OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquests into the deaths of SH and AW**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2009/233 and 2010/402
DELIVERED ON:	25 January 2013
DELIVERED AT:	Brisbane
HEARING DATE(s):	19 October, 26-30 November 2012
FINDINGS OF:	John Lock, Brisbane Coroner
CATCHWORDS:	Coroners: inquest, suicide whilst inpatient, absconding, observation & leave policies, “hotspot” for suicide, suitability of acute unit for some patients

REPRESENTATION:

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Introduction

1. On the evening of 25 April 2009, Ms SH, a 25 year old female, was pronounced deceased at the base of the Buranda car park. The car park is located at 250 Ipswich Road, Woolloongabba, opposite the Princess Alexandra Hospital ('the Buranda car park').

2. On the morning of 2 February 2010, Mr AW, a 24 year old male was pronounced deceased at the base of the Buranda car park.

3. SH and AW had been in-patients in the East Wing ward ('the ward') of the Princess Alexandra Hospital ('PAH') Mental Health Unit. Both had been suffering significant chronic mental health issues prior to their deaths.

4. At the time of their deaths, SH and AW were both under an Involuntary Treatment Order ('ITO') and on 15-minute visual observations and not allowed to leave the ward without an escort. Despite these orders, both frequently left the ward unescorted, including immediately prior to their deaths.

5. These deaths were not the only cases of deaths occurring in Queensland Health facilities, where patients who were not allowed to leave the ward unescorted, did so and took their own lives. In some of those cases they were on involuntary treatment orders. The deaths of ST and WF were other matters under investigation by me. There have been prior to these deaths other cases known to me where patients left the ward and utilised the nearby Dutton Park Rail line or Ipswich Road to take their own lives. Since these deaths I am aware of two voluntary patients who were on visual observation regimes, left the ward and took their own lives. One jumped from the Buranda car park and the other from the Storey Bridge.

6. Suicide is a major public health problem. People who have a mental illness are at greater risk of suicide but even then it is still an infrequent event. It is acknowledged that the task of predicting when someone may commit suicide, even by experienced mental health clinicians, is inherently difficult and is often not possible. Despite the research into known risk factors, individuals who are determined to commit suicide will do so despite the best efforts of mental health workers and/or a supportive family.

7. The issue that was of concern to me with these deaths is how such an event can occur when someone is an inpatient in a psychiatric facility and on an observation regime and restricted to escorted leave.

8. It is acknowledged that patients who are receiving voluntary treatment are clearly in a different position to those on involuntary treatment orders, although it is still of concern that a voluntary patient on an observation order is able to leave a ward. Assuming there is a clinical basis for the observation order, what is the point of the order if it is not able to be enforced? It is even more problematic when the patient is on an ITO, an observation regime and subject to a Limited Community Treatment Order (LCTO) which do not allow them any unescorted leave. The question that arises was how these tragic events have occurred on the hospital's watch and whether is there anything that could have been done to prevent it. I accept there was never going to be a simple answer to this question.

9. After considering the evidence that had been gathered during the investigation in relation to each of these four deaths I decided to seek a response from Queensland Health. On 29 November 2011, I wrote to the Director General of

Health seeking information concerning the deaths of the four inpatients, including a copy of any incident reports or investigations, a statement from a hospital executive addressing the management/restraint of patients on an ITO/LCTO on 15 minute visual observations who leave the ward or attempt to leave the ward; and risk management strategies implemented since the deaths to avoid similar deaths occurring.

10. It has to be said the response to the request was not particularly comprehensive, nor did it provide me with any assurance or feeling that there would be any changes. Accordingly, I decided to hold an inquest focusing on the deaths of SH and AW to find how the deaths occurred, and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. I would also be better informed when considering those other deaths that were also under investigation.

Issues to be considered at Inquest

11. The issues for the inquest were proposed at the coronial pre-inquest conference. No submissions were made concerning the proposed issues. In addition to the findings required by s45(2) of the Coroners Act 2003, namely the identity of the deceased, when, where and how they died and what caused their deaths, the other issues included:

    a. The adequacy of the supervision of SH and AW whilst in-patients at the PAH, Mental Health Unit;

    b. The enforcement of orders regarding specific leave requirements made pursuant to the *Mental Health Act 2000* which were in place at the time of the deaths of SH and AW;

    c. AW's use of and access to alcohol and drugs whilst an in-patient in the PAH Mental Health Unit;

    d. The steps taken by the PAH to negotiate the erection of safety barriers at the Buranda car park; and

    e. The adequacy of the relevant PAH policies and procedures.

12. During the inquest, a number of other issues were identified. These included:

    a. The adequacy of the patient handover between staff working on East Wing;

    b. Nursing responsibilities when a patient threatens suicide;

    c. The appropriateness of accommodation for a Forensic Order patient; and

    d. The appropriateness of accommodation for female psychiatric patient's after the birth of a child.

13. On 19 October 2012, I made a non-publication order in terms of section 41 of the Coroners Act 2003 prohibiting the publication of the name of, and/or information that identifies or is likely to identify Ms SH, Mr AW, Mr ST and Mr WF.

14. At the conclusion of the inquest hearings it was proposed I should receive written submissions from Counsel Assisting, Ms Zerner and responses to those submissions from each of the counsel who were granted leave to appear at the inquest. I am particularly indebted to Ms Zerner for the extensive and comprehensive manner in which she prepared this inquest. Her submissions and recommendations were also comprehensive and I have extensively adopted the facts as set out in her submissions in this decision. I also thank each of the other Counsel who appeared in providing very helpful responses in a timely manner.

The scope of the Coroner's inquiry and findings

15. An inquest is not a trial between opposing parties but an inquiry into the death. The scope of an inquest goes beyond merely establishing the medical cause of death.

16. 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.

17. As a result, a Coroner can make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future. 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.

18. Proceedings in a coroner's court are not bound by the rules of evidence but that does not 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 origin or source when determining what weight should be given to the information.

19. A Coroner should apply the civil standard of proof, namely the balance of probabilities. However the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, then the clearer and more persuasive the evidence needs to be for a coroner to be sufficiently satisfied it has been proven to the civil standard.

The East Wing and Buranda Car Park

20. The East Wing of the PAH Mental Health Unit has 28 beds. It is an open (not a locked) ward between 8am and 8pm and is locked at night. It houses voluntary and involuntary patients. Involuntary patients are generally admitted against their will. The current Nursing Unit Manager, Felicity Morgan advised the split of patients would be around one third involuntary and two-thirds voluntary patients.

21. The East Wing is an acute unit. The evidence of a number of witnesses including the Executive Director of Mental Health for Metro South, Dr Crompton was that the average stay of a patient is about 12 days. There are no recreation areas other than a small courtyard. Entertainment facilities are limited with 2 communal televisions and little else. The unit does not have the staff resources to provide long term rehabilitation. The relevance of this to this inquest is that

AW had been an in-patient for 462 days and the evidence of many witnesses was this was far too long given the confines of the unit.

22. I conducted a view of the East Wing unit as well as the West Wing and Acute Observation Area (a secure locked ward) at the conclusion of the inquest in the company of Dr Crompton. The description of it being "confining" is accurate with it feeling crowded with narrow corridors. A number of witnesses described the difficulties in conducting visual observations and that is readily appreciated upon touring the facility. The rooms are basic. The courtyards were relatively open, with little grass areas and would be oppressive for use in even moderate weather conditions. It would be uncontroversial to say that neither the East nor West wings were suitable for long term patient stays.

23. A number of nurses gave evidence that it was a frequent occurrence for patients to leave the ward when they were not permitted to. Some witnesses said that to some extent the recent introduction of the policy preventing smoking on the hospital wards or grounds has meant greater absences of patients; given the evidence a majority of mental health patients are smokers. During my brief visit there was a constant progression of patients leaving and entering the facility, often with cigarettes in their hands. I do not intend to enter into a debate or pass judgement about the utility of that policy decision, but clearly it is another factor which makes managing the ward more difficult.

