBY, Consultant Medical Oncologist, Redcliffe Hospital
- Dr Michael MULLER, Senior Visiting Medical Officer, Royal Brisbane and Women's Hospital
- Inspector Deborah DARGAN, Workplace Health and Safety Queensland
- Ms Carol TIPPER, Manager, employee of residential care facility
- Ms Sue BEASLEY, Executive Manager, employee of residential care facility
- Ms Pam BRIDGES, aged care industry consultant

Background

8. John Drane was aged 75 at the time of his death. He had never married and had no children. He remained very close to his brother, Frank and Frank's wife Gay and their children. He had at one time taken on the full time role as a carer for his mother. He was well loved and supported by his family when his health had deteriorated. His family described him as vibrant, engaging and a 'gentleman', a view supported by statements of MCQ staff describing his sociability, independence and helpfulness.

9. Mr Drane became a resident at the MCQ in early 2012. The facility provided residential aged care facilities and a retirement village. The site catered for low care, high care, dementia care, respite care, palliative care as well as retirement living. Mr Drane was assessed as requiring low care. He was a long-term cigarette smoker and continued to smoke.

As part of his care plans, smoking assessments were conducted by MCQ, which largely permitted him to smoke unsupervised. He had been provided with a smoking apron.

10. Mr Drane's recent medical history included cancer of the bladder with the discovery of a tumour during the course of investigation of ongoing symptoms over a few months. This had been diagnosed in August/September 2013 and was initially treated with two (2) transurethral resection procedures. The next stage of treatment involved him receiving a combination of chemotherapy and radiotherapy. His other medical history included smoking induced emphysema, some cognitive impairment, poor mobility, osteoarthritis and right bundle-branch block.

11. Dr Bigby, Mr Drane's oncologist, stated he was a frail but independent man with some memory issues. Dr Bigby had some concerns about how Mr Drane would tolerate the treatment but believed the combination of radiotherapy and chemotherapy would add some benefit. Mr Drane was able to and did consent to the treatment. His cancer had not spread to other organs and there was some potential of a cure.

12. According to his brother, Mr Drane's well-being had deteriorated in the latter part of 2013, in large part due to incontinence arising from a side effect of the surgical interventions. His regular walks to the Sandgate shops were curtailed. He had lost a lot of weight. Notwithstanding his deteriorating health, there is little evidence that Mr Drane was particularly sad about his predicament. He had expressed some optimism about the future, and had made future plans. He had enjoyed being with family over the Christmas period. He had certainly never mentioned taking his own life to family and there is no reference in his hospital records or MCQ records, which would remotely suggest this as a possibility. There is no suggestion in the records that a diagnosis of clinical depression was ever contemplated.

13. On 7 January 2014, Mr Drane had a peripherally inserted central catheter (PICC line) inserted at Redcliffe Hospital to facilitate the chemotherapy infusions. Frank Drane had taken him to Redcliffe Hospital. He said Mr Drane's mood was, under the circumstances relatively up-beat.

14. On 8 January 2014, Mr Drane attended by organised patient transfer with the Queensland Ambulance Service (QAS) at Royal Brisbane and Women's Hospital (RBWH) for his first treatment of radiotherapy. He was too late to receive his first set of chemotherapy at Redcliffe Hospital and returned to MCQ.

15. On 9 January 2014, Mr Drane received his first set of chemotherapy at Redcliffe Hospital in the morning and then a second set of radiotherapy at RBWH. He returned via an ambulance from RBWH to the MCQ facility at about 13:42 hours. It is apparent that a short time later he went to a

smoking room located on level 2. It is evident he was not a regular user of the smoking room, preferring other designated outside areas to smoke. He was observed by domestic cleaning staff, Lynda Johnston to be smoking a cigarette at around 14:10 hours. Mr Drane was not using a smoking apron.

16. Mr Drane was again seen by Ms Johnston when she returned to the smoking room between 14:20 and 14:30 hours. At that time his clothes were on fire. It was unclear as to how he had become alight. There was one other resident in the room at the time. The fire was eventually extinguished by staff members. QFES were called and may have played a part in dousing the flames. The fire investigator contacted police. QAS were first contacted at 14:34 hours, perhaps indicating the incident occurred at closer to 14:30 hours. QAS arrived at 14:37.

17. Mr Drane was taken by QAS at about 15:00 hours to the Burns Unit at RBWH. On admission he was noted to have received burns to an extensive part of his body (estimated at up to 65%), which were considered non-survivable. This poor prognosis was discussed with Mr Drane, who had remained conscious, and his brother Frank, and palliative care was agreed to and was provided. He died shortly after 22:00 hours.

Autopsy results

18. A partial internal and external only autopsy examination was ordered.

19. There was significant pre-existing natural disease with severe narrowing of the arteries of the heart (coronary atherosclerosis) associated with enlargement of the heart, emphysema and cancer of the bladder. There was no evidence of distant spread of the cancer.

20. The external examination showed burns involving approximately 45% of his total body surface. There were no burns within the respiratory tract. It was the pathologist's view that the cause of death was due to the significant burns. His other significant conditions including coronary atherosclerosis, emphysema (associated with smoking) and cancer of the bladder would have made him more susceptible to the effects of burns.

Concerns of family

21. Frank Drane, understandably expressed a number of concerns as to how these events could occur to his brother in such a short space of time, with such intensity, in a public room, and without an alarm being raised until it was evidently too late.

22. The circumstances certainly suggested that Mr Drane may have fallen asleep whilst smoking, which could explain why the incident occurred without him having called for help or endeavoured to put the fire out

himself. There were questions as to whether the use of a 'smoker's apron', which was able to be supplied by the facility was enforced.

23. The family do not believe John Drane would have deliberately set himself on fire and throughout the investigation, including the recent revelations of the opinion of the fire investigator, maintained their concerns.

The investigations

Queensland Police investigation

24. QPS attended at approximately 15:00 hours on 9 January 2014. It is apparent QPS were called by fire investigator Gregory Jones who had been called to the incident. By that time Mr Drane had been taken to RBWH and the smoking room had been cleaned by domestic staff. There were apparently concerns about the toxicity or otherwise of the chemotherapy infusion. Nursing management staff took and provided photographs of the scene taken prior to any cleaning.

25. The photographs showed one burnt chair with what appears to be towels draped over the back. Photographs showed fire extinguisher residue covering the floor, one lighter on the floor and one white cigarette lighter on an adjacent chair.

26. The police investigation was conducted by Detective Senior Constable Janelle Walsh. She told the court she was assisted by Scenes of Crime forensic officer, Shane Scarinci and QFES investigator, Gregory Jones.

27. Police were informed that at approximately 14:30 hours one of the cleaners opened the door to the smoking room and observed John to be on fire. A female resident was also in the smoking room at the time. DSC Walsh stated she was informed that the female resident suffered from poor mobility, was reliant on a walking frame, and suffered from levels of dementia and a brain injury.

