OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Jennifer Elizabeth Bell**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Maroochydore
FILE NO(s):	CCMS 137/2007
DELIVERED ON:	16 December 2010
DELIVERED AT:	Maroochydore
HEARING DATE(s):	5, 22, 23 & 25 November 2010
FINDINGS OF:	J A Hodgins, Coroner
CATCHWORDS:	CORONERS: Suicide, traffic incident, adequacy of clinical handover and psychiatric reviews

REPRESENTATION:

Counsel Assisting:	Mr J Tate, Crown Law
Queensland Health:	Ms S Gallagher instructed by Ms C Lee, Cooper, Grace & Ward
Mr C Bell	

INQUEST INTO DEATH OF JENNIFER ELIZABETH BELL

Introduction

[1] These are my findings in relation to the death of Jennifer Elizabeth Bell ("Jennifer"). These findings seek to explain how her death occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. The findings will be given to the family of the person who died and to each of the persons or organizations granted leave to appear at the inquest. A copy of the findings will be placed on the website of the Office of the State Coroner.

The Coroner's Jurisdiction

[2] A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

[3] An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case[1] it was described in this way:-

> *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires"*

[4] The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, a coroner is authorised to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future[2].

[5] A coroner must not include in the findings or any comments or recommendations or statements that a person is or may be guilty of an offence or civilly liable for something[3]. However, if, as a result of considering the information gathered during an inquest, a coroner reasonably suspects that a person may be guilty of a criminal offence; the coroner must refer the information to the appropriate prosecuting authority[4].

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[1] R v South London Coroner; ex parte Thompson (1986) 126 S.J.625
[2] s 46 Coroners Act 2003
[3] s 45(5) and 46(3) Coroner Act 2003
[4] s 48 Coroners Act 2003

[6] Proceedings in a coroner's court are not bound by the rules of evidence because the court may inform itself in any way it considers appropriate[5]. That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information. This flexibility is a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.

[7] A coroner is to apply the civil standard of proof, namely the balance of probabilities. The approach though is 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 trial of fact to be sufficiently satisfied that it has been proven to the civil standard[6].

[8] A coroner is also obliged to comply with the rules of natural justice and to act judicially[7]. No findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. It includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The evidence

[9] All the evidence given during the inquest has been considered. Reference will be made to the evidence considered appropriate to record in these reasons and necessary to understand the findings made.

Queensland Police Service Investigation

[10] Senior Constable Stephen Knight, Forensic Crash Unit, Coolum conducted the forensic investigation into the accident.

[11] On arrival at the scene at 11:50pm he observed that general duties police had cordoned off the northbound lanes of the Bruce Highway. Inside the cordoned off area he saw one truck, five cars and one deceased female, being Jennifer. He spoke to a number of the drivers involved. It was noted that the weather was clear and fine and visibility was dark. He made observations about the road and surrounds. The Bruce Highway consisted of two southbound lanes and two northbound lanes, divided by a grassed median strip about 10 metres in width. The outside of both lanes are defined by a continuous white line. The road was bitumen and in good condition. It was a designated 100 kph zone. There was no form of street lighting.

[12] The driver of the truck stated he was driving north bound when he observed through the headlights a female standing on the highway. The driver swerved to avoid colliding with the female but she walked towards the trucks

[5] s 37 Coroners Act 2003
[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 Sir Owen Dixon J
[7] Harmsworth v State Coroner [1989] VR 989 at 994

direction and the truck collided with her. The truck driver immediately stopped the truck and observed the female on the roadway deceased. The driver commenced trying to stop oncoming vehicles but four vehicles subsequently drove over the body.

[13] At the completion of the investigation, Senior Constable Knight compiled a detailed report for the Coroner[8].

Coronial Issues

[14] The police coronial report comprehensively dealt with factual issues surrounding the motor traffic incident. The primary issues that emerged were as follows:-

1. How is it that Jennifer took her own life shortly after being reviewed and examined by two experienced community health workers?

2. Why was Jennifer not admitted to Nambour General Hospital, that day, for clinical assessment by a psychiatrist?

3. Given Jennifer's longitudinal history, was the assessment, case planning, treatment and care offered by Nambour General Hospital sufficient?

4. Are there systemic issues that caused, or contributed to, the decisions and actions taken by Nambour General Hospital's inpatient and community care staff in relation to Jennifer's case?

[15] Detailed examination occurred as to what recommendations should be made to lessen the chance of a reoccurrence of this category of tragedy in the future.

Medical History

July - December 2006

[16] On 10 July 2006 Jennifer gave birth to her son Bailey. Mr Jodie Sharp is the father of the child and was her de facto partner. On discharge from the Nambour General Hospital it was noted she was a high risk for postnatal depression. The suggested management was for her general practitioner to follow up with her.

[17] In August 2006 Jennifer had surgical treatment for her breast. Her mother raised with hospital staff that Jennifer was severely depressed and required counselling. This was not arranged. On discharge on 27 August 2006 her mother again raised concern about her emotional state. The discharge plan was for social workers to be contacted for review and support.

[8] Exhibit 3

[18] In December 2006 Dr Vuocolo, General Practitioner diagnosed postnatal depression. Jennifer was noted not to be suicidal. Some obsessed traits were noted; but to the extent of an obsessive compulsive disorder. Dr Vuocolo saw her on 15, 19, 21 and 22 December.

Christmas Day 2006

[19] On Christmas Day, 25 December 2006 Jennifer was found by neighbours in a dam partially immersed, knife in hand and had self-inflicted lacerations on both arms.