24. The East Wing faces Ipswich Road with the Buranda car park immediately across Ipswich Road via an over pass bridge. The East Wing has a direct view across to the Buranda car park. The pathway leading from the unit immediately draws you towards the car park access overpass a short distance away. The Buranda car park is privately owned and is not under the control of Queensland Health. It does not have safety barriers constructed to enclose the car park and provides easy access to those who may wish to jump from it. The carpark is a known "hotspot" for those attempting suicide. An alternative car park at the PAH, constructed more recently is enclosed by outside barriers.

Observations and Leave

25. Every patient on the ward is subject to visual observations for their own safety. The frequency of the observations is decided by the treating team depending on the patient's risk. Nursing staff can increase the frequency of observations but cannot decrease the frequency without consulting a doctor.

26. Registered Nurse ("RN") Morgan describes the current observation checking routine was for *a* particular nursing staff member to be allocated to the task of undertaking visual observations for all patients over a specified period of time during a shift. That nursing staff member must observe the patient before marking him or her as 'present', 'pass' (on approved leave) or 'absent with or without leave' on a slip which is carried around on a clipboard and stuck into the patient's chart at the end of each shift.. The inquest heard that patients would frequently abscond from the unit.

27. Patients on an ITO or a Forensic Order are not able to leave the ward without a Limited Community Treatment Order. The LCTO specifies the nature and duration of leave a patient on these can have, including escorted or unescorted leave, as well as other restrictions. Escorted leave means the patient is allowed leave with a staff member. Unescorted leave means either leave without an escort, or escorted leave with a nominated responsible adult. Details of a patient's LCTO were contained in a folder held in the office area.

28. Patients are made aware of the conditions and the impact that breaking them might have on future leave entitlements.

29. In the case of a Forensic Order made by the Mental Health Court, under the *Mental Health Act 2000* any change to leave conditions under a LCTO had to be approved by the Mental Health Review Tribunal ('MHRT'), which review must occur at least every six months, although patients can request an earlier review.

30. The Mental Health Review Tribunal held any hearings relating to patients in a room near the main entrance to the East Wing.

Relevant Facts – SH

Treatment History

31. SH was first diagnosed with schizophrenia complicated by polysubstance abuse including heroin, cannabis and amphetamines in 2001. She had experienced recurrent episodes of psychotic episodes and had ten previous admissions to the PAH prior to her most recent hospitalisation. She was managed in the community through the Inala Mental Health Services.

32. SH was poorly compliant with her medication and erratic in her engagement with those who attempted to provide her with treatment and support. SH had struggled with drugs for a number of years and had consistently taken illicit drugs. Her mother was of the opinion SH took drugs to counteract the side effects of her antipsychotic medication.

33. In or around July 2008 SH fell pregnant. At the time she was free of positive signs of psychosis and was being treated with depot flupenthixol. After she fell pregnant, SH not unreasonably expressed concerns to her treating psychiatrist about the potential adverse effects of her medications on her baby. As she was free of positive signs her wish to cease the medication on a trial basis was respected.

34. However, in February 2009 SH began to relapse with persecutory ideation, disorganised thinking and disorganised behaviour. She was advised that she should recommence antipsychotics and it was recommended that she take haloperidol in a low-dose. Unfortunately she did not comply with this advice and she relapsed into a florid psychotic state. She continued with intermittent substance-abuse. She was admitted to PAH for 4 days and then discharged.

35. There were concerns with respect to her health and safety and that of her unborn baby .The Department of Child Safety was notified of the concerns for the unborn child. SH was returned to hospital as an involuntary patient on 26 March 2009 where she was to remain until the birth of the baby. She was placed initially on constant and then on 15 minute visual observations.

36. PAH did not have a mother and infant care unit for psychiatric patients and accordingly her obstetric and birth needs were managed by Mater Mothers. A meeting was held between PAH treating staff and Mater staff. Detailed notes for the planned birth were documented.

37. Over the next period leading up to the day of her death there was a constant pattern of SH leaving the unit when she was not meant to but then returning. This occurred most days and often for hours at a time or on multiple occasions

during a day. Her absences were generally noted in the visual observation chart. Sometimes "absent without leave" paperwork was completed and signed when she had been absent for more than 2 observation periods but generally SH returned before it was sent out for enforcement.

38. Her absences were noted on 28, 29, 30 March 2009. On 31 March a decision was made that SH was not to have any unescorted leave. She went missing on 1, 2, 3 and 4 April.

39. On 5 April 2009, SH was noted to have a puncture wound to her right elbow and was then absent from the ward from 12.30 to 2pm. On her return SH was transferred to the Acute Observation Area ('AOA') and was nursed one on one.

40. On 6 April 2009, SH was transferred back to the open ward subject to being placed on constant observations until the doors of the ward were shut at 8pm. On 7 April 2009, constant observations were ceased. A Limited Community Treatment (LCTO) form was completed. Under the heading 'Period of limited community treatment', both Escorted day and Unescorted day are ticked. The comments include, "*4hrs/day; only with her mother 2hrs/day*" and "*Please not by herself*".

41. On 9 April and 10 April 2009, SH was absent from the ward on multiple occasions and when she returned to the ward of her own accord she was abusive towards nursing staff. She was assessed by Dr Vaziri as remaining disinhibited and perplexed; guarded and hostile; high risk of AWOL and vulnerability. She concluded SH remained psychotic. This diagnosis did not change.

42. On 14 April 2009 SH was noted to be absent from the ward from 3.15 to 6pm. The psychiatric registrar was notified and the paperwork forwarded. The Queensland Ambulance Service ("QAS") returned SH to the Emergency Department. SH was not able to say why, and where she went, or why she called the ambulance.

43. On 15 April 2009 at 1.45am, SH was assessed to be in labour. The Mater Mothers was consulted and it was decided she would be transferred when her contractions were three minutes apart.

44. On 16 April 2009 at 10.30pm, SH was transferred to the Mater Mothers hospital and gave birth to her son JH at 2.13am. Her mother and sister were present for the birth. SH was transferred back to the PAH at 5.35am. The baby stayed at the Mater to be monitored. SH was irritable saying to staff she had been promised once her baby was born she would be discharged with her baby.

45. SH's mother said she and SH had understood SH would stay at the Mater after the birth of her child and they were surprised when she was discharged straight away and returned to the PAH.

46. On 17 April 2009, SH visited her son with her community social worker. On 18 and 19 April 2009, SH went on leave for a few hours with her mother and sister. On 19 April 2009, SH expressed anger after endeavouring to telephone her ex-boyfriend. It seems she was also angry when her mother had said she could take her to the nursery and that she could not attend a family meeting, the following day.

47. On 20 April 2009, Dr Leggett and the medical team reviewed SH. The notes record Child Safety had informed SH's mother that the baby was to be under her care and that the plan was for SH to go and stay with her mother. Further, the notes record Dr Leggett was of the opinion SH could have access to her baby under her mother's supervision. SH's medications were reviewed. Haloperidol was ceased and she was to receive IM Risperdal Consta 25 mg and 2mg Risperidone orally. The plan was for SH to be discharged at the end of the week and that she could have four hours leave from the following day. It is noted that at this time her LCTO was not formally varied.

48. On 21 April 2009, SH went on leave with her mother and baby from around 2pm to 4pm. The notes record SH spoke to her mother on the phone and ended up smashing the phone but said "sorry". SH's mother says when they were on leave SH was imagining people talking about a person she knew. She says she told staff to let the doctor know she was concerned about taking SH out again as she had the baby with them.

49. On 22 April 2009, SH was heard to be abusing her mother on the phone and then was noted missing from the ward but later returned.

50. Dr Leggett says he briefly saw SH in the corridor at her request. He says on neither 20 April 2009 nor 22 April 2009, nor at any other time in the course of his involvement in her care did he observe SH to be in any way depressed or complaining of depression. Dr Leggett says SH was eager to be discharged to be involved in her baby's care.

51. On 23 April 2009, SH was absent from the ward from 11.15am to 1.30pm. SH's mother says she saw SH in hospital that day and she was still imagining things.