28. DSC Walsh spoke with the female resident who was extremely distressed and difficult to communicate with, she thought due to her brain injury and onset of dementia. She was only able to say that 'he lit himself on fire' and she had seen 'his pants on fire'. She also provided a video recorded statement some weeks later. On that occasion she stated 'I did remember him setting fire to himself. That's all I remember'. She did state he was standing up at one stage although this evidence was a response to a question where she was asked if Mr Drane was standing and she replied 'he was standing'.

29. The versions of events given on both occasions were consistent. A number of witnesses such as Nurse Hudson and Ms Johnston described the female resident as being in a state of shock at what she was seeing.

30. Although it was raised as a possibility that this resident intentionally lit Mr Drane's clothes, DSC Walsh stated this is highly unlikely given her

poor mobility. It is apparent the issue of her cognitive impairment as a result of the suggestion of dementia was not explored in any detail and was accepted at face value and the statements of the resident not regarded as reliable.

31. In fact it is now apparent that the resident had only weeks later been assessed at MCQ with a minimal level of cognitive impairment based on the use of a Psychological Assessment Scale tool. She did have difficulty in communication due to the hypoxic brain injury but Nurse Hudson stated in evidence that at the time of the incident the resident had a good memory, could give answers to direct questions and she would not discount something she said. Her dementia has since seriously deteriorated and she was not called to give evidence.

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32. The report of DSC Walsh also stated medical staff at RBWH believed the injuries were not a result of self-harm or assault. On the burn pattern sustained they were of the opinion that the injuries were likely caused as a result of him smoking a cigarette as there was no sign from his burn pattern injuries that any accelerant was involved. The report stated that from his injuries it appeared to have been a slow burn starting on the lower shirt, and that it was probable Mr Drane was slow to react due to his existing medical conditions.

33. Professor Michael Muller treated Mr Drane at RBWH. He stated that he does not recall discussing the pattern of burns with police. He did not smell any accelerant. Professor Muller was only recently asked to provide a statement but in that statement he did say, *there was no indication from the patient having been assaulted and he described his cigarette causing the fire. It is entirely plausible that his combination of illness, frailty, cognitive impairment, and type of clothing led him to being slow to react and not preventing the fire from spreading.*

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34. Given the similarity in the words of Professor Muller and those adopted by DSC Walsh in her report, it is likely she spoke to Professor Muller and recorded that opinion in her report.

35. On examination by forensic investigators and QFES investigators, it was noted there were no traces of accelerants found at the scene. The fire damage was localised to the chair where Mr Drane had been sitting at the time of the fire and neither cigarette lighter had suffered fire damage.

36. Statements were taken from nursing and management staff. A domestic staff member, Ms Lynda Johnston told police she entered the smoking room at approximately 2:10–2:15 hours and had a brief conversation with Mr Drane who told her he had just been to hospital and he was wanting to have a cigarette. She then left the room. She said Mr Drane looked terrible, weak and sick and not as she had seen him in the past.

37. Around 5-10 minutes later she returned, opened up the door and saw Mr Drane on fire. She described him sitting in the chair looking at her with

his hands on the arm of the chair. Prior to opening the door she had not seen or smelt any smoke.

38. She then ran down the corridor looking for assistance and attempted to smash the fire alarm, which was behind a pane of glass. She was unable to smash the glass panel to access and press the fire alarm. In any event other staff members had been alerted and arrived to assist. Fire blankets were placed on John in an attempt to put out the flames. Multiple fire blankets were ineffective and fire extinguishers were then deployed, followed by the domestic staff forming a human chain passing wet towels along the lines of nursing staff to place on John to extinguish the flames. Witness accounts described the flames as extremely difficult to extinguish.

39. Mr Drane's family have expressed their gratitude to the staff in their endeavours to extinguish the flames.

40. Most of the witnesses had no recollection of Mr Drane saying anything nor did he move while sitting in the chair as they were attempting to extinguish the flames. He was not seen to move his hands to his eyes, something Professor Muller said was often an instinctive reaction. Professor Muller also said Mr Drane was very calm in hospital but this is not unusual as the pain has usually abated because nerve endings have been burnt through and morphine had been administered.

41. Ms Heather Gambetta stated she heard John saying 'help, help, I'm on fire'. Nurse Hudson recalls he was sitting in his chair and said 'Help me, help me'. It is noted that there were no burn injuries to his hands, indicating no attempt was made by Mr Drane to try and extinguish the fire. Professor Muller did say it was unusual that the palms of the hands and the front of the left arm were not burnt. This could indicate a lack of protective action, which was unusual and occurs usually where the person is frail or affected by alcohol or drugs.

42. DSC Walsh noted similar incidents have occurred in other nursing home type facilities. She considered that a phenomenon called the 'wick effect' played a possible role. This refers to the concept that once clothing has caught fire, the skin is split, thereby releasing flammable fats. The clothing then allegedly acts like a wick and the body burns as long as a source of fuel, i.e. fat remains. Fire Investigator Jones discounted this theory as this phenomenon does occur, but generally later in a fire development where considerable heat is involved and is not really consistent with a quick burning fabric fire.

43. DSC Walsh considered domestic and nursing staff acted effectively and quickly once Mr Drane was discovered on fire, to manage and contain the situation.

44. DSC Walsh concluded this was an accidental ignition. She concluded the likely source of the ignition was caused while Mr Drane was smoking

a cigarette, causing part of the red hot ash to fall, igniting his shirt around the waist area. Initial smoulder spread quickly to flames covering his body, due to his clothing acting as an accelerant. His health and poor mobility inhibited him from extinguishing the initial ignition.

Queensland Fire and Emergency Service investigation

45. Gregory Jones carried out an investigation as to the cause of the fire. He has internal organisational training and accreditation as a fire investigator. He said the investigation was carried out in conjunction with QPS who were the lead agency. The fact the two organisations did not provide the other with their respective reports is a matter of considerable concern.

46. Mr Jones stated the integrity of the fire scene and the room of origin was damaged as the staff of the facility had thoroughly cleaned the area prior to the arrival of all investigators.

47. A number of photographs were taken at the scene by staff before cleaning the room and by Scenes of Crime officer Scarinci. Mr Jones attended at the scene on 9 January 2014. The designated smoking area is accessed via a pair of hinged doors, which open into the smoking room. The smoking area displayed no fire, heat or smoke damage. The only indication of any fire activity was some residue of the extinguishing-medium after the use of a dry powder extinguisher and a number of dark hand prints on the wall on the western side of the middle windows that Mr Jones considered were most probably from Mr Drane's hands post-fire or persons assisting Mr Drane. The limited amount of heat produced by this quickly evolving fire involving the clothing did not activate the thermal detector located within the smoking area where the fire had originated.

48. The remains of Mr Drane's clothing in the chair he was sitting on were recovered and repositioned within the area of origin as they had been removed when the area was cleaned.