[20] On admission to the Nambour General Hospital, she was referred to the Mental Health Acute Inpatient Unit. It was noted that she had been feeling overwhelmed since the birth of her child and felt unsupported by her partner. She said that her period had commenced that morning and her feelings became out of control. She denied any desire to hurt her baby. She stated she was a cleaning freak, had lost weight and was not sleeping. Excessive compulsive behaviour was noted. A medium risk for deliberate self harm was noted.

[21] Family members reported during visits that Jennifer had said that she still did not want to be alive. Her mother noted to staff that Jennifer had never been very good at expressing her feelings and had always been a bit closed.

[22] Jennifer expressed a reluctance to leave the hospital. She did not see a future. She was anxious about returning home and expressed these feelings over a number of days.

[23] Jennifer was discharged on 31 December 2006. The discharge plan noted that the Community Assessment and Treatment Team should follow up by linking her into a counsellor for cognitive behaviour therapy for obsessive compulsive traits. She was assessed as being still at risk of depression. It was also noted that she had been commenced on antidepressants and given some psychotherapy. It was further noted that she was no longer suicidal.

January 2007

[24] From 31 December 2006 until 8 January 2007 Jennifer was contacted and reviewed by the Community Assessment and Treatment Team. She was interviewed at the holiday apartment in Caloundra. She did not wish to return home. Mr Sharp (her husband) expressed concern about multiple caregivers and expressed the desire for “one on one to start”. Mr Bell expressed the view that she had obsessive behaviour for some time.

[25] She was admitted as an involuntary patient at Nambour General Hospital from 8 January 2007 to 22 January 2007 as a result of increased suicide ideation. She was extremely anxious with repetitive themes of cleaning and hopelessness. She did report intrusive thoughts of killing herself. An inpatient assessment was made of her obsessive compulsive symptoms.

[26] The treatment plan was to stabilise her mental state and work towards community management. On discharge it was noted that her mood was still depressed but no longer suicidal. Her treatment needs were assessed to be more appropriately met in the community and more beneficial for her to receive treatment there.

[27] Jennifer indicated an intention to stay in Brisbane, so was referred to the Community Care Team at the Princess Alexandra Hospital Health Service District and to Dr Taemets, Belmont Private Hospital for ongoing care in relation to her postnatal depression. On 24 January 2007 Jennifer was registered with the Princess Alexandra Hospital Health Service District Mental Health Division. On 26 January 2007 she was referred to the Mobile Acute Assessment Team to monitor her mental state while residing in Brisbane and to complement her cognitive therapy course at Belmont Private Hospital. On 16 February 2007 she was discharged from the Mobile Acute Assessment Team as she had failed to respond to attempts to contact her between 6 February and 9 February 2007.

[28] Dr Taemets first saw Jennifer on 23 January 2007. He noted that she had been having quite a great deal of difficulty coping since the birth of her child. She described an increase in obsessive compulsive symptoms and a worsening depression. She had become obsessed with cleaning her house.

July 2007

[29] On 24 June 2007 Mr Bell contacted Princess Alexandra Hospital Triage regarding his concern for Jennifer's mental state. Princess Alexandra Hospital Triage referred her to the Mobile Acute Assessment Team. Ultimately on 12 July 2007 she was discharged to the care of her general practitioner Dr See and private psychologist Celia Lane. Her suicide risk was noted to be high. Jennifer saw the psychologist on 4 July 2007, 11 July 2007, 18 July 2007, 30 July 2007 and 6 August 2007. The purpose of the consultation was Cognitive Behaviour Therapy once a week for four weeks. The program was designed for people who may have experienced some of the negative consequences of depression and anxiety. Celia Lane informed Ms Ash on 13 August 2007 that Jennifer did not participate in therapy and this was inhibiting any possible progress.

[30] On 23 July 2007 Jennifer's sister, Laura contacted Princess Alexandra Hospital Triage regarding Jennifer's mental state. She was referred back to the Mobile Acute Assessment Team. On 24 July 2007, Dr Annie Shek, Psychiatry Register referred Jennifer to Continuing Care North for case management. On 30 July 2007 the transfer occurred.

[31] Dr Shek's letter provides a useful insight into Jennifer's mental state towards the end of July 2007. Dr Shek noted Jennifer had been presenting in the last month in crisis following the break down of her relationship with her partner. Significant symptoms of anxiety and depression were noted with poor sleep and motivation. She felt ineffective, unable to function like "normal" people, and of being a poor mother. She was also having fleeting suicidal ideations. She displayed significant dependent and avoidant personality traits. Long-term case management was likely to benefit her.

Also, it was noted that she was likely to bounce from service to service in crisis.

August 2007

[32] Ms Georgia Ash, Psychologist, Continuing Care North, was appointed Jennifer's Case Manager. She telephoned Jennifer on 3 August 2007. Jennifer was aware of the transfer, keen to engage, still depressed, nil thoughts of harm to self and nil suicide ideation. From this phone call Ms Ash formed the view that Jennifer was functioning okay, appeared to be in safe accommodation, was relatively stable and in the care of her family. She mentioned the appointment with the private psychologist and engaging in relationship counselling.

[33] On 7 August 2007 Ms Ash received a phone call from Jennifer's sister about an incident that led to a domestic violence order being made against Jennifer.

[34] On 9 August 2007 Ms Ash spoke to Jennifer about the incident. She sounded flat with low mood. Jennifer admitted doing something stupid and regretted it. She guaranteed her safety and denied suicidal ideation.

[35] On 10 August 2007 Ms Ash made a home visit to Jennifer's sister's place. Jennifer was unwell. She was cooperative with the interview process and provided consent to discussions with her family and did a Beck Inventory Assessment. Her family was supportive and caring; but frustrated with Jennifer's dependency issues. The Beck Inventory Assessment is a self report measure and Jennifer's score was congruent with her presentation. Jennifer endorsed the item "I have thoughts of killing myself but I would not carry them out". Ms Ash also performed a risk assessment which indicated a moderate risk for violence and a high risk for suicide. However, Ms Ash formed the opinion that Jennifer was not at imminent risk of suicide or self harm.