52. Dr Leggett says whilst the plan was that SH would be discharged into her mother's care on 24 April 2009, SH's mother requested SH remain in hospital until her mental state had improved somewhat. It was considered she should be kept in hospital over the weekend to allow sufficient supports to be put in place to enable her to be discharged, either to her mother's house or to her own unit. When told of this decision SH became angry and started punching the doors, walls and windows. She was given sedation and settled.

53. Later that day SH advised the nurse caring for her that she would like her mother to have a meeting with the treating team. She also asked that her belongings be put in storage because she alleged people were stealing her belongings.

The Day of SH's Death – 25 April 2009

54. In the early afternoon of the day of her death SH was heard to say she was going to go across the road and throw herself off the car park. Given the outcome the significance of this statement is obvious. There were inconsistencies in the versions of events of a number of witnesses as to who was told or knew about this conversation. Those inconsistencies became even more contentious as the inquest approached, as a number of addendum statements were produced in the weeks before the inquest. The inconsistencies raise questions as to the veracity of the witnesses and unfortunately have to be dealt with in some detail in this decision.

55. On the day shift of 25 April 2009, Enrolled Nurse (EN) Wendy White had been allocated to care for SH.

56. EN White says at around 1.15pm she overheard SH say during a telephone call to her mother, words to the effect, *'I'm going to go across the road and throw myself off the building'.* EN White believes this was in response to a request for money, which her mother refused. EN White says she interpreted SH's statement as a very angry outburst in the context of not getting what she wanted. She did not interpret SH's words, or the tone in which she said them, as indicating a wish to self-harm. She says she allowed SH some time to settle, which SH did. She did not ask SH any questions in relation to what she had said and had not heard SH make a threat like this before.

57. SH's mother does not recall the specific threat from SH, however remembers her saying "*may as well…*" and asked SH to repeat what she said but she would not. In oral evidence SH's mother said when SH did not get her own way, sometimes in anger she would threaten to take an overdose of heroin but SH had never mentioned the car park before. She also said SH had no previous suicide attempts history.

58. SH's mother, Mrs H, says she had received 10 – 12 phone calls throughout the day of SH's death and this was unusual. Mrs H is of the opinion SH was desperate to obtain illicit drugs to counter the side effects of the medication she was taking. She did not think SH was suicidal and said SH had made plans for the following day for her sister to bring the baby up to the ward. Further, Mrs H said on the Thursday before her death SH was not normal and highly drugged and had started to imagine things again. Mrs H says she told SH's case manager that SH's medication needed to be corrected because she was hearing things and that her discharge needed to be delayed until Monday to get her medications fixed.

59. Mrs H is critical of the staff as she considers she was not listened to regarding the change in SH's medication and alleges the male nurse who telephoned her about SH's death laughed when he advised SH had been hearing things from the television. Acting Clinical Nurse ("CN") McKenzie does not recall calling Mrs H.

60. EN White also recalls receiving a phone call around 2.50pm from Mrs H informing her that SH had suggested to her sister there was a person on East Wing who could supply her with illicit drugs and suggesting EN White keep a close eye on SH. EN White does not recall that request but I accept this is what Mrs H said. In any event EN White says she observed and monitored SH closely and SH made no attempt to leave the ward and mostly sat quietly in the foyer for the remainder of the shift.

61. Of significance is EN White wrote progress notes in the records as follows:

13.15pm *SH has slept most of this shift in the TV room. When awake SH is elevated loud & delusional. Stating "the Doctors are discussing my heart condition with all the other patients". Overheard on the phone to her mother stating 'I'm going to go across the road and throw myself off a building'. Abusive to her mother when she refused to give SH money today.*

Addit
13.30pm *SH has phoned her solicitor to help her be released from hospital.*

14.50pm *Phone call from SH's mother. SH phoned her sister Mandy asking for money as there is someone on East Wing who can supply her with illicit drugs.*

62. EN White did not consider the threat needed to be escalated to the Nurse Unit Manager. She did not consider SH's mental health had deteriorated, or that she was depressed or a risk of suicide. She did not conduct a Risk Assessment. She did not recall having any discussion about these events at the handover to incoming staff.

63. On the evening shift commencing at 2.30pm, RN Jacqueline Cesna was allocated to care for SH. She had previously been allocated SH and knew her. RN Cesna says she recalls SH was displaying psychotic symptoms and paranoid thoughts and had offered her some quiet time and PRN medication, which SH refused. In her statement she said SH "*seemed the same as usual, if anything, less psychotic than I had seen her before. She did not seem depressed or express any concerns about her baby to me*". In oral evidence RN Cesna conceded she was concerned about SH's condition.

64. RN Rendell-Goodhew was part of the permanent nursing pool. She did not work in the Mental Health Unit on a regular basis. She attended on SH for the first time whilst also working the evening shift, and says she recalls at the handover that SH was considered a high flight risk. She completed the visual observations from 4.45pm to 5.45pm and recalls having some difficulty in locating SH during her initial visual observation at around 4.45pm.CN McKenzie gave evidence that pool staff had to rely on patients and other staff to inform them of who the patients were in the ward and it was difficult for a pool nurse to complete the 15 minutes visual observations as they were not familiar with the patients.

65. RN Rendell-Goodhew in her first statement signed on 19 January 2012, says that "whilst it is not documented in the PAH clinical chart" when she located SH, she told SH she had trouble finding her, and that SH responded by saying, 'I might have gone across the road to jump off the car park building'. RN Rendell-Goodhew says this was said in a 'smart alec' manner given the tone of her voice and facial expression. RN Rendell-Goodhew says she questioned SH on this and said words to the effect, 'You would not want to do that, would you?' and that SH replied to the effect 'Yes, I would'. In oral evidence Ms Rendell-Goodhew said SH had a slight change in tone when she said 'Yes, I would', which made her think SH may not be joking.

66. Accordingly, RN Rendell-Goodhew says she raised SH's comments with the team leader, (who at the time was Acting CN McKenzie) as she was concerned as the ward was unlocked and SH may have had a suicide plan and was at risk of following through with it. RN Rendell-Goodhew says the nurse in charge dismissed her concerns. CN McKenzie denies this information was passed on to him.

67. In her second statement signed in November 2012 RN Rendell-Goodhew she says she made a ¾ page note of these conversations and inserted a fresh page in the progress notes.

68. It is evident from the statements of two witnesses that SH was seen at about 4.50pm walking over from the Woolworths car park of the Buranda Shopping Centre. The 15 minute visual observation chart does not have SH recorded as

absent during this time and it is probable this was at the time RN Rendell-Goodhew was trying to locate SH.

69. RN Cesna wrote in the progress notes at 5.40pm, and says she noted the entry from the morning shift which stated "*overheard on the phone to her Mother stating,* "*I'm going to go across the road and throw myself off a building*"". It is unclear as to why RN Cesna had not looked at the records before this time, although it needs to be said the previous threat was not mentioned at the handover.

70. RN Cesna says she mentioned to Acting CN McKenzie that SH had threatened to harm herself that morning and had refused PRN medication. In oral evidence RN Cesna said when she told CN McKenzie about SH, he shrugged his shoulders. She asked him what to do, and he suggested she give her a few moments and then try the PRN again. RN Cesna says this is what she did. Acting CN McKenzie denies he was told about any threat by SH to throw herself of the carpark.

71. RN Tepairi was allocated to complete the visual observations from 5.45pm to 6.45pm. She does not recall speaking with SH but has some general recollection of observing her at times throughout the shift. She says she recorded that she observed SH at 5.45, 6, 6.15 and 6.30pm intervals but recalls SH leaving the ward for brief periods. She recalls Acting CN McKenzie had said he had seen SH out the front of the ward talking to a man on a motorbike, although CN McKenzie denies this. Further, RN Tepairi says at around 6pm she observed SH ask RN Cesna for her wallet and that RN Cesna gave SH her wallet, which had been kept in the safe. She says she is fairly confident she had observed SH in the courtyard at 6.30pm. RN Tepairi says after completing her round she recalls SH walking down the corridor past the open door to the TV room and heard her shout 'Why does the fucken television keep saying my name?'. She says SH sounded angry and distressed.