49. Mr Jones stated the fire damage observed on the chair is consistent with the damage on the two armrests with more damage on the left side than the right side; the lower left side of the back rest displays an area of partially consumed vinyl covering with exposed and partially consumed foam padding; the remaining vinyl covering surrounding and extending above this exposed foam is deeply charred and discoloured with areas of blistering surface extending to the top of the back rest on this side only. The right side back rest displays less damage with a small area of exposed foam padding and charred and blistered vinyl extending upward approximately 200mm. This damage indicated there had been direct flame contact extending from the lower to upper areas of this chair.

50. Mr Drane's clothing was examined. The under and over shirt were constructed of a cotton blend t-shirt type material. His long trousers were

of a polyester cotton blend. Mr Jones opined the fire damage displayed was consistent with the bottom of the trouser legs being ignited and subsequent upward fire progression due to convection and direct flame contact from Mr Drane's shoes and socks up the front of the trouser legs to the crutch area, where it has then ignited the upper body garments. Mr Jones stated that fire extends upwards. If the fire had originated in the lap he said the fire would go up the upper body but would not go down the legs.

51. The path of fire travel was from the top of each of Mr Drane's shoes upward to shoulder level to the front surfaces of his clothing. The fire did not extend beyond Mr Drane and the chair he had been sitting on.

52. Tests were carried out on similar fabrics with medication obtained from the Redcliffe Hospital oncology unit. Mr Jones stated the medical treatment received on the morning of the fire has not been identified to cause the emission of flammable liquid vapour or gases from the skin or body, and the medication carried as part of the treatment was not found to promote fire growth or ignition of similar clothing to that worn by Mr Drane. The investigator conducted atmospheric testing in contiguity to the clothing that Mr Drane was wearing at the time of the fire. No elevated levels of volatile organic compounds were detected.

53. Mr Jones repeated on a number of occasions in his evidence that there were very unusual aspects of the case. He believes the possibility of flammable gases/vapours exuding from the skin or body after this type of treatment needs further research, as the rate of fire growth and the partial consumption of Mr Drane's clothing from his shoelaces to his shirt collar is unusual for a person who was in the seated position.

54. It was the opinion of the investigator that the fire damage observed on the clothing and the chair Mr Drane had been sitting on at the time of the fire could have been caused by direct flame contact (by the two disposable lighters that were found) to the front lower sections of his trousers legs, with legs extended whilst in a seated position, and the fire has progressed upward to involve the front only of his trousers. Due to the extra fabric gathered at his lap whilst in the seated position, the fire has intensified in this area causing the damage observed on the chair and on the front of the upper body clothing.

55. The investigator opined that it was highly unlikely that a dropped cigarette would ignite the clothing worn by Mr Drane and a fire ignited in a person's lap would not cause the fire damage to the lower sections of trousers and socks as observed on both left and right legs.

56. As two persons were in the room at the time of the fire, Mr Jones stated either person may have ignited the clothing, although it is possible that Mr Drane has ignited his own clothing intentionally using the lighters found on either side of his chair. He repeated that rapid fire growth and

partial consumption of Mr Drane's clothing from his shoelaces to the shirt collar is unusual for a person in a seated position.

57. Mr Jones provided an addendum report. Further tests were conducted on 13 May 2016 as to the path of fire travel. A further series of small fires were ignited on the clothing placed on a canvas clad dummy. The clothing obtained was of the style and of similar materials worn by Mr Drane. The clothing used for these tests was the same for all three flame ignited tests, and the one set of clothing was used for all cigarette ignition tests. The cigarette used for the ignition tests were Marlboro Red, Australian fire risk compliant, reported to be the same as used by Mr Drane.

58. Five tests for flaming ignition caused by placing a lit cigarette on multiple areas of the clothing and on the seat cushion between the legs of the dummy, did not attain flaming ignition. One cigarette that was placed on the seat cushion between the legs self-extinguished within eight minutes leaving a 1.5 cm melted section of vinyl seat covering. Four other cigarettes burnt to the butt and left holes in the fabrics on which they were placed only. The fabrics located under the layer that cigarettes were placed on, displayed heat and smoke damage only. The tests in no way prove that a cigarette dropped on clothing or upholstery cannot ignite these items, as it is well documented that this can occur and cotton and cotton blends are more susceptible to ignition than most fabrics.

59. The three targeted ignition tests displayed similarity where rapid fire extension was observed on vertical or near vertical surfaces and minimal fire spread on downward angled surfaces. No drop down of ignited fabric materials was observed, only the drop down of the internal rubber filling of the dummy in video 2 can be seen.

60. The test burn observed in video 3 best replicates the damage to Mr Drane's clothing and body above the knees. The approximate time of ignition at the knees to the level of fire involvement of his clothing that was exposed to flaming combustion was 4 to 5 minutes. This path of fire travel does not explain the fire damage displayed on Mr Drane's lower limbs, trousers, socks and shoes.

61. Test 2 was ignited at the dummy's feet and displayed extensive damage to the front and underside of the chair and a prolonged period of time at the transition from vertical flame travel from the feet to knees to the horizontal travel from knees to waist. Nine (9) minutes elapsed before fire had extended to the head and chest.

62. Test 1 extended from the lap of the dummy to the head and chest within three minutes and less than 200 mm of the lateral fire spread was observed towards the knees of the dummy.

63. In Mr Jones' opinion the only way fire could have extended from a single point of origin to damage the clothing and body of Mr Drane as observed,

would have been from a point of ignition at or near the trouser hem line whilst he was standing, or he has stood up whilst the fire was extending up the legs past the level of the knees.

64. Mr Jones opined the alternative hypothesis would be multiple seats of fire. He said it would be unlikely that multiple seats of fire could have been ignited by discarded or mishandled smoker's materials. The fire damage and directional indicators observed at the fire scene and testing fires indicate that accidental ignition by discarded or dropped smoker's material of the clothing worn by Mr Drane is unlikely but possible. The most probable source of ignition would have been by direct flame contact by a person or persons unknown either accidentally or intentionally.

Office of Fair and Safe Work Queensland

65. Office of Fair and Safe Work Queensland (OFSWQ) conducted an investigation. Inspector Deborah Dargan completed the report. Ms Dargan had been informed by Police that the initial view was this was a case of suicide and she acknowledged this impacted somewhat on the investigation conducted.

66. The facility advised that upon admission a 'Smoking Assessment Resident Safety Status' document was completed by a registered nurse. This document revealed that Mr Drane had an initial smoking assessment completed on 15 February 2012. The facility was advised that Mr Drane had a history of alcohol abuse and while under the influence of alcohol, a cigarette had set fire to furniture in his private residence. This incident precipitated his moving to care.

67. Upon admission Mr Drane was put into a high dependency area and monitored for alcohol use. After a period of time it was determined there were no significant behavioural issues and he had no trouble smoking. As a result he was moved upstairs where residents were more independent.