[36] On 13 August 2007 Ms Ash spoke to Jennifer on the telephone. She states that there was not a lot of change in Jennifer's presentation and she tried to motivate Jennifer to move forward with her life. Her family remained concerned because she was not helping herself and not engaging.

[37] On 14 August 2007 Jennifer attended Princess Alexandra Hospital Emergency Department where she was assessed and referred to her treating case manager on 16 August 2007 for follow up.

[38] On 16 August 2007 Ms Ash telephoned Jennifer who informed her that she would not leave her sister's house on 14 August 2007 and her father took her to the Princess Alexandra Hospital. She was not admitted as she was no threat to herself or others. She indicated she wanted to return to the coast and commence working. In a further phone call the same day Jennifer said she was going to the coast the next day. There was nil suicide ideation and could guarantee safety.

[39] On 20 August 2007 Jennifer informed Ms Ash that she was at the Sunshine Coast minding her son. She also stated she wanted to work out things with

Mr Sharp. Ms Ash also that day signed off an Individual Care Plan for Jennifer (albeit unlikely it was complete).

[40] On 29 August 2007 Ms Ash had a phone call from Jennifer who was still on the Sunshine Coast. Jennifer stated she was not getting any better and distressed regarding this. It was emphasised that Jennifer needed to take responsibility for herself, to actively engage in therapy and make some decisions for the future.

[41] On 29 August 2007 Jennifer attended Psychiatric Emergency at Nambour General Hospital for anxiety, depressive symptoms and inability to sleep. She was referred back to the Princess Alexandra Hospital to keep an appointment on 30 August 2007. Ms Ash was contacted by the Nambour General Hospital and there was a mutual exchange of information.

[42] On 30 August 2007 Ms Ash made a home visit to Jennifer. Jennifer was difficult to engage with. Her movement back and forward between Brisbane and the Sunshine Coast made it difficult for Ms Ash to move forward with her care and management. No improvement was being made. Ms Ash had not formed the view that Jennifer was imminently suicidal, as she kept on denying thoughts of self harm and suicidal ideation.

September 2007

[43] On 3 September 2007 Ms Ash saw Jennifer at home. Jennifer had not improved, but she was agreeable and willing to engage by attending a psychiatrist appointment, re-engaging with her private psychologist, and setting her future goals. She wanted to return to the Sunshine Coast and commence work. Residency was contingent on Mr Sharp allowing her to see her son.

[44] At the team review meeting on 4 September 2007, Jennifer's case was presented. The notes made by Ms Ash are instructive, in that they point to the reason why no follow up occurred when Jennifer did not attend the psychiatric appointment on 6 September 2007, in that it was understood she would be transferring to the Sunshine Coast mental health service. The notes are as follows:-

> "*Team review – case presented. Advised of instability of housing. Frequent moves from the Sunshine Coast to Brisbane. Generally presenting on Sunshine Coast in crisis. Outcomes- Jennifer has guaranteed she will stay in Brisbane for four weeks. Continue with case management until this date. Review in one month. If Jennifer continues to be unstable and presents in crisis in Nambour – possible option: close to service – transfer to Sunshine Coast.*"

[45] This note signifies that Ms Ash felt she was not making progress with Jennifer. This lack of progress was due to Jennifer not engaging, the continual moving between Brisbane and the Sunshine Coast and the relationship difficulty with Mr Sharp. If she was moving to the Sunshine Coast, then a transfer to that service was warranted.

[46] Later in the morning on 4 September 2007, Ms Ash telephoned Jennifer and informed her of the outcomes of the team review and the appointment with the psychiatrist on 6 September 2007. There was discussion about minding her son on the weekend. There were two telephone conversations on 5 September 2007 in which she expressed guilt regarding disappointing family members. In the first conversation the appointment the next day was confirmed.

[47] On 6 September 2007 Jennifer did not attend the appointment. Surprisingly, there was no follow up as to why Jennifer did not attend the appointment.

[48] On 14 September 2007 Mr Bell informed Ms Ash that Jennifer had returned to the Sunshine Coast. He stated it was unclear as to whether it was a permanent move. Mr Bell was informed that Jennifer would be closed from the Continuing Care North Team. Subsequently, on 17 September 2007 Ms Ash phoned Jennifer who confirmed she was on the Sunshine Coast and most likely would stay up there. Jennifer was informed she would be closed from the Continuing Care North Team and Jennifer requested she be referred to Sunshine Coast Mental Health. Jennifer reported some improvement in mood and nil suicide ideation. Ms Ash noted that it was difficult to engage the client and had difficulty with consistency of contact.

[49] On 20 September 2007 Ms Ash referred Jennifer to the Sunshine Coast Mental Health Team by sending a facsimile that advised Jennifer had been closed to the district and was aware of her referral to Sunshine Coast Mental Health service for continuing care. The progress notes and both risk assessments were attached. No discharge summary was completed.

[50] Ms Ash stated in evidence that she really did not get to know Jennifer. She had three consultations with her. Jennifer did not open up. Her behaviour was erratic in that she was continually moving between Brisbane and the Sunshine Coast. Her behaviour was influenced by the state of her relationship with Mr Sharp. The focus was to get her stable and put a management plan in place. Her behaviour was consistent during the period of engagement. A phone assessment of Jennifer on 17 September 2007 was that she was a low risk for violence and a medium risk for suicide. Jennifer denied suicidal ideation and was continuing to take medication prescribed.

