OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of a Mental Health patient**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2313/04(9)
DELIVERED ON:	25 May 2007
DELIVERED AT:	Brisbane
HEARING DATE(s):	19 February, 30 April, 1 & 2 May 2007
FINDINGS OF:	Ms Christine Clements, Deputy State Coroner
CATCHWORDS:	CORONERS: Inquest, Mental Health, involuntary treatment orders, assessment of suicide risk, procedures for intermittent observation orders

REPRESENTATION:

Mr Craig Chowdhury of Counsel– appearing to assist the Coroner

Mr James McDougall of Counsel – representing Dr Gills; instructed by Flower & Hart Lawyers

Mr B Farr of Counsel – representing the Belmont Hospital and staff, instructed by Minter Ellison Lawyers

Ms D Condon of Counsel – representing the Princess Alexandra Hospital, instructed by Crown Law

The *Coroners Act 2003* provides in s45 that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These are my findings in relation to the death of a mental health patient. They will be distributed in accordance with the requirements of the Act and an edited version placed on the website of the Office of the State Coroner.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The scope of the Coroner's inquiry and findings

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 ;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case 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.* [1]

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, the Act authorises a coroner 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] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[3]

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

[2] s46

[3] s45(5) and 46(3)

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because section 37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* 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 has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

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.[5] 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.[6]

It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.[7]This means that 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. As *Annetts v McCann*[8] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

Introduction

The deceased had a history of depression. She had a number of hospital admissions, the first in May 2004 when she was admitted to the Wesley Hospital for depression; she was later admitted to the Toowong Private Hospital in 2004 due to another bout of depression. She was discharged from Toowong Private Hospital on 16 June 2004 after it was considered she was well enough to return home. In July 2004 she attempted to commit suicide by taking an overdose of medication and going into a local Reserve. After being located she was admitted to the Logan Hospital and following her discharge from the Logan Hospital she was transferred to the Belmont Private Hospital. She remained in the Belmont Private Hospital until she was discharged on 1 August 2004. She was readmitted to the Belmont Private Hospital on 21 August 2004 and discharged on the 30 August 2004 after refusing electroconvulsive treatment (ECT).

Dr Unwin is a psychiatrist with extensive experience in treating the mentally ill. He commenced practice in 1964 and became a fellow of the Royal Australian and New Zealand College of Psychiatrists in 1972. He is also the Director of Medical Services at Belmont Hospital. He gave evidence at the inquest into this death. Dr Unwin saw

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[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

[8] (1990) 65 ALJR 167 at 168

the deceased from 16 July 2004 when she was transferred from Logan Hospital after an overdose. He indicated she had initially been diagnosed by him as suffering dysthymic disorder and generalised anxiety. She was displaying symptoms of lethargy, tiredness and anxiety. She was also suffering from a skin disorder and was experiencing feelings of itching and burning all over her body.

Further assessment by Dr Unwin concluded that she was suffering major depressive disorder with co-morbid somatozation disorder. She was discharged home on 1 August 2004 and prescribed antidepressants and antipsychotic medication.

On 16 August 2004 the deceased was reviewed by Dr Unwin at his rooms. She remained depressed and agitated and the Avanza medication was increased.

She was re-admitted to the Belmont Hospital on 21 August 2004. This occurred over a weekend and the admitting psychiatrist on call was Dr Alcorn. She was suffering generalised anxiety and an antipsychotic, Haloperidol was prescribed. Dr Alcorn raised the possibility of treatment via ECT. Upon Dr Unwin's review, it was decided to continue the drug therapy with Haloperidol before further considering ECT.

By 24 August 2004 preparation for the ECT was continuing. On the weekend of 27 August 2004, the deceased had weekend leave. Upon her return there was a consultation with the deceased, her husband and Dr Unwin. She and her husband had made their own inquiry and had considered the option of ECT and declined to accept the advice.

On 30 August 2004, Dr Unwin discharged the deceased from hospital. He did so after the deceased and her husband had considered his advice for treatment. Dr Unwin stated he considered the deceased to still be unwell and continuing to suffer a delusional belief that she had an infectious skin condition that was causing other people's deaths. She also believed that she should die.