68. A Smoking Assessment Resident Safety Status document was then updated with ongoing assessments performed on 4 April 2012, 3 March 2013 and 23 August 2014.

69. The smoking assessment determined:

- He could be in possession of his own cigarettes in his room and smoke them in the smoking area;
- He could not possess a lighter in his room; and
- He did not require a smoking apron or assistance when in the smoking area.

70. The investigation revealed that medically, Mr Drane had no mobility or manual dexterity problems. The investigation did not reveal the exact circumstances as to how Mr Drane became alight.

71. The investigation noted that since the incident a number of post incident interventions were implemented.

72. OFWSQ made the following relevant conclusions:

- Upon admission to the facility Mr Drane was assessed and a smoking assessment document was completed;
- The assessment tool addressed physical and cognitive capacity for smoking and identified any intervention requirements;
- Mr Drane was identified as able to possess cigarettes in his room and smoke unsupervised, however he was not permitted a lighter in his room;
- The care plan was updated on 4 April 2012, 3 March 2013 and 23 August 2013 with no changes to his unsupervised status;
- Mr Drane was an independent resident with no indication that he was physically incapable of holding a cigarette or extinguishing his cigarette, he was able to mobilise to and from smoking areas without assistance;
- The investigation concluded there is insufficient evidence that Mr Drane had a reduced cognitive ability or functional capacity that would make smoking without supervision intrinsically unsafe; the investigation considered the facility had correctly identified the hazard, adequately assessed the risk and subsequently implemented satisfactory controls to ensure the safety of smoking residents at MCQ;
- Post incident changes to documentation have been made to allow assessment by a General Practitioner when certain risk factors are identified in residents, however there is no evidence that a GP review would have identified the need for supervised smoking by Mr Drane.

Review of Masonic Care Queensland records

73. An Aged Care and Assessment Team (ACAT) record dated 16 January 2012 recommended Mr Drane have low-level residential care to support the needs of himself and his current carers. It specifically noted that support required included a monitored environment for cigarette consumption and ongoing management of alcohol intake.

74. A comprehensive medical assessment was conducted when Mr Drane was admitted. This noted that he was a smoker and a smoking agreement was put in place and signed on 15 February 2012. A Smoking Assessment Resident Safety Status form was completed. This seems to suggest the form was completed on 15 February 2012, updated on 4 April 2012, 3 March 2013 and 23 August 2013.

75. This documentation noted a past history of cigarette burns to furniture. At least one of the forms indicated that with that history a number of

strategies should be put in place including being supervised one-on-one by a staff member, wearing a smoking apron and not to be allowed to keep cigarettes in his possession. It is apparent that subsequent assessments indicated he was able to have cigarettes in his room with no lighter and no other specific needs were required including those of visual supervision or a smoking apron.

76. The records note the history of diagnosis of a bladder tumour. This noted an intention for radiotherapy and chemotherapy.

77. It is common knowledge that chemotherapy and radiotherapy can have debilitating side effects. Prior to the commencement of therapy it was noted by Mr Drane's oncologist in correspondence to the GP, care of the Masonic Care Queensland, that he was rather frail and they intended to be very circumspect as to tolerability given he was not as robust as he once was. Dr Bigby explained in evidence that there were concerns as to how Mr Drane would tolerate treatment but they came to the view there would be benefit in combining the two treatments and felt that with the supported accommodation he was in there would be adequate supervision to allow it to go ahead. Mr Drane had in his view some memory issues but understood the treatment proposed and was keen to proceed as it gave him potential for a cure.

78. The facility was advised in writing by Redcliffe Hospital and RBWH about the proposed treatments, which were to commence on 8 January 2014. The facility records in fact are quite complete and have copies of a number of letters from his oncologists, addressed to his GP, noting the proposed treatment.

79. The issue of reviewing and assessing Mr Drane in light of this treatment was raised by Nurse Hudson. She made an entry in the nursing notes at 7am on 9 January 2014 that he needed to be assessed. The evidence from Nurse Hudson and of Ms Susan Beasley, the newly appointed Executive Manager for Residential Care, was that this review would necessarily have to take place after treatment commenced to ascertain how it had impacted on Mr Drane. Unfortunately Mr Drane arrived back at the facility unannounced and within thirty minutes was on fire. There was practically no time for a review.

80. Post incident changes were made to ensure the Smoking Assessment Resident Safety status form was updated six monthly for residents as well as after a change in medical or physical circumstances. As well a registered nurse has been overseeing the reassessment and review of residents who currently smoke at the facility. An additional section was added to the form. If the resident has any of the items on the list such as dementia, signs and symptoms of depression, decreased dexterity, loss of smell or loss of cognitive function, then the resident must be reviewed by their General Practitioner to establish if the resident can smoke without direct supervision.

81. Informal education sessions would continue to be provided to registered staff to remind them of their responsibilities for ensuring the care-staff supervise residents who smoke and to reinforce care-staff responsibilities for monitoring resident safety.

82. Subsequently MCQ have also determined that from 1 October 2014 all MCQ sites became smoke free environments and smoking is no longer permitted within associated buildings or grounds.

83. For residents who resided in MCQ facilities prior to 1 October 2014, and who continued to wish to use smoking products, those residents will be assessed regarding their capacity to comply with the smoking policy and their ability to smoke safely. Assessments will be conducted on a six monthly basis and as the resident's condition changes. Smoking may only take place in designated smoking areas.

84. All residents currently residing in MCQ facilities, who use smoking products, have also been given the opportunity to engage in a QUIT program or consult with a GP to discuss the use of nicotine replacement products.

Report by Pam Bridges

85. MCQ helpfully commissioned an independent expert review by Pam Bridges. She has a nursing background but more particularly has very extensive experience in the aged care sector at managerial level and is now a consultant to the industry.

86. Ms Bridges gave evidence about residential aged care generally and that it is governed by the *Aged Care Act 1997* and a *Charter of Resident's Rights and Responsibilities (the Charter).*

87. Ms Bridges stated it is the responsibility of an aged care provider to assess the care needs of all residents and to monitor and review care plans on an ongoing basis. It is normal practice to review care plans every three months or at any time when the resident's health status has changed significantly.

88. Ms Bridges stated that Mr Drane was appropriately assessed as low care, and in fact his care needs were at the lower end of low care needs. Relevantly in relation to depression, the Cornell Scale Assessment was undertaken on 28 August 2013 and scored 1 (minimal impairment).

89. There were no behaviours identified under wandering, verbal behaviour and physical age. It was noted Mr Drane was a smoker. A smoking assessment was undertaken on the day he was admitted in 2012 and a further review was undertaken on 23 August 2013. It was noted that Mr Drane was able to self-mobilise to the smoking area and there were no problems identified with dexterity or smoking. His preferred times for smoking were during the day and after meals.

90. However, Ms Bridges noted the smoking assessment form states that if any items were listed on the form, including relevantly in this case a past history of cigarette burns to furniture, then certain strategies should have been implemented. These included either being supervised by staff; a staff member being in close proximity when smoking; wearing a smoking apron and not being allowed to keep cigarettes in their possession. Accordingly strategies listed above should have been implemented.