72. Acting CN McKenzie says at 6.15pm he recalls a nurse advising him that she could not locate SH and that he was involved in a search for her. He says SH had returned prior to 6.30pm because this was the next time the visual observations were due and she was present for those. It is likely Acting CN McKenzie is mistaken about the times. Acting CN McKenzie recalls SH being agitated and distressed when she returned to the ward and that she was speaking loudly to her attending nurse. He recalls being asked his opinion and that he suggested the nurse administer the PRN medication.

73. RN Cesna says shortly after speaking with Acting CN McKenzie about SH expressing suicidal ideations, she offered the PRN medication again to SH and she accepted it at or around 6.30pm. RN Cesna recalls after giving the medication to SH she returned to her room and slammed the door in her face.

74. Acting CN McKenzie says at or around 6.30pm he recalls SH approaching him whilst he was in the nurse in charge's office asking for her key card out of the safe. He says he reminded SH it was ANZAC Day and that the shops were closed. CN McKenzie says he advised SH of this, as he was concerned she would be frustrated if escorted leave could be arranged, and then the shops weren't open. He recalls SH then storming away walking back to the main section of the ward and that this was not unusual for SH. He says it is not possible to see the door to the ward from the nurse in charge's office.

75. CCTV footage from the Buranda car park reveals SH entering the lift of the car park alone at 6.34.41pm although for technical reasons the accuracy of this time cannot be confirmed.

76. At around 6.40pm, RN Cesna says she signed off all patients but was not able to locate SH. Acting CN McKenzie says sometime between 6.30 and 6.45pm he was advised SH was not able to located. He directed staff to complete the AWOL paperwork.

77. RN Cesna says she went outside to try and locate SH. At around 6.50pm, a visitor approached her and informed her that a blonde pregnant lady had jumped from the car park. RN Cesna says after speaking with the visitor she immediately returned to the East Wing to inform Acting CN Ian McKenzie and then she and some other colleagues ran over to the car park.

78. SH was found by visitors to the PAH who had been walking through the car park. They rang 000 and were provided instructions from the QAS regarding CPR which they commenced. No direct witnesses to the fall have been identified.

79. The QAS arrived to the scene at approximately 6.55pm and attempted resuscitation but this was not successful.

Inconsistencies in Evidence

80. Acting CN McKenzie says he is certain he was not advised by any staff member of SH having expressed suicidal ideation on 25 April 2009. He says this is because he would have taken steps to arrange a psychiatric review and would have had a higher level of involvement in her nursing care. Acting CN McKenzie does not recall having any interactions with SH or being made aware of any issues of concern prior to 6.15pm.

81. In a subsequent statement, Acting CN McKenzie advised he has a clear recollection the first time he was told SH had made threats to self harm was after her death. This occurred in the office area with RNs Cesna, Tepairi and Williams, whilst Dr Pun reviewed SH’s notes in preparation for speaking with her family. Acting CN McKenzie recalls Dr Pun reading aloud from SH’s record the entry about throwing herself off a building. Acting CN McKenzie says he was shocked by the information and that nobody else present said anything. Acting CN McKenzie recalls speaking with other nursing staff later in the medication room and nobody indicated they had been aware of any threat of self-harm earlier that day. Acting CN McKenzie says had he been aware, he would have had a higher level of involvement in SH’s care, including:

    a. locking the doors to the Mental Health Unit and liaising with the Director of Mental Health;
    b. asking nursing staff to keep a particularly close eye on SH;
    c. revising SH’s medical records to get some context for the making of the threat;
    d. notifying the on call Psychiatrist; and
    e. providing the patient with appropriate PRN medication.

82. Specifically Acting CN McKenzie denies RN Rendell-Goodhew advised him of her conversation with SH or raised any concerns with him regarding SH. RN Rendell-Goodhew was of the view the person she spoke with was dismissive of her.

83. RN Rendell-Goodhew was adamant shortly after speaking with CN McKenzie that she recorded her conversation on a new progress note page and inserted it into the chart. The alleged progress note has not been located.

84. The progress notes as they were copied and ultimately provided in original form to the Coroner have an entry by EN White at 2.50pm. There is a line struck through the last 4 lines of the page. The entry on a next page is that of RN Cesna at 5.40pm. RN Rendell-Goodhew said it is not her usual practice to strike through the bottom of a progress note prior to going to a new page. However, she advised it was her usual practice to file a new progress note in the file at the time she writes the progress notes. She said she is confident she wrote the note because she wanted to cover her backside at the time. She recalls getting another page from a filing cabinet and inserting it in the chart such that it was not loose.

85. EN White advised it was not her normal practice to put a strike through the progress notes when there were lines remaining on the previous page. RN Cesna does not recall putting a strike on the page following EN White's notes. RN Cesna is adamant that she wrote her entry at 5.40pm and they were contemporaneous. She does not recall having to put a new progress note page into the chart. RN Tepairi says she does not recall reading the progress notes prior to SH's death but that she did read RN Cesna's last recordings after SH's death and does not recall seeing any notes completed by RN Wendell-Goodhew.

86. RN Rendell-Goodhew does not recall seeing her notes when she photocopied the record for the police and says she had no reason to think or believe that her notes would not be there. RN Rendell-Goodhew says she raised the issue of her progress note with her legal representatives when she completed her first statement in January 2012 and was advised not to worry because the document could not be located.

87. RN Rendell-Goodhew's legal representatives subsequently provided a statement attaching the file notes from her previous legal representatives recording her instructions. The file notes record that RN Rendell-Goodhew was convinced she had documented in the chart but then later says she still wonders if she wrote in the chart. It reports RN Rendell-Goodhew thought she wrote in the chart after doing the visual observations and she had raised the issue with the level 2 nurse. It was decided to leave any reference to the progress note out of her statement if it could not be located.

88. I accept RN Rendell-Goodhew raised the conversation with Acting CN McKenzie. It is consistent with the facts as they were recorded earlier in the day and she has nothing to gain by making up such a conversation. In fact if she had wanted to absolve herself of any responsibility she would not have said anything about the conversation at all. Furthermore given she was unfamiliar with the unit she took what would be considered a normal course of action to speak to the person in charge.

89. What is difficult to reconcile is did she write a note, and if so, what happened to it? There are a number of possibilities. I consider on balance RN Rendell-Goodhew is mistaken and she either did not document her conversation with Acting CN McKenzie, or if she did she is mistaken about placing it in the medical records. There is no evidence the note was deliberately removed.

90. RN Tepairi was adamant Acting CN McKenzie had told her SH had been speaking with a male out on a motorbike at around 5.30pm and that this conversation occurred before SH's death. Acting CN McKenzie has a different recollection.

91. It is uncertain as to the importance of this issue other than as a collateral issue related to credit and I do not consider it necessary to determine it.

92. I am more certain about RN Cesna having a conversation with CN McKenzie after she wrote her progress notes at 5.40pm. She is adamant, and I accept she told him of SH's earlier threat to EN White about throwing herself off the car park, SH's psychotic symptoms, and that SH was refusing her PRN medication. She says she first became aware of SH's earlier threats when she wrote in the progress notes at 5.40pm. RN Cesna said she reported this to Acting CN McKenzie along with her concerns about SH and that Acting CN McKenzie shrugged his shoulders and suggested she wait and retry administering PRN.

93. RN Cesna says after SH went missing she did not raise her concerns with Acting CN McKenzie because she had already raised them with him. She conceded she should have documented her conversation with Acting CN McKenzie in the progress notes.

94. Acting CN McKenzie recalls having a conversation with a nurse who was concerned about SH because SH was anxious and distressed. He recalls suggesting the administration of PRN medication. He does not recollect any specific conversation he had with RN Cesna.

95. Neither RN Tepairi nor RN Cesna recalls speaking with Dr Pun after SH died. However, both recall speaking with Dr Crompton. Whilst RN Tepairi recalls a conversation in the medication room with other staff after SH's death she does not recall anyone saying, "I didn't know", "why not handed over".