[51] On 21 September Ms Angel of the Sunshine Coast Mental Health Service Continuing Care Team was nominated as the case manager for Jennifer.

[52] On 22 September 2007 Jennifer telephoned the Sunshine Coast Mental Health Service. Her mental state and medication was discussed and Jennifer agreed to a home visit by Ms Angel on 24 September 2007. Jennifer said she did not require a visit over the weekend and said she would call in if required. On 23 September 2007 Jennifer received a telephone call from the service to assess her mental state.

[53] On 24 September 2007 Ms Angel made a telephone call to Jennifer and attended a home visit in company with Alison Noble. Jennifer was in the company of Mr Sharp and her fifteen month old son. An initial mental state assessment was conducted and an initial care plan was developed. Her

mood was anxious, hopeless damning of her self. She had guilty thoughts regarding the effects she was having on people around her. Her medication was not helping her. She had nil suicide ideation. Ms Angel assessed her as having postnatal depression, significant obsessive compulsive disorder and also borderline personality disorder. Overt tension between her and Mr Sharp was noted. An appointment was made for 1530 hours on 25 September 2007 with Dr Milad, Consultant Psychiatrist who had seen Jennifer during her admission to Nambour General Hospital in January 2007.

[54] On 24 September 2007 Ms Angel also had a telephone conversation with Jennifer on her Centrelink benefits.

[55] On 25 September 2007 Ms Angel had five telephone conversations with Jennifer about her psychiatric appointment. Initially she declined to attend the appointment and requested a home visit by a psychiatrist. She refused to attend despite the offer of transport to and from Caloundra to Nambour for the appointment. Later in the day she phoned to say that she would now attend the review by Dr Milad. Ms Angel by this time had returned to Nambour and was unable to offer the transport. Mr Sharp was unwilling to drive her. She was not able to drive herself. She did not attend the appointment. Jennifer said she would attend her general practitioner that day and Ms Angel said that if Jennifer was not going to keep her appointment to see the consultant psychiatrist that day, then attending her general practitioner was better than seeing no doctor for a review.

[56] On 27 September 2007 Ms Angel had a telephone conversation with Jennifer in which Jennifer stated she had moved out of the marital residence and did not want Mr Sharp to know the address. A home visit from a psychiatrist was requested; but Dr Banzali was not available and no other psychiatrists were available for a home visit that day. An arrangement was made for an appointment on 28 September 2007 with Dr Banzali at Caloundra Hospital.

[57] On 28 September 2007 Dr Banzali reviewed Jennifer's medication. The `plan was to have Jennifer:

- cease Stillnox; and
- reduce Citalopram to 20mg every other day for three days and then cease; and
- start Efexor XR 75mg after the cessation of Citalopram; and
- take some further medications listed in the clinical notes.

October 2007

[58] On 1 October 2007 at about 11:45pm Jennifer phoned her sister Kylie. Kylie could hear a lot of traffic noise in the background. Jennifer told her that she could not sleep and she and Mr Sharp had an argument and she had left the house. She had gone to buy a drink and clear her head. She said that she was at the Moby Dick, a petrol station. Jennifer asked Kylie "If I walk in front of a truck do you think it will kill me?" Kylie said to Jennifer that they had already discussed the outcomes and that she'd more likely with her luck become a paraplegic. Jennifer asked her two or more times "Will it kill me,

will walking in front of a truck kill me?" Kylie then implored her not to do it. She told Jennifer to go home and not to continue to argue with Mr Sharp. Jennifer said she would. The call ended.

[59] Kylie at approximately 11:55pm phoned Ms Donna Margetts of the Mental Health Hospital Assessment Team, Nambour General Hospital and reported her concerns about the telephone call from Jennifer. Ms Margetts attempted to contact Jennifer on her mobile phone; but it went through to message bank. A message was left to contact, including telephone contact number of the service. Kylie was phoned back and advised to contact police with relevant details. Also, that Jennifer's treating team would be informed in the morning of developments. A further attempt was made by Ms Margetts to contact Jennifer at 3:30am; but again the phone went through to message bank.

[60] On 2 October the Continuing Care Team received faxed information from the Mental Health Hospital Assessment Team on contact with Jennifer's sister. Ms Angel phoned Jennifer at 9:30am whilst in transit on another acute, on-call matter. She informed Jennifer of Kylie's phone call during the night and Jennifer's query about the outcome of walking in front of the truck. She was settled and denied any active suicide ideation. She arranged a home visit that evening.

[61] At 12:00 Mr Sharp phoned Ms Angel expressing anger, frustration and fear regarding Jennifer's mental state. He was concerned she may harm herself. He believed she needed admission to make her wake up to herself. Ms Angel informed Mr Sharp of the recent psychiatric review and the planned home visit that night. Mr Sharp stated that he did not know where Jennifer was so was unable to provide any information about her current mental state.

[62] At around 5:30 that evening Ms Angel and Mr Robert Goodwin, Clinical Nurse made a home visit to Jennifer's home. They met Jennifer and her son on the front patio area. She interacted well with both of them. She was cooperative, maintaining good eye contact, her speech was normal, spoke quietly and asked questions appropriately. She checked her son's nappy and kept a watchful eye on him. She had some food (dim sim and soy sauce). While she displayed some visible anxiety/physical agitation and low level mood this was less than at a previous visit. She did not present with a sense of overwhelming helplessness or hopelessness but was actively seeking reassurance that the anxiety and depression would get better.

[63] When discussing the previous night she said she had been seeking support or reassurance from Mr Sharp. He had been trying to sleep and he did not want to be disturbed by her. She was concerned she was hurting him and she did not want to hurt him. Ms Angel reassured her that the illness could make her feel bad about herself and guilty and that she was not hurting Mr Sharp. Rather that the illness was hurting them both. Jennifer indicated she understood and acknowledged this. She was not able to settle the previous night and had started driving to Brisbane to her fathers address but she became too tired to continue. After the phone call to Kylie she returned

home to Mr Sharp. She took her night time medication and then slept on the sofa for the night and slept through until the morning.