91. Ms Bridges noted that Mr Drane was very independent and had settled happily into life at MCQ. He was by all accounts a much loved resident who interacted well with staff and other residents. There were inconsistencies in the smoking assessment tool, which were regrettable. It appears he was assessed overall as being able to smoke unsupervised, and this assessment was confirmed on two later assessments. Mr Drane smoked on the premises largely unsupervised for almost two years without any recorded incident. Although the smoking assessment tool suggested he have no cigarettes in his possession and no lighter, as Mr Drane walked to the shops most days, he had the ability to smoke away from the premises as he pleased and bring back unsecured lighters and cigarettes.

92. Ms Bridges stated that otherwise in the documentation provided, she found evidence of ongoing assessment and care planning for Mr Drane.

93. In Mr Drane's circumstances, his health remained relatively stable up to and including the commencement of radio-chemotherapy treatments. He appeared to have maintained his independence and although additional assistance was offered by staff, he did not wish staff to assist.

94. Ms Bridges stated the documentation shows evidence of staff monitoring his specialist appointments, treatments and transport needs during the last few months. During this time his brother Frank routinely escorted Mr Drane to appointments and at other times QAS services were arranged by staff.

95. By all accounts from the documentation reviewed, Mr Drane was very happy living at MCQ and with the level of staff support and assistance he was offered and received. She believes that the responsibilities of MCQ as set out in the Charter appeared to have been met and his rights under the Charter appeared to have been respected.

96. Ms Bridges noted that the documentation demonstrated Mr Drane moved around the complex without restriction as well as taking almost daily walks to Sandgate or to the shops. These activities were recorded in his care plan or in progress notes on a regular basis. Mr Drane also attended the Men's Shed activities and regular bus outings. He left on social leave on many occasions, usually in the company of his brother.

97. Mr Drane was free to come and go as he pleased, but there was evidence staff were prepared to assist him if he so wished. He remained fiercely independent and in such a case the Charter requires he be permitted to exercise independence. He was not left to merely reside at the facility, as there is also evidence that information was relayed to MCQ and Mr Drane's GP following specialist appointments and evidence that his GP attended on the average weekly and as needed as well as reviewing all specialist feedback.

98. The issue of Mr Drane's coming and goings on social and medical appointments was considered. Ms Bridges stated there is no need under the applicable legislation or in accordance with proper practice to document the movements of low care residents other than to ensure the resident signs in or out to alert staff as to his whereabouts.

99. The progress notes do indicate when Mr Drane departed the facility for social leave or for medical appointments. Staff appeared to be well aware of what was arranged and recorded this information.

100. The records show that Mr Drane's health status was monitored closely by staff, from when he first commenced investigations for his cancer, and subsequently during his treatments. Because his functional ability appears to have altered very little during this time, there was no pressing need or occasion to formally reassess him. Ms Bridges stated that in the documents reviewed there was no apparent time or event that would lead her to conclude that a further re-assessment or risk assessment was required. Such a reassessment would only ordinarily occur outside the three month cycle once a significant change in condition has been observed. She considered that the records show that staff were very attentive to Mr Drane's condition and needs during this time.

101. Ms Bridges was asked to review the letter from Dr Bigby dictated on 18 December 2013 and received at MCQ addressed to Dr Balthes his GP on 8 January 2014. She stated there was nothing in this communication that would necessitate or prompt staff at MCQ to undertake any additional care over and above the care already been provided. There is no indication in the letter that there was likely to be any significant change in care needs, or the need or extent of any need.

102. Ms Bridges stated that in terms of assessments to decide whether a care plan should be changed, that process must necessarily react to the observed condition of the resident once the treatment had been administered and he had returned to the facility. Progress notes dated 9 January 2014, state that assessments were to be reviewed. Ms Bridges stated that the flagging of the need for nursing staff to review assessments was very appropriate, as this ensures that the issue should receive prompt attention when the resident returns after treatment, which is the first opportunity to do so in such a case.

103. Ms Bridges was of the opinion that the care provided for Mr Drane was consistent with his assessed care needs at that time. There was evidence that his condition was altering since he commenced his radiation and chemotherapy and she feels confident, having reviewed how staff were monitoring his condition, that any changes or future needs would have been managed appropriately when the time arose.

104. Ms Bridges does not believe a different approach to his care or supervision prior to the fatal incident would have changed the ultimate outcome. This is particularly so because up until a few days before his demise, Mr Drane apparently continued to function at his usual level.

105. A Patient Self Reporting Health History conducted by RBWH on 16 December 2013 indicated that he was enjoying life and felt cheerful most of the time. He reported some difficulties with shopping and mobility. He did not have any increasing fatigue. Ms Bridges did note the earlier Patient Self Reporting conducted at Redcliffe Hospital on 4 December 2013 showed Mr Drane may have been struggling a bit, which on the basis of the score warranted a Social Work referral. She stated that this tool is a useful one and considers it could be utilised in the aged care sector in appropriate patients. The fact that there was a more optimistic self-assessment 12 days later in itself would have been useful information to have been communicated to the nursing home.

106. This raised the issue of how there could be better communication between aged care facilities and hospitals/GPs both ways in cases where there may be an increased risk of self-harm.

Conclusions on the issues

107. It is incumbent on a coroner to endeavour to make a finding where possible of whether a death has been caused by accident, by intent of a third party or that the deceased intended to take his own life. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.[1] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[2]

108. Hence I need to have a high degree of satisfaction before making a finding of intentional harm by a third party or one of suicide as distinct from accident, and if that is not possible an open finding may need to be considered.

109. I am satisfied that a third party was not directly involved in Mr Drane's death. The other resident in the room was not involved in setting Mr

[1] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[2] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

Drane alight. There did not appear to be any defensive action by Mr Drane, as it is evident he did not use his hands to try and extinguish the flame. He made no mention of being assaulted or set alight to MCQ staff, to QAS, to hospital staff or his brother. He was conscious, communicating, noted to have a GCS of 15 at all times and had ample opportunity of saying something to that effect.

110. There is no account in the medical records as to how the fire started although Professor Muller said his memory was Mr Drane said a cigarette lit his clothing. Professor Muller said it was unusual the palms of his hands were not burnt.

111. The only other account came from the other resident in the room. She had difficulties in communication due to a brain injury but was not considered to have other than mild impairment by dementia. She gave two consistent stories to police at different times that 'he lit himself on fire' and she had 'seen his pants on fire'. She repeated in her video interview that she 'did remember him setting fire to himself' and that at some point he was 'standing up'.