Dr Unwin advised that although he could not guarantee a cure, his advice was that ECT and continuation of antipsychotic medication would assist her. She had experienced unpleasant side effects from the medication (Haloperidol) including the sensation of suffocating. She told Dr Unwin she would not take the medication. She and her husband also informed Dr Unwin that they had considered the option of ECT and had decided not to undergo such treatment. Dr Unwin considered that although they were wrong in his professional opinion to reject his advice, they did so in a considered and informed way. He explained that although she was delusional concerning her belief about her physical condition, he considered she was still rational and sufficiently capable of making the decision to decline treatment.

Most importantly, the deceased and her husband both thought at the time she was somewhat improved in her mental state. In particular, she was not expressing or considering suicide at this time. Dr Unwin took into account the view of the patient and family member.

Dr Unwin's notes recorded at the time indicate he advised them that "*I accordingly have warned them both that in my opinion, she was still unwell, still delusional*".

He gave the firm opinion that "*antipsychotics and ECT was the only answer*". Dr Unwin advised them strongly that the deceased could become suicidal again. There were no current suicidal thoughts or plans. He immediately wrote to her general practitioner alerting him to these circumstances and advising the deceased to return should there be a recurrence of suicidal thoughts. He told the inquest that although patients can consciously lie on occasion about whether or not they are suicidal, it is a question of clinical judgment to test all the information available by conversing and engaging with the patient to check reliability. He acknowledged she was at heightened risk of suicide because she remained delusional. He told the inquest that he considered whether or not an involuntary treatment order should be made but decided that it was not appropriate to "*ride slip shod*" over the wishes of both the deceased and her husband.

Given these circumstances, Dr Unwin believed it was not required of him by law or appropriate to subject her to an involuntary treatment order. He discharged her on the following medication; Avanza 45mg at night, Stilnox 2 tablets at night, and Xanax, 250 mg.

The expert opinion of Dr Jacinta Powell was available to the inquest. As she acknowledged, her opinion was provided with the benefit of hindsight and only on the basis of review of documentation. However, Dr Powell considered that given the ongoing delusional belief coupled with refusal of treatment and risk of suicide in the context of a recent attempt to suicide, the deceased was at serious risk of significant deterioration in her mental health. She would therefore, have considered an involuntary treatment order on 30 August 2004 when Dr Unwin discharged the deceased from the Belmont Hospital. I acknowledge there is scope for difference in clinical opinion and decision making as I believe was reasonably demonstrated between the views of Dr Unwin and Dr Powell. Dr Powell also noted that in the circumstances where a patient refused treatment, she might be referred for a second opinion. Dr Unwin considered there had been wide review of the deceased's condition by other practitioners at various times, none of whom had stated that enforced treatment pursuant to the *Mental Health Act 2000* was indicated.

It remains one of the most difficult decision making exercises for mental health practitioners as well as one of the hardest decisions for a bereaved family to accept when a decision is made not to invoke an involuntary treatment order.

The deceased in fact, remained in the community until another sudden decline on Sunday 19 September 2004. Her daughter came home to find her mother in a highly distressed state. The deceased believed that a minor skin disorder she had been diagnosed with, keratosis, was infective and was causing infection and death throughout the world. She could not be persuaded this was not reality and she expressed the desire to end her life to stop causing harm to other people. She was delusional and hysterical. Her daughter contacted the Belmont Hospital but was advised there was no doctor available after hours to assess or admit her. The Princess Alexandra Hospital was contacted and she was taken there.

At the Princess Alexandra Hospital she was seen and assessed by a nurse trained in psychiatric assessment, Ms Tracy, and by the psychiatric registrar, Dr Nowell and subsequently the psychiatrist, Dr Jelesic-Bojicic. Due to the deceased's delusional

thinking, distress and suicidal thoughts, she was assessed as at risk of suicide and not safe to be sent home. She required immediate involuntary treatment. There was no bed immediately available at the Princess Alexandra Hospital in their psychiatric unit and so she was kept in the emergency department. As she had previously been treated at the private Belmont Hospital, arrangements were made to transfer her to that hospital the next day, still subject to the involuntary treatment order. It was considered preferable for her to be transferred than to remain in the stressful environment of the emergency ward. In that ward, she was either given special, one on one care by a nurse, or placed in a room reserved for such patients which was close to the nurses' station. It appears from the record that overnight the deceased was monitored on fifteen minute observations in the room close to the nurses' station.[9] I also note that for some time at least, a family member remained with her at the Princess Alexandra Hospital while in the emergency ward.

The appropriate documentation recording her assessment, history and the decision making process to invoke an involuntary treatment order was prepared at the Princess Alexandra Hospital. A call was made by Dr Jelesic Bojecic to the Belmont Hospital.