[64] Jennifer denied any current active suicidal plan or intention. She stated she wanted to get better and wanted to know when she would get better. She asked for reassurance a number of times that she would get better and stated she wanted to get back to work.

[65] Jennifer was asked whether Mr Sharp wanted to participate in the assessment and she went into the house to see if he was awake. She did this and low voices were heard. She came out and said he did not want to participate.

[66] Arrangements were made to visit Jennifer again on 4 October 2007. The visit lasted forty-five minutes. The assessment of the two mental health workers at the end of the home visit was that Jennifer was not at imminent risk of suicide or self-harm. She was in agreement with the plan developed with her during the visit, for using distraction strategies, daily activities planning, compliant with medication and continuing community mental health service treatment including contacting the service at any time and for a planned home visit on 4 October 2007.

Root Cause Analysis

[67] A Root Cause analysis was completed on 8 August 2009[9]. The delay of nearly two years in doing the analysis was due to administrative oversight.

[68] A contributing factor to Jennifer's death was that no multidisciplinary clinical review procedure meant there was no requirement for a psychiatrist or a multidisciplinary team clinical review to occur. Subsequently there was no overarching treatment plan including a diagnosis and formulation, which possibly increased the likelihood of the unexpected death. A Multidisciplinary Team (MDT) Clinical Reviews Procedure was developed and initiated in February 2009[10].

[69] A second contributing factor was there was no policy or procedures regarding clinical risk management which possibly contributed to a lack of recognition in Jennifer's deterioration, resulting in a lack of escalation from the mental health service. A Clinical Risk Assessment Policy was developed and initiated in January 2008[11]. The policy has been supported in implementation with an education programme run by the mental health education team.

[70] A lesson learnt was that communication and coordination problems occur when two separate mental health districts are providing treatment to the same client. No state-wide policy or procedure existed for the shared care of clients requiring contact with more than one district. The recommendation

[9] Exhibit 8 Root Cause Analysis Team Report
[10] Exhibit 23 Multidisciplinary Team (MDT) Clinical Reviews - Sunshine Coast – Wide Bay Health Services District Procedure
[11] Exhibit 24 Suicidal Behaviour – Risk Assessment and Management – Sunshine Coast – Wide Bay Health Services District Procedure

was that clarification was required within the state for inter district shared care of clients who receive services from more than one service.

[71] A further lesson learnt was that information sent by fax between services did not communicate the urgency of the situation. It was recommended the Workplace Instruction Clinical Handover be reviewed to ensure that best practice guidelines are provided for the district mental health service particularly in regards to faxed documentation.

[72] The final lesson learnt was that it was unknown how effective the use of telephone by mental health services is in regards to the triaging and assessing a client's level of risk. The recommendation was that a workplace instruction based upon best practice guidelines be developed with key performance indicators.

[73] The recommendations of the Root Cause Analysis Team Report have been implemented[12].

Psychiatric Evaluation

[74] Three expert psychiatrists gave evidence. Dr Paul Schneider, Clinical Director, Continuing Care North participated in the weekly clinical community meeting that reviewed Jennifer. Dr David Alcorn, Consultant Psychiatrist and Medical administrator was the court appointed expert and furnished two reports[13]. Dr Joan Lawrence, Adjunct Professor in Psychiatry, University of Queensland provided a report[14] that addressed two specific issues[15]:-

> "(a) The adequacy of the handovers of the care of Ms Jennifer Bell between Queensland Health providers and comment upon the accessibility of information between the public and private health care providers (if appropriate).
> (b) The adequacy of the steps taken by Queensland Health providers to provide psychiatric review to Ms Bell in the community (within the community care and assessment team model and/or the community care team model of care)."

[75] Dr Lawrence was of the view that many layers contributed to Jennifer's mental illness. Following the birth of her son in July 2006 she developed postnatal depression. She had bonding problems with her son due to a difficult birth, breast abscess and did not breast feed. She developed an obsession about cleaning. The marital difficulties also increased. It also involved difficulties with decision making, indecisiveness, obsessive behaviour and dependency on family members. Also, Jennifer was reluctant to open up and did not engage well. An additional complicating factor was the moving back and forwards between Brisbane and the Sunshine Coast. It undermined continuity of care and the ability of her case manager to get to know her thoroughly. She had a very severe Major Depressive Disorder with psychotic features, the extent to which varied from time to time. The

[12] Dr P. Swierkowski, Executive Director Medical Services, Nambour General Hospital in evidence
[13] Exhibits 10 & 11 Reports dated 23 March 2009 & 8 November 2010
[14] Exhibit 12 Report dated 9 November 2010
[15] Exhibit 12 paragraph 1.1

obsessive behaviour was accentuated to the point of an Obsessive Compulsive Disorder.

[76] Following the suicide attempt on Christmas day 2006, Jennifer was hospitalised in Nambour General Hospital and discharged with community care. She was subsequently hospitalised on an involuntary treatment order. This latter hospitalisation had a profound effect on her in that she had a fear of being hospitalised again. It partly explains her not attending the psychiatric appointment scheduled by Continuing Care North on 6 September 2007 and the subsequent non-attendance at the appointment arranged by the Continuing Care Team, Nambour General Hospital with Dr Milad on 25 September 2007. Dr Milad was the treating psychiatrist when Jennifer was hospitalised under the Involuntary Treatment Order in January 2007. The non-attendance at the psychiatric appointments were lost opportunities to fully assess her, including the adequacy of prescribed medication.