112. I accept this evidence should be somewhat discounted but not disregarded, because of the paucity of evidence regarding the resident's capacity to give an accurate version at that time and as well she could not be tested on her version at the inquest. The resident was unable to provide really any more detail, although she accurately described in minor detail the events that followed. However, the version of events given by the resident is consistent with the hypothesis of the QFES investigator that the fire emanated at the feet of Mr Drane. He may have been standing, as described by the resident, allowing the flames to more quickly spread to his lap and upper body and then he sat down. This also explains why there was little damage to the underside of the chair. It is further possible that in addition Mr Drane lit himself at various points on his clothing, again consistent with the rapid spread of the fire.

113. The QFES investigator's evidence is that it is highly unlikely a dropped cigarette would ignite the lower sections of the trouser legs. The trousers did not have cuffed hems which could entrap a cigarette. Tests revealed a dropped cigarette to the lap area was unlikely, but possible (because such an event has been known to occur), to result in a rapid burn seen in this case but not to the legs. It should also be noted that for some years all cigarettes used in Australia utilise fire retardant bands to the paper slowing the burn rate.

114. The evidence against a finding of suicide largely rests with the fact that Mr Drane had not been noted to be depressed or overly sad at his predicament; he was well supported by his family and to a some extent the staff at MCQ; he had some prospects and confidence of a cure; he had some future plans and he had never expressed such negatives thoughts to his family or nursing and medical staff. There is no suggestion he was unwell to the extent he did not have capacity to know

what he was doing. As well, although self-immolation is very much a lethal method of suicide, to ensure death an accelerant is usually used.

115. At the scene he was heard by two persons to request help, but in contrast he was also said to be quiet and calm and made no effort to use his hands to try and extinguish the fire and just sat in the chair.

116. Hence if he did make that decision to take his own life it was completely unexpected and unpredictable. Unfortunately that is very often the case where suicide occurs. There is no warning and often these tragic decisions are made impulsively and without any planning. It is speculative but maybe not a coincidence that he made the decision shortly after having his first combined set of radiotherapy/chemotherapy, was feeling quite unwell and may have decided this was enough for him.

117. After reviewing all of the evidence, I have come to the unfortunate conclusion that Mr Drane intentionally set fire to himself in such a fashion to cause a rapid spread of the fire and to cause life threatening injuries. The fire emanated at his lower trouser area after he utilised one or two cigarette lighters. He probably stood at one point which allowed a more rapid spread over his clothing and may have ignited a number of areas of his clothing. I accept the distress this finding will cause to Mr Drane's family who could not have predicted or prevented these events.

118. In reviewing the police report, it seemed on the face of it evident that the police investigator was not aware of the alternative conclusions of the investigation of the Queensland Fire and Emergency Service. It turns out this was not the case. DSC Walsh says Mr Jones had discussed his opinion with her and DSC Walsh was aware of it when she prepared her report to the coroner. It was most unhelpful that the alternative view was not included in her report as it would have ensured further investigation by my office would have taken place immediately. It was only in preparing final witnesses for the inquest that Mr Jones provided his report. Mr Jones believes he may have been asked by police to send his report but he agrees he failed to do so unintentionally. That also was most unhelpful.

119. It is also apparent that the suggestion that this was a case of suicide was considered by police initially as this was also relayed to OFSWQ Investigator Dargan and was shared in email communication with OFSWQ. That alternative conclusion was not mentioned in any reports to the coroner. The OFSWQ investigation was not assisted by either a QPS or QFES report.

120. Hence, the coronial investigation focused on the scenario of a dropped cigarette being the cause of the fire and concentrated on the assessment and management by MCQ of the risks caused by Mr Drane's smoking habit, particularly in the context of his recent medical treatment.

121. As this office was in regular contact with Mr Drane's family, including providing them with updates and reports, they also presumed this was an accidental death. It would have compounded their grief to be told over two years later there was an alternative conclusion of a particularly distressing nature being suggested. This should never have occurred.

122. I agree with Ms Jarvis' submission that QPS, QFES and WHSQ collaboratively review their involvement in this matter and identify the most practical and efficient means for ensuring that when the various agencies are involved in investigating a death or serious injury involving a fire, that the roles and responsibilities of each agency are clearly defined and appropriately carried out to ensure relevant information is shared. I am aware QPS and OFSWQ have entered into a Memorandum of Understanding and along with other agencies investigating workplace deaths meet regularly and it is believed this has improved communication and liaison. A similar model may include QFES involvement. It is understood that in fact there may be two projects underway discussing these various issues between QFES and QPS. This includes the *Reducing Unlawful Fires (including Arson) Investment Proposal* jointly between QPS, QFES and Rural Fire Service Queensland approved in 2014 but waiting implementation. QPS have also looked at the issue in the form of a *QPS Reducing Unlawful Fires Initiative Proposal*. Given much of the work has been conducted I urge the agencies to implement and/or complete these proposals.

123. It is evident the MCQ facility had conducted assessments over a range of Mr Drane's capacity to undertake daily activities, including smoking.

124. I accept that from the time of his admission to the facility in early 2012 to around August 2013, there was little indication that smoking by Mr Drane would have been unsafe. He was then diagnosed with bladder cancer. His treatment was to include a combination of chemotherapy and radiotherapy. The facility was appropriately informed and updated about the treatment being provided to him.

125. MCQ staff had noted that Mr Drane needed to be further assessed as such treatment is well known to be debilitating and more so to an elderly person.

126. It may have been optimal to have re-assessed after his recent diagnosis and surgical procedures. What a re-assessment of his smoking and other capacities would have found is unclear. It is clear an appropriate decision had been made to review him after chemotherapy had commenced. It is evident that the events that occurred took place very soon after his return from hospital giving no practical opportunity for that assessment and review.

127. MCQ have since changed their policies to require re-assessments each six months or as the resident's condition changes, for current residents

who smoke. No new residents will be permitted to smoke within the grounds or buildings.

128. I find that the care provided by MCQ was appropriate and the improvements conducted by MCQ are also beneficial, particularly if the finding had been one of accidental dropping of a cigarette. The fact that Mr Drane would take his own life could not have been predicted by MSQ but raised the issue of the benefit of risk assessments specifically looking at such an event.

Mental Health and Suicide Risk Assessment

129. Dr Bigby, Mr Drane's oncologist, agreed depression and anxiety is a major issue with patients and such conditions would not be unusual for a person receiving oncology treatment. Dr Bigby stated that his Oncology Department had limited access to resources to address those real psychosocial problems. He had no welfare worker, one overworked social worker and a shared psychologist. These limited resources have been raised by him as an issue for some time. He is optimistic later this year he will have a full time welfare officer, and more social work and psychologist support.

130. Recent media reports indicated concern that suicide rates have increased significantly in Australia in recent years. Certainly in Queensland that is the experience of the Coroners Court. In my own experience it is of real concern there appears to be increasing numbers of elderly people who are taking their own lives in the context of deteriorating physical conditions, almost always on their own, without warning and often violently. Not all are suffering from clinical depression, or if they are, this is undiagnosed.