96. Acting CN McKenzie recalls being shocked when Dr Pun reviewed the chart and mentioned EN White's entry. He says there were three other nurses present at that time. He does not recall having a conversation with Dr Crompton. Acting CN McKenzie did not raise his recollection of the discussion with Dr Pun until he provided his supplementary statement of 16 November 2012. He said it came about following clarification from his legal representatives and that could be one explanation.

97. Dr Crompton advised he arrived to the ward, as he was the executive staff member on call. He did know any of the nursing staff on duty. He says he would have spoken to staff but does not recall what he said. He does not have any recollection of looking in the medical records and that would not be something he would usually do.

98. Dr Pun advised in a statement obtained during the course of the inquest that he did not know the nursing staff in the PAH Mental Health Unit as he did not usually work there. He does not recall discussing the progress notes with the nursing staff. However, he recalls it was a highly charged atmosphere.

99. I accept it is more likely than not that Dr Pun did not read aloud from the progress notes as CN McKenzie suggests.

The LCTO issued for SH

100. The utility or indeed the futility of the LCTO in force for SH was the subject of some comment.

101. Dr Leggett says the leave restrictions documented on SH's LCTO were not something that he would have ordered for a sustained period. Dr Leggett was of the view SH's LCTO was an irrational order if it could not be complied with due to SH's continual absconding. He said it was not an order he would have made and saw it as a futile order. Dr Leggett agreed SH's leave entitlements and visual observations were incongruent with her planned discharge.

102. Dr Leggett said he expected the registrar to lead discussions concerning patients and to advise him of the LCTO and any changes to the LCTO. Dr Leggett advised he did not recall SH's leave being discussed with him. Dr Leggett was of the view a lower amount of visual observations would have been appropriate, particularly towards the end of SH's hospitalisation.

103. Dr Vaziri said the responsibility for LCTO's was the consultants and they ordered the leave and the registrar wrote it up. Dr Vaziri says she did not initiate or change SH's leave as it was Dr Leggett's responsibility. Dr Vaziri conceded she should have completed a new LCTO when the order was changed on 17 April 2009 to provide 4 hours escorted leave.

104. The Multidisciplinary Team Review Meeting of 22 April 2009 has the visual observations status changed to hourly. Despite this documented change, the visual observations remained at 15 minutes and the original LCTO made by Dr Vaziri remained in place. Dr Vaziri was on leave but someone should have made the adjustment.

105. The evidence supports a conclusion there was clearly a break down in communication concerning the roles and responsibilities between the consultant and registrar on this and I suspect other issues. Dr Leggett agrees the LCTO's in place for SH were somewhat illusory given her continual absconding and whatever is or should be the position regarding responsibilities for review of the LCTO, the inevitable conclusion is the ultimate responsibility rests with the consultant.

SH's symptoms prior to her death

106. Since SH's death, her mother has consistently believed that there was a deterioration in her condition following the change of her medications on 20 April 2009. Mrs H says SH was desperate to get money to buy drugs to counteract the symptoms she was experiencing from the drugs. She did not consider SH was suicidal or that there were any signs of suicide.

107. It is not difficult to conclude there was SH's mental state deteriorated by or on 25 April but it is difficult on the basis of the evidence before me to necessarily link that to any change in medication. It is just not that clear. In this respect, Dr Smith disagrees with Dr Reddan who both reviewed the circumstances of SH's death and provided reports. Dr Smith considers it cannot be said that the change in SH's medication made no difference. Dr Reddan was of the view the change in SH's medication leading up to her death was of minimal significance, if any, to her ultimate suicide.

108. There is evidence SH was or had become delusional by the day of her death. That is based on her mother's evidence as well as that of nursing staff who

were concerned she was more unwell. She was angry and distressed as well as hearing messages from the television. Drs Leggett, Smith and Reddan generally agree on this point.

109. Dr Leggett was not informed of SH's reaction to not being allowed to be discharged nor the need for the administration of intramuscular Haloperidol on Friday 24 April 2009. He says a doctor should have been called to review SH. That is even more evident after she made the threat to jump off the car park to her mother. He said the threat in the context of her transient exacerbation of delusions would have added weight to the need to review SH. On this aspect Dr Leggett agrees with Dr Smith who considered qualified psychiatric staff should have been involved. Dr Reddan considered the nursing staff at least should have engaged with her to find out what was going on and what she was thinking.

110. Dr Leggett noted SH could manifest delusional thinking from day to day and that she had a fluctuating illness even if it was well controlled. Dr Leggett did not consider there had been deterioration in SH between the week prior to and up until the morning of her death. However, he acknowledged there was deterioration on the Saturday.

111. Dr Leggett is of the view SH should have been reviewed on the afternoon of 25 April 2009 when she was reported as floridly delusional. Dr Leggett was of the opinion that SH not being allowed to go home may have been a determining factor in her deterioration but says nobody can know what was in SH's mind and that impulsive suicide is common. Dr Reddan agrees with this view.

Expert Opinions regarding the management of SH

112. Dr Reddan was retained by the Office of State Coroner to provide her expert opinion concerning the management of SH, AW, and WF. SH's family retained Dr Selwyn Smith to provide an expert report in relation to civil proceedings they have commenced against the PAH.

Opinion of Dr Smith

113. Dr Smith says the possibility of a postpartum psychiatric disorder and in particular postpartum psychosis was not raised as a diagnostic possibility within the documentation he reviewed. However, he says it is not possible with any degree of certainty to establish whether SH had experienced post-partum psychosis that would have placed her at increased risk of harm to herself or her newborn child.

114. Dr Smith says SH's conversation with her mother regarding throwing herself off a building may have been precipitated by her learning that she would not have custody of her child and that she also could not be with her child on her own. He states, "*Despite such a significant remark there is no recording that senior personnel including senior nursing staff or her treating psychiatrist was made aware of the potential for self harm. The level of monitoring and in particular the implementation of constant nursing care was not increased. SH was also not removed to a more secure unit where the risk of absconding would be significantly reduced*". Dr Smith is of the opinion the conversation SH had with her mother and her desire to obtain money to obtain illicit drugs are factors which qualified psychiatric staff should have been concerned with and acted upon.

115. Dr Smith is of the opinion "*there was a failure to meet an appropriate standard of care in providing medical services to SH and in particular preventing her from absconding from hospital on 25 April 2009 and entering the building opposite and jumping to her death*". Further, he states there was a "*Failure to meet the appropriate standard of care in implementing constant nursing care and modification to her pharmacotherapeutic regime and the engagement of closer one to one interaction with SH in my opinion substantially contributed to her absconding from the unit and her resultant fatal injury*".

116. Dr Smith said that schizophrenia may relapse at any time. He considered SH was subject to a number of psychological blows. These included childbirth, limited access to her child, and that she was told she would have to stay in hospital on 24 April 2009. Dr Smith believed SH should have been reviewed after her medications were changed on 20 April 2009 to assess for positive and negative effects. He is of the view the discharge plan should have been undertaken with less haste. Dr Smith is of the view that the symptoms SH exhibited on 24 and 25 April 2009 should have meant closer supervision including one on one interaction with SH with an experienced nurse, social worker, psychologist, or psychiatrist, constant observations and that her medications be reviewed.

Dr Reddan

117. Dr Reddan notes SH had only grudgingly co-operated with treatment and never developed a good therapeutic alliance with mental health services. She considered this was likely to have been due to a number of factors including, but not limited to, SH's lack of insight into the severity of her condition and its underpinnings and to her disinterest to give up drug use. Dr Reddan notes she was aggressive and abusive and would have caused considerable concern and frustration to her mother.

118. Dr Reddan notes the constant observations and placement of SH in the AOA presented difficulties in themselves as SH was very resistant to such manoeuvres. Dr Reddan is of the opinion there is no evidence SH had developed a depressive disorder or even transient baby blues immediately prior to her death. She considered SH's angry reaction to not being discharged on 24 April 2009 was not surprising. She considered an experienced nurse would be able to handle the situation and the reaction in itself did not mean a doctor should have been called. She reiterated that the psychiatric registrar would have usually reviewed the patient at least three times per week.