The Clinical Practice Coordinator at Belmont Hospital, Mr Michael Daly spoke with the psychiatrist from the Princess Alexandra Hospital. His recollection was that he clarified with the referring doctor that she did not require a bed in a secure area. The reason for this clarification was that there was no such bed available at Belmont at that time. Mr Daly says he understood from the referring doctor that the patient could be managed in an open psychiatric ward and thus the referral was accepted. Dr Jelesic Bojecic indicated she could not recall this detail but thought it possible it may have been discussed. Given the evidence that there were no secure beds available at Belmont Hospital at the time and Mr Daly's evidence of clarifying this issue, I accept the understanding was reached that the patient could be adequately cared for in an open psychiatric ward.

I note the subsequent independent review by Dr Powell also affirmed that it was suitable with appropriate supervision and observation to care for the patient in an open psychiatric ward at the time of her admission to Belmont Hospital. Likewise, Dr Unwin expressed the opinion that admission to a closed ward was indicated where there was a "*clear present emergent risk of harm*" that could not otherwise be managed by close supervision. Dr Unwin also indicated that even when subject to fifteen minute observations or if placed in a secure ward, it was impossible to guarantee absolute safety for a patient determined to self harm.

On 20 September 2004, the patient was transferred from the Princess Alexandra Hospital to the Belmont Private Hospital. As in the public sector, the care of a patient with mental illness is a team delivered service including psychiatrists, nurses trained in psychiatric care and allied health professionals. Mr Michael Daley was a well qualified and experienced psychiatric care trained nurse. His role as Clinical Practice Coordinator included the admission function for the patient on 20 September 2004. He placed her on thirty minute observations prior to her assessment by a psychiatrist at Belmont Hospital. He was aware of her previous admissions to Belmont and the previous suicide attempts. He spoke with the deceased and her husband. He recalls

[9] Evidence from nurse Tracy

she was agitated and still delusional about her skin condition. She was willing to participate in treatment.

In accordance with the requirement of the *Mental Health Act 2000* and no doubt, the admitting hospital's standard practice, the deceased was assessed by a psychiatrist.

In the early evening of 20 September 2004 she was seen by the psychiatrist, Dr Gills at the Belmont Hospital. Dr Unwin was on leave and had arranged for Dr Gills to be his locum. Dr Gills was admitted as a fellow in psychiatry in 2004. He could not say if he read all the notes relating to the deceased before seeing her but was sure he read the referral material. The deceased presented with symptoms of a depressive illness with psychotic features including somatic delusions and delusions of guilt. Dr Gills had available to him the information from the Princess Alexandra Hospital record that the deceased had expressed suicidal thoughts. However, in her interview with Dr Gills she denied any thoughts of suicide. Indeed, she appeared to acknowledge that she was unwell and required treatment. She consented to being hospitalised, being given medication and for treatment in preparation for ECT. This was in contrast to her refusal on 30 August 2004. Dr Gills assessed her at only a score of 30 on the GAF scale indicating a very low level of current functional thought and behaviour in her overall life decisions at the time. She was severely impaired, although Dr Gills would not go so far as to say that she was unable to make any rational decisions. She consented to treatment. After discussing her condition with her husband, Dr Gills ordered she be placed on fifteen minute observations and noted this in the medical records and advised Belmont Hospital nursing staff directly. His note in the 'Doctor's Admission Assessment' document includes the following; "*Admit involuntary treatment order 15 min obs ++ Nil leave*".

Dr Gills also gave evidence he verbally informed the nurse on duty that observations were now required every fifteen minutes.

The addition of ++ after the word 'obs' (observations), may appear cryptic nevertheless the 'nil leave' direction would seem quite clear. After hearing evidence from the doctors and the nurses, the interpretation was in fact, quite variable.

Dr Gills expected the direction would stand as he, the assessing treating doctor at the time, had directed. He did not expect this would be changed by a nurse. He explained he had added the two plus signs to highlight that he was ordering a change from the initial level of observations set by the Clinical Practice Coordinator, Michael Daly who had set thirty minute observations.

He thought that 'nil leave' would include a prohibition on going out into the grounds of the hospital.

The next morning, on 21 September 2004, Dr Gills saw the deceased again for more than 30 minutes. Dr Gills' interview was conducted in the presence of her Clinical Practice Coordinator, Mr Michael Daley. During this further interview, she asked reasonable questions about the proposed treatment before giving her consent to ECT. Again she denied any suicidal thoughts during the interview. She denied she had any problems with the medication prescribed to her the previous day.