131. A week prior to the inquest, I was made aware by the Queensland based Australian Institute for Suicide Research and Prevention of a selected research paper considering physical diseases as predictors of suicide in older adults.[3]

132. I requested the assistance of the Office of the State Coroner Domestic and Family Violence Death Review Unit (DFVDRU) who have considerable multidisciplinary experience over a wide range of areas of social issues including not only domestic violence, but child protection and mental health/suicide prevention. A brief literature review was conducted.

133. In summary, I am advised that research indicates that depression and severe physical health conditions may increase risk of suicide amongst older persons, with some indication of an elevated risk immediately after diagnosis. Suicidal behaviour amongst older persons is often undertaken

[3] Erlangsen, A., Stenager, E. & Conwell, Y (2015) Physical diseases as predictors of suicide in older adults: a nationwide, register based cohort study, Social Psychiatry and Psychiatric Epidemiology, 50: 1427-1439

with greater intent, and greater lethality than amongst younger cohorts. Elderly persons are less likely to discuss their plans prior to death and are more likely to choose more lethal methods.

134. The research suggests depression amongst this cohort is under-diagnosed, and therefore under-treated. There is a strong relationship between depression (or the presence of depressive symptoms) and suicide in older persons.

135. This cohort is in regular contact with health providers because of treatment of their medical condition (and therefore a captive audience in terms of screening and assessment) and therefore it is an ideal point of intervention for suicide prevention strategies.

136. Similarly, aged care facilities should also be cognizant of suicide risk amongst residents, as well as their physical health, particularly in periods of known elevated risk (immediately after diagnosis) or where there may be an absence of protective factors, noting that staff have an important role to play in the emotional and social well-being of residents.

137. Training may be of benefit for staff in aged care facilities to assist in the detection of suicidal ideation or other mental health concerns.

138. A copy of the literature review conducted by the DFVDRU is attached to this decision, for which I thank them.

Findings required by s. 45

Identity of the deceased – John Edward Drane

How he died – John Drane took his own life when he set his clothing alight in such a manner to ensure a rapid spread of fire across his clothing. This was probably in the context of a deterioration in his physical wellbeing due to treatment for bladder cancer. His actions could not have been predicted by members of his family or staff at his nursing home.

Place of death – Royal Brisbane Hospital, Herston

Date of death– 9 January 2014

Cause of death – 1(a) Burns
2 Coronary atherosclerosis; emphysema; smoking; urothelial carcinoma of bladder

Comments and recommendations

In light of the research referred to in relation to physical diseases as predictors of suicide in older adults, and the evidence of Dr Bigby that this is a real

psychosocial issue which needs resources to address the issue, I recommend that the Queensland Department of Health, in partnership with the aged care sector and the general practitioner sector, implement routine screening and assessment for elderly persons diagnosed with and/or undergoing treatment for significant physical conditions, together with screening for depression (given the correlation between the two).

I further recommend that the Queensland Police Service, Queensland Fire and Emergency Service and Workplace Health and Safety Queensland collaboratively review their involvement in this matter and identify the most practical and efficient means for ensuring that, in future, when the agencies are concurrently investigating a death or serious injury involving a fire, that the roles and responsibilities of each agency to inform each other's recommendations and to properly advise and put all relevant evidence before the investigating coroner, are clearly defined and appropriately carried out. This may include entering into a Memorandum of Understanding and/or implementing current initiatives being the *Reducing Unlawful Fires (Including Arson) Investment Proposal* and *QPS Reducing Unlawful Fires Initiative Proposal.*

I close the inquest.

John Lock
Deputy State Coroner
Brisbane
15 June 2016

Attachment A

Suicide Risk and Prevention in Elderly Persons with Co-occurring Physical Health Conditions

- In addition to psychiatric disorders, the presence of physical disease has been linked to increased risk of suicide in older adults, however this relationship is not directly causative and the elevated risk may be because of pain or feelings of perceived burdensomeness, situational factors such as impairments to daily living or temporal factors such as recent hospital contact or hospitalisation or distress with respect to a recent diagnosis[4].
- It is also suggested that certain physical health conditions, such as strokes, diabetes, heart disease and chronic obstructive pulmonary disorders have been linked to a higher rate of depression after diagnosis, the presence of which can be underdiagnosed, and therefore not treated in older adults[5].
- The under diagnosis of depression also makes it difficult to clearly establish the inter-relationship between physical health, co-morbid mental health conditions and suicide risk through research.
- There is a strong correlation with affective disorders for suicide risk in later life, with an indication that whilst physical illness and functional impairment may increase risk, this relationship is mediated by depressive symptoms[6].
- Further, whilst common illnesses (inclusive of both psychiatric and physical illnesses) are independently associated with an increased risk of suicide in the elderly, the risk appears to be cumulative and exacerbated among patients with multiple illnesses[7]
- The trauma associated with a diagnosis of cancer may itself trigger immediate health consequences independent of the effects of the disease or the treatment; with estimates of the relative risk of suicide post-diagnosis being 12.6% during the first week and 3.1% during the first year for one study[89]. This relationship was most notable in those patients with a poor prognosis, irrespective of pre-existing, diagnosed psychiatric conditions.

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[4] Erlangsen, A., Stenager, E. & Conwell, y> (2015) Physical diseases as predictors of suicide in older adults: a nationwide, register-based cohort study, *Social Psychiatry and Psychiatric Epidemiology, 50*: 1427-1439.
[5] Lebowitz, B.D> Pearson, J.L., Scneider, L.S. et al (1997) Diagnosis and treatment of depression in late life JAMA 278:1186-1190.
[6] Conwell, Y., Duberstein, P.R. & Caine, E.D. (2002) Risk factors for suicide in later life, *Society of Biological Psychiatry,*
[7] David, N., Juurlink, M.D., Hermann, N. (2004) Medical illness and the Risk of Suicide in the Elderly, *Internal Medicine 2004; 164* (11) 1179-1184
[8] Fang F., Fall, K., Mittleman, M.A. et.al. (2012) Suicide and Cardiovascular Death after a Cancer Diagnosis, *The New England Journal of Mediicine*
[9] Also see http://www.reuters.com/article/us-cancer-prostate-idUSTRE61162M20100202

Suicide in nursing homes and long-term care facilities

- Whilst there has been some research which suggests that suicide risk is lower in long term care settings like nursing homes, due in part to levels of staff supervision, other research indicates that rates are similar to that amongst older persons in the community[10].
- Given the high prevalence of natural-causes deaths and functional decline amongst residents within nursing homes and long-term care settings, this can be a source of anxiety for other residents[11]. Although it is not uncommon for residents to discuss death, including suicide, staff may be reluctant to engage in these discussions[12], which may preclude open discussions about suicidal ideation or intent.
- Another American study also identified that despite long term care being seen as a protective factor for suicide, because of the high levels of staff surveillance, reduced access to lethal means and opportunities for intervention by health care providers, factors such as low social support and depression may increase risk[13]. There is however strong evidence to highlight the positive role that staff play in the promotion of psychosocial well-being amongst residents[14].