119. Dr Reddan opined it is easy to be clear in hindsight concerning the statements SH made to the nursing staff about jumping off the PAH car park on the day of her death. Dr Reddan considers it is likely the nursing staff did not take SH's conversation with her mother as a serious threat of planned suicide. Further, she says this is evidenced by SH's mother who on ringing back an hour later did not mention the threat but was concerned about SH's drug seeking. Dr Reddan says whilst understandable that the staff did not interpret the statement as a clear threat of suicide, it would have been advisable for the staff member to have approached SH and ask her about the statement. She says this may have opened up a dialogue about her frustrations and enabled a more detailed assessment of any risk of suicide to be made. Dr Reddan, states: "*It is highly unlikely however that such a conversation would have led to any deepening therapeutic rapport as it might with other patients in view of SH's longitudinal history and her manifest hostility towards the mental health staff*".

120. Dr Reddan says until what was seen as essentially a throw away conversation between SH and her mother there had been few threats of self-harm and there had been no escalating or substantial self-harming behaviour.

121. In oral evidence Dr Reddan was of the opinion the hallucinations or other psychotic phenomena noted on 25 April 2009 were opportunities for nursing staff to engage with SH and find out what was going on and what she was thinking. She said there is no substitute for reaching out to a patient and discussing with the patient what he or she is thinking or feeling and that that is the most important aspect of the therapeutic relationship. She believes staff may have dismissed what SH had said because of her history of unreliability. Dr Reddan agreed there was deterioration in SH's condition in the 24 hours prior to her death. Dr Reddan said it was difficult to establish what destabilised SH and that it could have been a combination of factors. Dr Reddan was of the opinion nursing staff should have been able to manage the ups and downs of a patient's mental state and it may have been difficult to get a medical review if there is only one registrar on for the whole of the service on a Saturday (which in this case was also a public holiday). However, this seemed to be on the basis the psychiatric registrar would have *seen SH on the Friday morning, which did not occur.*

122. Dr Reddan did not consider SH required daily psychiatric monitoring but said it was usual for a patient to see a psychiatric registrar at least three times per week, for example Monday, Wednesday and Friday and SH would normally have been reviewed on the Friday. Dr Reddan did not believe it was unusual to administer Risperidone PRN.

123. Dr Reddan is of the opinion SH's absconding was primarily driven by her dissatisfaction with being readmitted at all and thus her desire for autonomy. Dr Reddan states, "*Absconding is what could be expected when patients do not want to be an inpatient and want some personal autonomy*". Dr Reddan says it is unclear as to what extent it was driven to attempt to seek of drugs. She states: "*In my opinion the management of her absconding was reasonable given the overall circumstances. Most of the time when SH absconded it was for short periods and nothing dreadful necessarily happened but the fear of the staff was that if she absconded after the baby was born was that she could represent some harm to the baby rather than a fear that she would harm herself. Given her longitudinal history, those expectations and priorities were reasonable*".

124. Dr Reddan said SH manifested impulsivity at times which would cause her to think and act quickly. She said nobody will ever know if she had been thinking about suicide before she left the ward on 25 April 2009.

Autopsy Report for SH

125. Dr Beng Ong performed an autopsy and provided an Autopsy report. He found SH had suffered extensive injuries, which included bilateral pneumothoraces, ruptured heart and lacerations and contusions to the lungs. Further, there were a number of fractures to her limbs.

126. The report concludes: "*the injuries sustained and pattern of fractures especially of the lower limbs were in keeping with a fall from height*".

Cause of Death

1(a) Chest injuries, *due to, or a consequence of*,

1(b) Fall from height."

127. The toxicology report confirmed a number of psychiatric drugs were detected in SH's system. Neither alcohol nor illicit drugs were detected.

Relevant Facts – AW

128. AW first presented to the PAH in 2003 but was not assessed as overtly mentally ill. He again presented in August 2006 following concerns about his behaviour over the preceding 18 months. The deterioration in his mental health occurred in the context of him abusing cannabis and amphetamines. He was diagnosed with Schizophreniform Psychosis and commenced on an anti-depressant, Valium, and a small dose of an antipsychotic medication.

129. From August 2006 to October 2008, AW was admitted to the PAH on eight occasions.

130. Dr Motamarri was AW's psychiatrist from 27 October 2008 until 20 January 2010. Dr Hlincikova took over his care from 28 January 2010 some four days prior to his death.

131. On 1 September 2008, AW was admitted to the PAH under an Authority to Return issued by Dr Leggett. AW was non-compliant with his medication and had been involved in an altercation with his father. He was discharged on 15 September 2008 and was not overtly psychotic but on 20 September 2008, AW assaulted his father. He was taken to the PAH for assessment but the psychiatrist assessing him revoked his Involuntary Treatment Order and he was released into the custody of the Queensland Police Service where he was charged with assault and remanded in custody.

132. On 1 October 2008, AW was transferred from a correctional facility to PAH Mental Health Unit due to concerns over his mental state and safety. He was admitted to the AOA. Dr Motamarri says AW's behaviour was bizarre with frequent nudity, shadow boxing, defecating on the floor, and threatening and assaulting others. He describes AW as being irritable, hostile, and aggressive with a blunted and fatuous affect and thought blocking. Dr Motamarri found AW to be guarded and difficult to engage with and thought his judgment was impaired. AW was placed on an ITO.

133. Whilst AW was in the AOA he began to express the belief that his right eye was evil. Subsequently, on 29 October 2008, AW gouged his right eye, resulting in emergency enucleation surgery, which was not able to salvage his eye.

134. After several months of treatment AW's mental state improved with him denying experiencing psychotic symptoms, his mood was euthymic and he was substantially more settled in his behaviour.

135. On 19 March 2009, Dr Motamarri completed a 'Request for approval for limited community treatment'. The treating team was concerned that continued long-term inpatient status would impede AW's recovery. The team proposed a graduated leave plan that could culminate in discharge on a very strict monitoring schedule.

136. In June 2009, the treating team agreed to develop a behavioural plan to deal with a number of identified recurrent behaviours which required addressing including violence/aggression/swearing; leaving the ward; smoking; PRN

medication; bullying; alcohol on the unit; playing 'possum' suicide; and sexual activity. Alcohol was not a significant problem at this time with only one episode of an alcohol related incident noted.

137. On 21 July 2009, Dr Motamarri wrote to the Director of Mental Health for an upcoming Mental Health Court hearing. He raised concerns about AW's frustration with remaining an in-patient. Further, he noted AW was experiencing depressive ideations and anxiety about his long stay on the ward. It was considered further improvement in AW's mental state and living skills would be best achieved living in the community. Further, he recommended the continuation of the ITO and the Forensic Order as AW remained at risk of relapse or exacerbation of his psychosis if he were to use illicit recreational drugs.

138. On 28 July 2009, the Mental Health Court made a Forensic Order which the treating team were required to abide by. The charges relating to the assault of his father were discontinued. The Order stipulated AW was to be detained for involuntary treatment or care in the "*Authorised mental health service THE PRINCESS ALEXANDRA HOSPITAL AHMS*". Further, the Mental Health Court issued a Notice of Limited Community Treatment Plan. The conditions state:

   Unescorted (on and off grounds of the hospital):

   a. That he be accompanied by a responsible adult nominated by the authorised psychiatrist;
   b. That he comply with the requirements of the authorised psychiatrist in relation to taking of prescribed medication and other treatment;
   c. That he refrain from using alcohol and illicit drugs and cooperate fully in random medical tests for those substances as required by the authorised psychiatrist; and
   d. That he return to the ward at the time specified by the authorised psychiatrist.

139. The evidence suggests order (c) regarding abstaining from the use of alcohol or illicit drugs is a relatively standard order. It should be noted that although there is reference to "unescorted leave" this is distinct from escorted leave with mental health staff. Any "unescorted leave" was leave whilst in the company of a responsible adult.