By this time she had the benefit of a night's sleep and medication. Dr Gills thought her condition had improved overnight.

Mr Don White was a registered nurse and the Unit Manager for the acute psychiatric ward at the time of her death. He continues to work at the Belmont Hospital in a casual capacity. His role in 2004 did not involve direct clinical care. His role was supervisory and resource management focused as well as assisting staff in trouble shooting problems as they arose. It did not appear from his evidence that Mr White had fully read or appreciated her worsening condition when she was re-admitted to Belmont Hospital on 20 September 2004.

Mr White's evidence was that in 2004 he had authority to review and downgrade observations. He said he would inform the doctor as a professional courtesy. His evidence was at odds with Mr Daly and others that he should not have decreased the frequency of observations without reference to the doctor. He explained the decision to change the observations from fifteen to thirty minutes as rectifying what he thought was a mistake. He referred to the fact that Mr Daly had originally placed her on thirty minute observations on admission but this of course, was prior to assessment by Dr Gills. I find that in fact, it was Mr White who made the mistake in changing the doctor's instruction for fifteen minute observations to thirty minute observations.

Mr White made a valid point that visual observations are only one of the mechanisms used to try to ensure safety. Of greater significance is the one to one engagement of staff with patients to continue assessing their ongoing mental state.

Mr White's evidence to the inquest was that he was alerted by a nurse that a patient was missing but he didn't think it was the deceased. He thought this was about 11.20am. He said if the patient was missing at 11.00am he should have been told. He said between 11.20am and 11.30am inquiries were made and he was in contact with Mr Daly whereupon it became clear it was the deceased who was missing and indeed, was the person at the Carindale Shopping Centre.

Nurse Allwood's evidence indicates that she was trying to inform Mr White about the deceased's absence. Overall where there was conflict between Nurse Allwood and Unit Manager White, I relied on the evidence of Nurse Allwood. She appeared more careful in note taking and more consistent with her recollection of events. She admitted to taking actions which, upon review, were not in accordance with policy but were at the time what she thought was the proper thing to do.

At about 11.20am, she tried to speak with Mr White but he was busy on the phone so she conducted a quick search herself. The problem of course was that the deceased had not been seen since 10.30am. Nurse Allwood's sense of urgency was no doubt allayed by the fact that the deceased had appeared to demonstrate her rational and reliable behaviour by retuning to the hospital after being given permission to walk in the hospital grounds unaccompanied.

Nurse Allwood's and Mr White's evidence again highlights the continuing need to clarify what various levels of observation mean and what procedures flow when it is discovered that a patient is missing.

Nurse Allwood had her tea break between 10.15am and 10.35am on the day that the deceased went missing from the ward. Nurse Allwood was assigned her care but the responsibility to maintain thirty minute observations was rotated between various nurses. She was told by Nurse Walden who had the responsibility to record observations at eleven o'clock that three patients had not been found. In accordance with her usual practice, the first thing that Nurse Allwood did was to check the ward. She found two of the three missing patients and also came across another patient who was distressed and took a little time with that patient. She said this was her understanding of common practice as quite often a patient would quickly be found in this way.

She acknowledged that by the time Nurse Walden advised her that the deceased was missing, it effectively meant she had not been sighted since 10.30am. She thought that Nurse Walden reported to her as she was the nurse assigned the responsibility for that patient. Her fears were not raised concerning the deceased because she had demonstrated her reliability in returning after an earlier walk in the grounds. When she too could not locate the deceased, she tried to report this to the Unit Manager, Mr White. He was engrossed in a phone call and rather than waste more time she continued her search. She was recalled to the office via intercom by which time information was coming into the hospital from police inquiring whether the hospital was missing a female patient.

Shortly after 10.44am that morning, the deceased committed suicide by jumping off the top level of a multi-story car park of the Carindale Shopping Centre. Some passers by immediately went to her assistance and flagged down a nearby patrolling police car. At about 11.00am police officers, Caton and Herbert arrived at the scene and contacted other police and the ambulance.