[77] As Dr Lawrence points out in her report[16]Jennifer was treated under the principles of modern psychiatric practice. Treatment occurs on a voluntary basis and can only be compelled by an Involuntary Treatment Order. Such an order is made when the person does not consent to treatment and is suffering from a mental illness such that they are at risk of harm to themselves or others and when a failure to accept the necessary treatment would lead to significant deterioration in their health. Mental health care is provided in the least restrictive way possible. Jennifer was detained under an Involuntary Treatment Order in January 2007. Thereafter, she was voluntarily treated in the private sector and in the public sector. Jennifer was not actively suicidal, in that she denied suicidal ideation and guaranteed her safety to the mental health workers. Dr Schneider commented in evidence that he was not sure that Jennifer would have met the criteria for a restrictive order.

Risk Management

[78] Risk assessment in psychiatry is more an art than a science. Predicting future behaviour of a mentally ill person is fraught with difficulty. The contemporary approach to psychiatric risk assessment is based on a standard approach which attempts to combine static factors (patient history and past behaviours) with dynamic factors (current mental state) in order to derive a risk characterisation of high, medium or low.

[79] Clinical risk assessments were conducted on Jennifer from her admission on Christmas Day 2006 at Nambour General Hospital and throughout her attendance at various mental health service providers. The assessments made were based on her past behaviour and not predictive of her future behaviour. Apart from one assessment[17], the assessment generally was that she was at medium risk of suicide. Ms Ash dealt with Jennifer through August/September 2007 and was of the view that her behaviour was consistent. She did increasingly become concerned enough to raise

[16] Exhibit 12 Report dated 9 November 2010 page 9 paragraph 6.4
[17] Ms Ash 10 August 2007 assessed at medium or high risk for suicide

Jennifer's case at team review. Ms Ash thought that her suicide risk assessment of Jennifer was quite similar to the assessment of Ms Angel.

[80] The late night telephone call by Jennifer to her sister Kylie on 1 October 2007 was a significant departure from her previous clinical presentation on suicidal ideation. The discussion of a method of suicide and telephoning from a location adjacent to the highway raised obvious alarm bells. The Continuing Care Team was alerted of the development. Mr Sharp also raised his concerns during the day. Ms Angel and Mr Goodwin attended Jennifer's residence and conducted a thorough interview with her. Mr Sharp was aware that Ms Angel and Mr Goodwin were going to visit that evening. He went to rest being exhausted through lack of sleep and concern. Jennifer went in to see whether he would join them; but did not do so. It left an impression (albeit incorrect) that matters had settled down.

[81] Ms Angel and Mr Goodwin left Jennifer that night without any reason to believe that Jennifer was an acute risk of harm. She was not suicidal. Jennifer had seen the principal house officer days before to change medication. A risk assessment had been done in recent days with an absence of suicidal ideation or intent. There was not a failure of care and/or neglect of any duty of care by either Ms Angel or Mr Goodwin.

[82] What then changed Jennifer after Ms Angel and Mr Goodwin left? Mr Sharp in the statement to the investigating police officer said that at about 10.30pm he could not take Jennifer continuing to talk to him about killing herself. He screamed at her to get out. He punched her in the leg to get her out. She begged him to let her sleep on the lounge but he did not let her because she would not sleep. She would wake up every five minutes talking to him about killing herself. It is apparent that this incident of domestic violence was at the point when Jennifer was truly on the edge of self harm. It tipped her over the edge. Mr Sharp and Jennifer had a turbulent relationship for some considerable time. Mr Sharp cannot be blamed for the subsequent event. He had been dealing with this difficult situation for some considerable time. He himself had run out of energy and was exhausted.

Section 45 findings

[83] The deceased was Jennifer Elizabeth Bell who was born on 16 August 1973.

[84] Jennifer died as a result of multiple injuries as a result of a pedestrian being involved in a motor vehicle collision.

[85] Death occurred at approximately 11.20pm on 2 October 2007 on the north bound lanes of the Bruce Highway, at Forest Glen, approximately 1.15 kilometres south of the Ilkley road overpass.

[86] Death was due to suicide by stepping into the path of a Prime mover truck and Semi trailer truck.

Recommendations

[87] A number of recommendations were made during the course of the hearing. Each has been considered.

[88] Dr Alcorn in his two reports has made a number of recommendations to improve the mental health system. However, as Dr Groves has pointed out[18] and was apparent from evidence given at the hearing[19], considerable progress has been made in the last few years to improve the system. The Queensland Government has a ten year plan for mental health being the Queensland Plan for Mental Health 2007 – 2017. A Queensland Government suicide prevention action plan is to be finalised in early 2011. It will have greater alignment with the National Suicide Prevention Strategy 2 (Living is for Everyone framework).

[89] In February 2010, a release of up-dated guidelines occurred, namely "Guidelines for the Management of People with Suicidal Behaviour or Risk". The aim of the guidelines is to assist Queensland Health clinicians with strategies in the assessment and community management of people assessed to be at risk of suicide who present to hospital emergency departments and mental health services. Principles inter alia relevant to this inquest are:-

- Clinicians should identify and involve the family or support people wherever possible with adults who are at risk of suicide, and in all cases when a child or adolescent is at risk of suicide.
- All people who attempt suicide need to be reviewed by a mental health clinician.
- Individuals who have previously attempted suicide are at increased risk of repeated non-fatal suicidal behaviour and suicide.