140. AW expressed extreme frustration with the restrictions placed on him and on the limited leave conditions of his Forensic Order. Dr Motamarri said AW was a young person who would display his frustration and anger by not doing what he was asked to do, including taking his medication. Further, he would become irritable and aggressive and revert to his old habits of drugs and alcohol and had poor insight into his condition.

141. Dr Motamarri says the possibility of AW's care being transferred to the medium secure unit at The Park was discussed with AW and his family in around August and September 2009. Dr Motamarri says he personally did not have any discussions with The Park about transferring AW there.

142. Dr Motamarri says in the end, the multidisciplinary team decided to keep AW at the PAH with the option left open for referral to The Park and for the matter to be reviewed again at a further date. He says this was due to the long waiting period at The Park; the graduated leave option being trailed for AW; the familiarity of AW's care being provided at the PAH; and having a more or less

consistent pattern of low risk of harm to others and low to moderate risk of harm to self.

143. On 15 September 2009, a 'Clinical Recovery Planning' meeting took place and amongst a number of initiatives, the plan included commencing weekly urine testing and random checks, as well as physical searches of AW and his room on a weekly and random basis.

144. Dr Motamarri conceded at the time the behaviour management plan was implemented in September 2009, alcohol was not a big issue as there had only been one incident at that time. The recovery plan of 24 September 2009 was reflective of the behavioural plan and Dr Motamarri said he would have expected that it would have been updated. The nursing witnesses who had cared for AW did not readily recall a behaviour management plan for AW and there was no evidence of a documented or formal plan concerning AW's escalation in alcohol usage.

145. Dr Motamarri said they had serious challenges to implement a behaviour management plan for AW because they were limited by the "carrots" which could be offered as an incentive due to the restrictions in place because of the Forensic Order. It is evident that whatever behavioural management plan was in place in September 2009, it had not been updated to address AW's increasing alcohol usage.

146. The evidence does not indicate there was much else happening to address AW's escalating non-compliance and use of alcohol, other than with leave restrictions, and although it is accepted it was difficult for staff due to the restrictions in place by the Forensic Order and the difficulties in managing access to alcohol in an open ward, more could have been done.

147. As noted by Dr Reddan, a much more structured behavioural program with more clear boundaries and consequences for specific, identified behaviour should have been implemented. She felt the plan needed to be simpler and that it needed more immediate consequences and more "carrots" as there was too much focus on "sticks". She considered the behavioural management plan was not helpful for staff regarding AW's alcohol problem, which developed after the behaviour management plan was implemented and that it could have been amended.

148. On 24 September 2009 after repeatedly breaching leave conditions and disruptive, threatening and un-cooperative behaviour, members of the treating team met with AW to discuss progress in relation to the behavioural management plan. He was transferred for a period to the AOA and then back to an open ward in October.

149. Full day leave with his family commenced but he continued to abuse alcohol and cannabis and this behaviour escalated from the end of October 2009. From this time until January 2010, AW was reported to be visibly intoxicated on 7 occasions.

150. On 3 January 2010, a patient reported AW and co-patients smoking marijuana in the East Wing courtyard. A search of his room was undertaken. It revealed a partially full bottle of vodka and empty bottles of beer, rum and vodka.

151. On 4 January 2010, Dr Leggett completed a 'Clinical report forensic order review'. He recommended AW should remain on a Forensic Order to ensure

AW's mental state could be monitored and for his compliance with ongoing treatment but suggested, amongst the standard restrictions, that AW be permitted to reside at a place approved in advance in writing by the treating psychiatrist. Dr Leggett says the aim was for AW to make some progress to give him hope of rehabilitation.

152. On 8 January 2010, AW's Limited Community Treatment Plan was updated and to be in effect until 17 January 2010. He was allowed up to 3 hours a day escorted leave with staff and unescorted leave of 3 hours a day with relatives and friends during the week, and 5 hours a day on the weekends with family members.

153. On 8 and 10 January 2010, AW was suspected of being intoxicated.

154. On 11 January 2010, AW was approached concerning suspicions he was intoxicated. AW admitted to drinking alcohol and "*produced 3 x 350ml Bourbon bottles and 1 x 750ml Vodka bottle on encouragement*".

155. On 11 January 2010, the Limited Community Treatment Review Committee supported Dr Leggett's recommendations of increased leave to full community leave but that AW could not be referred to transitional housing until such housing was approved by the Mental Health Review Tribunal.

156. On 12 January 2010, AW was noted to be drinking alcohol around 12pm. He was breathalysed with a reading of 0.102. He was dismissive and reluctant to answer questions but said he was drinking due to boredom.

157. On 13 January 2010 three bottles of vodka were found in his bathroom. He later admitted he had been drunk for five days. He was transferred to the AOA for 15 days and his leave was cancelled for this period. AW voiced hopelessness/helpless themes regarding transfer to AOA and wished he was dead. He said if he had been on the open ward he would have jumped off the car park across the road. He stated he was turning into an alcoholic and blamed it on the length of his hospitalisation. It is my opinion, he was correct in this assessment.

158. On 15 January 2010, AW's Limited Community Treatment Plan was revised to escorted leave, 30 minutes with staff every 24 hours.

159. Despite the initial plan to remain in AOA, AW was released back on to the open ward on 18 January 2010 as a result of bed shortages.

160. On 19 January 2010, Dr Motamarri ordered six hours unescorted leave by the end of the week and to move up to 12 hours unescorted leave the next week. Dr Motamarri explained in his evidence that restricting AW's leave was increasing his frustration and they had to attempt to demonstrate that AW could meet the requirements of the MHRT.

161. On 22 January 2010, AW admitted to his case manager he was drinking up to three bottles of vodka per day over about a five-day period. On 23 January 2010, AW had leave with his father from 8.10am to 2.10pm and returned with slurred speech. His leave was revoked.

162. On 24 January 2010, AW's mother was expressing numerous concerns and requested a family meeting to discuss her concerns. She wrote to Dr Motamarri but it is evident he did not receive the letter until 16 March 2010. On 29 January

2010 Mrs W voiced concerns about a new consultant taking over AW's care and requested a meeting with Dr Hlincikova and Dr Motamarri.

163. Dr Hlincikova advised she had an informal handover of AW with Dr Motamarri and Dr Jensen (the psychiatric registrar). She had planned to meet with Mrs W and had asked for such a meeting to be arranged although events a few days later took over.

164. Although a changeover in consultants was not desirable for continuity of care reasons, it would be unreasonable to expect that changes would not eventually occur. That said, given Mrs H's concerns had been expressed and noted in the medical records, better communication was desirable prior to the changeover particularly in light of the escalation in the use of alcohol and the scheduled MHRT review. This is reflected as a lesson learnt in the Root Cause Analysis ("RCA").

165. On 24 January 2010 at 6.15pm, AW went missing but returned 30 minutes later and appeared to have an altered state of mind, mild slurred speech and unsteady gait. AW admitted to smoking half a joint. AW was expressing bizarre themes but denied any suicidal or aggressive thoughts. He was assessed by a psychiatric registrar as having a deterioration of his mental state in the context of smoking marijuana.

166. As a result, on 25 January 2010, his leave was revoked. The notes record, "*Voicing vague suicidal ideation relating to if sent to AOA or ongoing behaviours*". Despite his leave being revoked he continued to leave the ward and was ambivalent concerning all nursing advice to refrain from doing so.

167. On 26 January 2010, AW was suspected of consuming alcohol. Later he told a nursing staff that he was planning to go back to AOA to control his alcohol abuse. He handed over $50 and his bankcard to the team leader. Dr Motamarri saw this as a potential breakthrough. At this stage his leave was for 'escorted leave', half-hour with nurse every 24 hours.

168. On the afternoon shift of 31 January 2010, AW was observed to go out and later come back to the ward. He was subsequently observed to be drowsy and unsteady on his feet. On 1 February 2010, he was remorseful about drinking the night before but his speech was still slurred and he was unsteady on his feet.