One of the police to arrive was Sergeant Mark Norrish. From previous experience, he suspected that the deceased may have come from the Belmont Private Hospital. He took a number of digital photographs and went to the hospital which is just across Creek Road from the Carindale Shopping Centre. He spoke to Don White. Sergeant Norrish asked Mr White if he could account for all his patients. Mr White replied *"Yes I can, if you have a seat and give me a minute I can get back to you".* Mr White returned a short time later with Michael Daley and advised Sergeant Norrish that a patient was missing. Sergeant Norrish then showed a photograph he had taken of the deceased. Both men recognised her. They were distressed.

Assessment of ongoing risk

Unfortunately, mental illness, particularly illness associated with depression, delusion and the risk of suicide, remains a very difficult area in which to reliably predict when a patient is at imminent elevated risk of serious self harm. There is no simple diagnostic tool available; instead a series of clinical evaluations of the patient's present condition and past history must be made. This assessment is supplemented by and tested for congruence with family and independently sourced information. As the various psychiatrists who gave evidence stated, in order to gauge a patient's current well being the continual process of risk assessment is essential. This process is a clinical task exercising judgment which can be assisted by the use of so called 'tick and flick' documents but is much more than mere completion of these forms.

The independent review provided by Dr Jacinta Powell recommended; *"Belmont Private Hospital give consideration to the introduction of a more comprehensive admission process including a clear suicide risk assessment and guidelines regarding the management of patients who have expressed suicidal ideation, have a recent history of a suicide attempt or present with conditions that place them at increased risk of suicide. Reassessment of risk should then occur in the event there is a change in a patient's mental state or circumstances at any point during the admission".*

Belmont Hospital has reviewed its admission and other polices as set out in the evidence of Mr Daly and in particular, the evidence of Mr McGurrin which I will not repeat. Suicide ideation management has now been highlighted in a documented process which will help to remind and guide staff in this continuing obligation. The clear identification of a nominated person with particular responsibilities has improved the observation regime.

Observations

The issue of the level of observation ordered for the deceased, what this level meant and what actually happened is crucial in this inquest.

Although Dr Unwin was away on leave and did not see the deceased on her admission in September 2004, he subsequently reviewed the information. His view was that he would "*watch her like a hawk"* during her admission because of the continuing delusion and resurfacing of suicidal thoughts. When asked if that would include being unable to walk out of the building, he relied *"Yes".*

He acknowledged there are multiple exits from the Belmont Hospital. There is no system of monitoring entry and exit except the requirement for observations as ordered. He explained to the court that even a delusional patient can be compliant with boundaries being set, for example a direction not to leave the ward except with permission. He considered the best method remained trained and continuing close observation of a patient. The only security at Belmont Hospital at the time was after hours night time security. Dr Unwin was supportive of consideration being given to closed circuit television, subject to proper rights of privacy being maintained. He acknowledged there have been other incidents of patients leaving the hospital without permission and of attempts and threats of suicide.

Dr Unwin was asked - *"what should happen if a patient is not present at thirty minute observations?* His response was - *"All hell should break lose"*. He expected that all hands would be called upon to search and if the patient was not found then the police should be notified if the patient was subject to involuntary treatment.

Mr Daly, the Clinical Practice Coordinator for Dr Unwin's patients, gave evidence that when he noted in the medical records the initial thirty minute observations for the deceased, he did not expect that she would be going out alone into the hospital grounds.

Directions about the level of observations after admission, are made by the treating doctor and are verbally advised to nursing staff and documented in the chart. That information is 'handed over' at the end of a shift to the incoming staff. Observations are carried out by a nurse assigned to that task only for half hour intervals. The nurse

marks in the sheet carried around the ward that the patient has been sighted at the required intervals of time. If the person was not seen, the Unit Manager was to be notified and then a search of the ward and hospital made. If the person was not located then the treating psychiatrist, police and family were to be informed.

Mr Daly confirmed that a nurse was not authorised to change the level of observations to a less stringent requirement without reference back to the doctor. The Unit Manager, Mr White was in error in doing so. Again, this may have reduced the watchfulness of staff concerning the deceased.

Mr Daly indicated that she should not have left the building with a notation in her file by Dr Gills which said 'nil leave'. The deceased should not have been given permission to go for an unaccompanied walk in the gardens. In fact, she did return to the hospital and reported back to Nurse Allwood after that walk which no doubt had the natural effect of allaying concern she may leave the hospital. I also note by this time, the direction changing the observation level made in error by Unit Manager, Mr White had occurred. Nurse Allwood was therefore working within the incorrect reference frame of 30 minute observations.