[90] At the time of Jennifer's death, a state-wide electronic health record, Consumer Integrated Mental Health Application (CIMHA) was being designed. It was implemented in November 2008. It is a consumer focussed clinical information system to support mental health clinicians in the provision of safer quality mental health services. It provides inpatient and community service information on patients. The timely access to clinical history information will assist the formulation of a plan during a risk assessment. As it contains prompts and/or alerts where multiple mental health and near-contemporaneous appointments occur, it should have the effect of increasing communication between providers, especially where disparate risk assessments occur. Evidence was given at hearing that CIMHA is being continually improved to increase the level of information available. Continual effort will need to be made to increase the knowledge and level of usage by mental health workers.

[91] The Queensland Centre for Mental Health Learning (QCMHL) has conducted training in suicide risk assessment and management since 2007. A standardised assessment document has been implanted across

[18] Exhibit 15 Letter of Dr Aaron Groves, Director of Mental Health, Queensland Health 2 November 2010
[19] Dr Taikato & Dr Swierkowski

Queensland. A one day workshop has been offered to provide clinicians with skills and knowledge to assess and respond to individuals who are at risk of self harm or suicide. The training encompasses:

- an understanding of suicide risk and protective factors;
- an understanding of the various aspects of suicide risk assessment, particularly what information to gather;
- an understanding of the risk management processes outlined in the guidelines for the Management of People with Suicidal Behaviour or risk; and
- an ability to apply the risk management processes to given case scenarios.

[92] In the Sunshine Coast area, twelve sessions of Critical Components of risk have been conducted since July 2009 with 191 participants.

[93] The standardisation of risk assessment tools and the state-wide training will address the concern that arose from the evidence of different risk assessment tools being used and differences in assessments.

Adequacy of Psychiatric Review

[94] Jennifer underwent a number of reviews by psychiatrists while admitted on a voluntary basis at Nambour General Hospital between 25 December 2006 and 31 December 2006. During admission on the Involuntary Treatment Order between 8 January 2007 and 22 January 2007 she had a number of reviews. On 22 January 2007 she was referred to Dr Taemets at Belmont Private Hospital for treatment for postnatal depression. She continued to be case managed by the Princess Alexandra Hospital Mobile Acute Assessment Team but was discharged on 16 February 2007 due to failure to respond to attempts to contact her.

[95] Jennifer's condition deteriorated in June 2007 due to difficulties concerning contact with her son. On 24 June 2007 Mr Bell contacted Princess Alexandra Hospital Triage and Jennifer was transferred subsequently back to the Mobile Acute Assessment Team. Jennifer was reviewed by four Psychiatric Registrars as follows:-

- 25 June 2007 Dr Katherine Isoardi;
- 6 July 2007 Dr Nicole Gastaldin;
- 23 July 2007 Dr Hlincikova; and
- 24 July 2007 Dr Annie Shek.

[96] While these Psychiatric Registrars were supervised by Dr Chen, having four different psychiatrists reviewing a patient in a month is not good practice. It is noted that Jennifer did not attend the appointment with Dr Linda Hamilton, Psychiatrist on 6 September 2007. The reasons Jennifer did not attend is not known. It is noted that there was an absence of any follow up to this non-attendance. Partially the reason for the lack of follow up appears to be that the Mobile Acute Assessment Team was aware that Jennifer was likely to return to the Sunshine Coast. However, this information was not confirmed until 17 September 2007 when Ms Ash spoke to Jennifer.

[97] Upon transfer of Jennifer to the Sunshine Coast Mental Health service, Ms Angel within three days of her transfer arranged an appointment with Dr Milad, Psychiatrist who had treated her earlier in the year. Jennifer was compliant with her medication; but said it was not working for her. Ms Angel made every effort to have Jennifer attend the appointment; but it did not eventuate. Jennifer did see a Psychiatry Principal House Officer on 28 September who organised alterations in her medication.

[98] There was a lack of continuity of psychiatrically supervised care of Jennifer. The initial movement from the Sunshine Coast was seen as in her best interest to address particularly the post natal depression. In June/July 2007 there was no continuity in the psychiatric reviews and they were carried out by junior psychiatrists albeit under supervision. However, a review of Dr Shek's letter of 24 July 2007 indicates she had a very accurate handle on Jennifer's psychiatric issues. It was Jennifer herself who prevented a more senior psychiatrist assisting her by not attending the appointments on 6 September 2007 and 25 September 2007. It is difficult to see what more the teams involved could have done to assist her.

[99] With the benefit of hindsight what should have occurred is that from June 2007 on, a senior and experienced psychiatrist should have engaged with Jennifer and overseen the work of the continuing care teams. It does point to the necessity of early contact by a psychiatrist when a patient is referred to a service. It is noted that there is now a model of care which provides for early involvement of a consulting psychiatrist. The Sunshine Coast-Wide Bay Health Service District has issued a procedural policy entitled "Multidisciplinary Team (MDT) Clinical Reviews" which provides for review of the mental health and treatment of the patient by a multidisciplinary team, one of whom is a psychiatrist. Clinical review of patients occurs at least once a week in the treatment setting and at a minimum of 91 days in the community setting. Any significant change in setting, mental state or risk initiates a clinical review by the team.

Recommendation

Where a patient has a history of engaging with a number of services and does not have stability of residence, that a consultant psychiatrist review the patient with seven days of contact with any new service. The purpose is not only to review medication but also assess the mental state and risk of suicide.

Adequacy of Handovers

[100] The medical records of Jennifer totalled 1039 pages. The large volume was due in part to the duplication of records being documents handed over from service provider to service provider. The changes of residence and service providers from discharge from Nambour General Hospital on 8 January 2007 led to the following involvements:-

- subsequent follow up by the Sunshine Coast Community Assessment and Treatment Team;

- Move to Brisbane to stay with father with referral to Dr Taemets, Private Psychiatrist at Belmont private Hospital for cognitive behaviour therapy;
- follow up case management and contacts at Princess Alexandra Hospital - Triage, Mobile Acute Assessment team, Continuing Care North on different occasions;
- General Practitioner Dr Jack See and Psychologist Celia Lane; and
- Return to Sunshine Coast Mental Health Service, Continuing Care Team.