Suicidal behaviour in the elderly

- Notably suicidal behaviour amongst older persons is often undertaken with greater intent, and greater lethality than amongst younger cohorts[15]. Elderly persons are less likely to discuss their plans prior to the death and are more likely to choose more lethal methods[16], which means they are less likely to survive a suicide attempt[17]. Their deaths by non-violent causes also may be mistakenly attributed to an illness[18] as opposed to an act of intentional self-harm.
- Whilst suicide rates are disproportionally high in the elderly, and they are more closely associated with significant mental illness or physical health concerns, they are correspondingly less likely to be recognised, or effectively treated, in those elderly persons who come into contact with services; indicating a need for health practitioners (i.e. GP's and

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[10] Mezuk, B., Lohman, M. Leslie, M. & Powell, V. (2015) Suicide Risk in Nursing Homes and Assisted Living Facilities 2003-2011, *American Journal of Public Health 105(7) 1495-1502*

[11] Ibid

[12] Davis-Berman, J (2011) Conversations about death: talking to residents in independent, assisted and long-term care settings, *Journal of Applied Gerontology, 30*(3) 353-369.

[13] Mezuk, B., Prescott, M.R., Trdiff, K., Vlhov, D. & Galea, S. (2008) Suicide in older adults in long-term care: 1990 to 2005. *Journal of the American Geriatrics Society, 56*(11), 2107-2111.

[14] Nakrem, S., Vinsnes, A.G., & Seim A., (2011) Residents experiences of interpersonal factors in nursing home residents, *Journal of Ageing Studies, 48*(11) 1357-1366

[15] Cattel, H (2000) Suicide in the elderly, *Advances in Psychiatric Treatment, 6(*2), 102-108 http://apt.rcpsych.org/content/6/2/102

[16] Carney, S.S. Burke, C.L. & Fowler, R.C. (1994) Suicide over 60: the San Diego study, Journal of American Gerontology sSoc. 142, 174-180

[17] Caine, E.D. & Conwell, Y. (1995) Suicide in the elderly: bias, infirmity and suicide *Crisis 16*, 147-148

[18] David, N., Juurlink, M.D., Hermann, N. (2004) Medical illness and the Risk of Suicide in the Elderly, *Internal Medicine 2004; 164* (11) 1179-1184

specialist care providers) to be educated regarding suicide risk in this population[19].

Opportunities for Prevention

- Understandably a diagnosis of a severe physical disease can be considered a stressful life event and greater recognition by health practitioners with respect to not only the medical care of the physical well-being of the patient, but consideration of the patients psycho-social support mechanisms may be beneficial in alleviating the impact of this distress, (including the associated suicide risk).

Interventions in health care settings

- Recommendations have been made to consider suicide risk assessment after diagnosis of severe diseases in older adults by health practitioners including in specialist medical care settings[20]. This is particularly salient as the earlier the intervention, the better the outcome with respect to addressing suicide risk for at risk geriatric patients[21].
- Gatekeeper training, and routine surveillance and monitoring for both depression and suicidal ideation, may be effective in these settings as there is regular contact with health care staff, particularly during the acute phase after diagnosis, as well as through treatment and during rehabilitation.
- It is also the case that older persons with physical health conditions are likely to require, and receive, ongoing medical treatment for their physical health concerns and as such this represents a sustained opportunity for early intervention for those at risk, prior to a situation escalating to a crisis point.

Assessment of suicide risk in nursing home and long term care settings

- Because older persons are less likely to disclose suicidal intent, and are less likely to be diagnosed with a mental health related concern (where one may be present) routine screening and assessment may be beneficial in a range of other settings, including nursing homes.
- Such screening should include the use of standardised assessment tools (i.e. the Geriatric Depression Scale or the Cornell Scale for Depression in Dementia) upon admission to nursing care settings[22]. This is salient given that a study of nursing home suicides found the presence of diagnosable mental disorders prior to the deaths, which indicates that

[19] Cattel, H. (2000) Suicide in the Elderly, Advances in Psychiatric Treatment, 6(2) 102-108
[20] Erlangsen, A., Stenager, E. & Conwell, y> (2015) Physical diseases as predictors of suicide in older adults: a nationwide, register-based cohort study, *Social Psychiatry and Psychiatric Epidemiology, 50*: 1427-1439.
[21] Ryan, C.W., Hall, M.D., Richard, C.W., et all (2003) Identifying Geriatric Patients at Risk for Suicide and Depression, *Clinical Geriatrics, 11*(10).
[22] Reiss, N.S. & Tishler, C.L. (2008) Suicidality in Nursing Home Residents: Part 1. Prevalence, risk factors, methods, assessment and management, *Professional Psychology: Research and Practice 39*(3), 264-270.

these suicides may not have been directly attributable to difficulties in coping with pain and disability, but likely influenced by diagnosable and treatable mental health disorders[23].

Strategies for assessment and intervention

- As with other age-cohorts these strategies should be targeted towards males, given they have rates of suicide that are disproportionally high comparative to females. This elevated risk has been linked to men being less likely to seek help for emotional distress, services not being 'male friendly' or easily accessible as well as men not wanting to appear weak or wanting to 'work things out' themselves[24].
- Despite depression having such a strong association with elevated risk of suicide later in life, interventions targeted at 'mental health' issues can often lead to lack of engagement by men, particularly those who adhere to traditional male roles, because of the stigma associated with mental illness.
- It is because of these factors that a proactive, direct and action-oriented approach, which includes routine screening of men for depression or other mental health concerns, can be beneficial in reducing suicide risk, in combination with assistance in accessing specialist services.
- Such assessments should take into account the presence of protective supports given there is some indication that social supports may mediate the negative functional or financial impact of an illness[25].
- To be effective, routine screening should only be seen as a structured guide with the onus on the practitioner to be an effective communicator, following up on any indicators of increased harm with clarification questions.
- For individuals who screen as at imminent risk of harm (i.e. with suicidal ideation, a plan and access to lethal means) hospitalisation may be necessary[26]. For those with expressed suicidal ideation but who screen at lower risk of harm, than permission should be sought to engage with the patient's social support system with professional follow-up care and further assessment.

[23] Suominen, K., Henriksson, M., Isometsa, E. et al. (2003). Nursing Home Suicides: a Psychological Autopsy Study, *International Journal of Geriatric Psychiatry, 18,* 1095-1101.
[24] Fact sheet 17 Suicide and men LIFE: Living is For Everyone Framework, Australian Government
[25] Conwell, Y., Duberstein, P.R. & Caine, E.D. (2002) Risk factors for suicide in later life, *Society of Biological Psychiatry,*
[26] Garand, L., Mitchell, A.M., Dietrick, A. et.al. (2006) Suicide in Older Adults: Nursing Assessment of Suicide Risk, *Issues in Mental Health Nursing, 27*(4) 355-370.