Comment

Despite the improvements in written documents regarding hospital policy and procedures around patient safety, there are issues still requiring the hospital's attention. Distribution of policy via e-mail is no doubt quick and efficient but requires certainty that all staff, including casual and agency staff, have in fact read and understood its content. The assertion that any changes are brought to the attention of staff at hand over time, the beginning or end of a shift, was not very re-assuring. The evidence at this inquest demonstrated that although staff might be dedicated, very experienced and caring, there was still a variation in the understanding of exactly what the terms 'nil leave' and 'fifteen minute observations' meant for patients.

Frankly, I doubt this will be improved until there is a shared opportunity in work time for doctors, together with nurses and supervising staff, to work through scenarios to clarify a common understanding and expectation of hospital policy and procedure. Mr Patrick McGurrin, the Director of Nursing indicated that *"people don't embrace policy"*.

As Dr Powell recommended, there needs to be both an implementation strategy and regular audit to manage understanding, compliance and feedback opportunities for staff and management. The observation policy must connect to the risk assessment process to mitigate risk.

Containment of patients

The issue of what mechanism, if any, was operating to stop the deceased from leaving the hospital at will is vexed. Mr Daly's evidence was that it took a mere four and a half minutes to leave the hospital building and be off the grounds. The family expectation is that their loved one would be kept safe from harm and restricted from being able to leave the hospital once she had been subject to an involuntary treatment order. The reality of modern best practice mental health care is that patients are given the greatest possible opportunity to participate and comply with their own treatment plans. Psychiatric wards are predominantly open wards and there are very few beds reserved for closed, locked occupation. The hospitals themselves are frequently open

to entry and exit, more so in the private sector perhaps than the public sector. Belmont Hospital has night time security only. There are numerous entry and exit points. Although there is a perimeter fence the entrance is open and apparently not easily adapted to a gate capable of closure and monitoring, perhaps by closed circuit television.

Within the hospital, the open acute psychiatric ward relied on the observation system to restrict a patient's movement. This system is based on a combination of the vigilance of nurses with responsibility for making set interval observations, coupled with the patient's willingness to comply. The suggestion that a nurse station or reception style desk at entry/exit points of the hospital seemed impractical given the number of possible points of egress.

Dr Unwin was convinced through his long experience that the most valuable system was properly conducted observations of patients by nurses trained and astute to the patients' continuing overall well being. Perhaps this is so, but the inquest clearly indicated a need for:-

1 A common understanding of exactly what restrictions on movement are implicit in various levels of observation.

2 A common understanding of what the term 'nil leave' means.

3 A common understanding of whether or not unaccompanied 'smoker's leave' is available to every patient irrespective of the level of observation.

4 A common understanding of the decision making process and record keeping required if a patient is given leave to exit the ward into the hospital grounds.

5 A common understanding of the degree of discretion allowed or period of time permitted for a patient not to be observed before reporting by the observation nurse to a designated person.

The Director of Nursing, Mr McGurrin was able to inform the inquest of many of the changes that have been implemented at Belmont Hospital. Some have been fairly recent and it is important that the hospital complete the process with adequate training, testing and monitoring to ensure that policies agreed to by senior levels of the organisation are truly embraced by all staff. The hospital is still considering such measures as the installation of closed circuit television to assist in some way with issues of both security and monitoring of patients' whereabouts to improve safety.

The means by which an individual hospital improves their awareness and responsiveness to mentally ill patients must ultimately be a decision for that organization. However, it is paramount that in the current treatment philosophy where every effort is made to engage with patients (clients) in a voluntary therapeutic agreement, strategies must be constantly devised and adhered to, ensuring that more vulnerable patients are quickly identified and treatment varied to assist them.

If a patient is incapable of meeting limits set for their own safety, then those with responsibility to care for them must be proactive. Invoking the more restrictive

mechanisms available under an involuntary treatment order as authorised pursuant to the *Mental Health Act 2000* must remain as an option to be carefully considered where individual circumstances require such intervention. The critical importance of a caring family, working together with dedicated and professional personnel is the foundation but those that work in this field must be supported by adequate staff resources and sound policy and procedure to guide their care of the mentally ill.

At the time of her death on 21 September 2004 at the Carindale Shopping Centre car park at Carindale, the deceased was suffering a major depressive and delusional illness. The cause of death was multiple injuries due to a fall from height. No other person was involved in her death.

The court extends sincere condolences to her family.

Chris Clements
Deputy State Coroner
Brisbane
25 May 2007