[101] The changes that occurred were due to her family seeking to provide suitable therapy for her, Jennifer's reluctance to engage, the marital turmoil and the moving backwards and forwards between Brisbane and the Sunshine Coast.

[102] Dr Lawrence is of the opinion that all of the treating agencies were assiduous in their duties in trying to ensure appropriate handover and follow up arrangements for the ongoing treatment of Jennifer between the various agencies and individual providers. Further, that the handovers were timely and appropriate and included clear documentation, amplified on occasions by personal contact by telephone as well as expediting transfer of information.

[103] This conclusion is supported by the evidence given by the Continuing Care North case manager Ms Ash and the Continuing Care Team case manager Ms Angel. However, given the volume of records it seems to be good practice if the case manager doing the handover completes a discharge summary. This enables a busy case manager to quickly pick up any key observations on a patient e.g. reluctance of Jennifer to engage. No discharge summary was done when Ms Ash transferred the file to the Sunshine Coast Mental Health Service.

[104] The Sunshine Coast-Wide Bay Health Service District (Southern Cluster) Mental Health Service has issued a Workplace Instruction for Clinical Handover[20]. It is a work instruction providing direction on the essential information required to ensure an appropriate clinical handover process. The work instruction is a good model to follow in ensuring brief and relevant information is provided when a patient is handed over from one service to another.

Recommendation

That a written handover summary be provide when a patient is being transferred from one service to another. The purpose being to ensure that the new service can easily be informed of current issues and develop strategies to address those issues. The Workplace Instruction for Clinical Handover policy procedure is a good starting point; but needs to be developed further to address transfer from one geographical region to another region.

[20] Exhibit 25

Family Collaboration and Support

[105] Mr Bell on behalf of the Bell family made a very thoughtful submission for better collaboration between family members and mental health workers. He expressed in evidence and during the days of hearing, how overwhelming the mental health system was to someone who wanted to assist a loved one. Who to contact? How did the process work? How did the family give collateral information? What use would be made of this collateral information? Was there a single point of contact to give and receive information e.g. about medication? These were the questions that came forward.

[106] It is acknowledged that not in every situation is there an alignment of the interests of a patient and the interests of the family or some members of the family. Privacy of information and the right of confidentiality is to be respected. However, not infrequently there is clear positive support from family members and greater collaboration is most desirable.

[107] At the first point of contact, it was submitted that a flow chart be provided to family members outlining the structure and management of the patient presenting with suicidal ideation and behaviour risk. The policy document Suicidal Behaviour – Risk Assessment and Management[21] has a flow chart for staff members. Such a document could be provided in the information to be given to family members to assist them in understanding and better participate in the mental health system.

[108] Further suggested was a family meeting with the treating team be held within a week of the patient's initial contact. At this meeting a single point of contact could be agreed upon. This person would have the responsibility to disseminate information within the family and give greater confidence to the mental health workers that information is flowing to the family. The responsibility of liaising with the family should be the responsibility of a dedicated officer. Such a position has been established at Continuing Care North and is being established at the Sunshine Coast Mental Health Service. A possible task for this person would be working with the case manager for the collation of collateral information.

[109] As noted above, the Guidelines for the Management of People with Suicidal Behaviour or Risk adopt as a principle the involvement of the family or support people wherever possible with adults who are at risk of suicide. The Multidisciplinary team (MDT) Clinical Reviews Policy[22] provides that the family/carers where appropriate and agreed to by the patient will be involved in the multidisciplinary team clinical review. It further provides that all endeavours will be made to ensure that the family/carers are seen and included at another time, particularly prior to discharge.

Recommendation

That Queensland Health adopt a policy of enabling greater collaboration with the families of mental health patients by providing:

[21] Exhibit 24
[22] Exhibit 23

- **publications that assist families to understand the mental health process, including a flow chart of the process;**
- **first point of contact for families; and**
- **a liaison worker to enable contact and involvement of families.**

[110] The Coronial Counselling Service provides the following support to families:-

- written and telephone contact with the bereaved at the time of death;
- after-hours contact information for suicide-specific service;
- follow-up where deemed appropriate or as agreed with the family;
- viewings of the body of the deceased; and
- on-going counselling.

[111] The written material provide to families includes a booklet regarding grief and trauma in a coronial context. The booklet emphasises the availability of counselling.

[112] It is a matter for the family to accept or not accept the offer of counselling. Mr Bell in his submission pointed out that some people need counselling straight away and others need it further down the track. He suggested that some sort of system could be initiated whereby contact could be made on a regular basis over a limited period of time advising that the offer was still available. However, contact from a counselling service no matter how well intentioned, can be distressing and can interfere with the independent healing of family members. Constant reminders of the death of a loved one can do more harm than good. Also, it is not good practice to make contact on a regular basis to renew offers not initially accepted.

[113] The Coronial Counselling Service made available a counsellor to attend the inquest and work closely with the family. The impression gained is that support was very helpful to the Bell family.

Concluding Remarks

[114] I thank Counsel assisting and all those who participated in this inquest. The approach taken by Ms Gallagher of counsel and her instructing solicitor Ms Carol Lee in diligently gathering and collating the complex medical records and their general approach to the inquest is commended. Also, Mr Bell was constructive at the inquest and handled a difficult task admirably.

I extend to Mr Bell, Ms Kylie Bell and the family of Jennifer my sympathy and condolences in their sad loss.

I close this inquest.

J A Hodgins
Coroner
Maroochydore
16 December 2010