169. Later in the shift Dr Hlincikova reviewed AW who still appeared to be affected by the alcohol he had consumed and was 'clowning around' throughout the assessment by Dr Hlincikova. The consultation was terminated prematurely due to the degree of AW's intoxication. She says he denied consuming alcohol and that they briefly discussed the MHRT meeting scheduled for the following day advising that even if he was not granted full discharge they would aim toward getting him discharged from hospital. She says she does not recall AW being distressed or angry. She denied saying to AW that 'if he continued drinking he was never going to get out of hospital'.

170. AW was breathalysed which revealed a reading of 0.132. His room was searched and an empty 375ml bottle of vodka was located. AW was apparently very angry, antagonistic and verbally abusive towards the security staff whilst this occurred.

171. Although nursing staff do not recall AW being particularly anxious or expressing any concerns about the scheduled MHRT the following day, Dr Motamarri said AW had been anxious in the past about MHRT reviews which he attended. He expected the orders made by the MHRT would be impacted upon due to AW's recent alcohol use. Dr Motamarri was of the view the MHRT would have been a big concern for AW as they would be looking at his alcohol usage and may have restricted his leave.

172. Dr Leggett was of the opinion AW's recent alcohol issues prior to his death would have been detrimental to his chances of obtaining leave from the MHRT. Dr Leggett agreed it was a conundrum, as the PAH was not a good place for AW however, he could not be discharged as he had not progressed due to his alcohol and behavioural issues.

The day of AW's death – 2 February 2010

173. According to the medical records, AW verbalised thoughts of suicide by jumping from the PAH car park on 4 May 2009; 1 July 2009; 25 August 2009; 5 October 2009; 4 December 2009; and 13 January 2010. AW knew SH and there is some evidence he may have given her a sip of an alcoholic drink on the day of her death. He was aware of how she died.

174. RN Batchler was the nurse in charge of the morning shift and says she does not recall any concerns being reported about AW at handover from the night shift. She says she was not aware the MHRT was scheduled for that day.

175. RN Hammond was allocated to care for AW at the commencement of the morning shift at 7am. He says he recalls there was mention about AW's drinking and the MHRT that afternoon. Early into the shift AW knocked on the door of the medication room. He says this surprised him because AW would normally sleep until midday. He recalls AW saying he was anxious/stressed and asking for some Valium. RN Hammond says he put AW's early rising and anxiety down to his appointment with the MHRT later that day. He recalls administering the Valium and advising AW to go and sit in the courtyard to have his breakfast and that he would come and talk with him after he had eaten. RN Hammond was of the opinion AW was a little flat but otherwise says there were no obvious changes. He says he intended to follow up with AW after he had finished administering the medications but did not get the chance.

176. RN Maestrado was allocated to undertake the visual observations from 7.15am to 8.15am on the ward. RN Maestrado could not locate AW at 8.15am and recalls giving AW 15 minutes because it was not unusual for AW to leave the ward for short periods and return. RN Maestrado was not aware AW's leave had been revoked.

177. Angela Breust, the administration reliever, recalls seeing AW at approximately 7.40am sitting down with his back against the wall against the office both with his head in his hands, and shaking, visibly upset, and unsettled. She thought the behaviour was odd but saw a nurse who she now knows is RN Batchler talking with AW.

178. RN Batchler says as she was writing up on the 'consumers board' at around 8am, AW walked past her and did not acknowledge her greeting. She recalls he turned the corner and heard him drink from the water fountain.

179. Whilst RN Batchler has confirmed the CCTV footage of the front entrance of the ward shows AW leaving the ward and that a few seconds later she appears to

have walked down the same hallway and looked outside in the same direction that AW had travelled, she has no independent recollection of AW leaving the ward.

180. RN Hammond says he continued to get organised in the medication room and that shortly after AW left, RN Batchler advised him AW had just taken off out the front door. RN Hammond says they agreed AW would probably return to the ward shortly as he had previously done on many occasions. They decided if he did not return in 30 minutes they would reassess the situation.

181. The CCTV footage clearly shows RN Batchler following AW out and given the evidence of Ms Breust and RN Hammond it is most likely RN Batchler did speak to AW, saw him leave and followed him to the door. It is unclear why she does not recall this event.

182. A Year 10 student saw a man fall from the car park. A doctor arriving for work came across AW, established the person did not have a pulse, and called for police and ambulance assistance at approximately 8.07am. QAS arrived at 8.16 but AW was clearly deceased.

Report of Dr Reddan

183. Dr Reddan reports AW was suffering a major mental disorder, although during the latter part of his admission his condition had improved considerably, despite his continued abuse of cannabis and alcohol. Dr Reddan notes AW threatened to jump off the car park on numerous occasions, most recently on 4 December 2009 and 13 January 2010. She considers there would have been major difficulties for staff in assessing the imminence or otherwise of suicide in AW's case.

184. Dr Reddan is of the opinion AW was at a higher risk of suicide than the general population. He was also prone to threatening aggression and to manipulative threats. She advised she would not be surprised if staff saw AW as very unreliable in his self-reports and says there is always the risk that a patient can cry wolf once too often, but says with the benefit of the precision that hindsight affords, "*AW had probably fantasised about suicide from the car park but is likely that the final decision to suicide was made close to the time he did so*".

185. Dr Reddan notes AW had been commenced on an antidepressant on 11 November 2009 but the autopsy report indicates no Fluvoxamine was detected. She says this suggests it is likely AW had been non-compliant with taking his prescribed medication without staff being fully aware.

186. Dr Reddan thought AW probably knew the medical staff view was to transfer him to the Medium Secure Unit at The Park and he is likely to have interpreted this very negatively and it would have been demoralising news. She states, "*It is clear that AW took little responsibility for his behaviour but it is also clear that he felt helpless and hopeless in the face of the capacity of others to determine his life. It is quite apparent that his mood tended to improve with some leave from the ward but then on the other hand, leave was often difficult because of his behaviour.*"

187. Dr Reddan states, "*AW was an extremely disturbed young man. Suicide was always a risk with him from early on but the difficulty would have been in predicting when it would occur as even in the most disturbed patients, suicide is still a low-frequency event. It is difficult balancing up the prevention of suicide*

with also helping the patient to have some quality of life, some enjoyment of their life and some autonomy, which is a critical aspect of being human".

188. In regards to AW leaving the ward immediately prior to his death, Dr Reddan is of the opinion staff were probably aware that AW was very unhappy about still being in hospital and that it is likely the nurses expected he would just return again so some complacency had probably developed. Dr Reddan said she thought the staff had become demoralised and powerless along with AW.

189. Dr Reddan raised the issue of AW's access to money to buy alcohol. Further, she said the problem with monitoring visitors and searching any bag AW bought back from leave was it would have been time consuming and probably offensive to his visitors.

190. Dr Reddan says whilst there is no evidence AW was intoxicated with alcohol at the time he suicided, it is likely to have exacerbated any depression or feelings of hopelessness and helplessness he was already experiencing. Therefore, the influence of alcohol in his outcome was indirect.

191. Dr Reddan is of the opinion AW's management was largely reactive rather than proactive or preventative. In regards to AW's alcohol and cannabis use and behaviour generally, Dr Reddan is of the opinion AW may have benefited from a much more structured behavioural program with clearer boundaries and consequences for specific, identified behaviour. She says in her view it might have been more prudent for AW's leave to be more closely tied to expectations around his behaviour to reduce inconsistency and to prevent inadvertent variable reinforcement of his behaviour. Behavioural programs need a balance of sticks and carrots for them to be effective but it can be expected that initially, the patient will escalate the acting out in response to the programme and staff need to hold their collective nerve.

192. She says, however, one of the difficulties for staff is that the provision of leave was not entirely in their hands. Dr Reddan appreciated the staff were hamstrung about the conditions placed on AW by the MHRT but considered a frank discussion with the MHRT was warranted after AW's psychosis receded. Further, she is of the opinion it is debateable whether ongoing inpatient care was really contributing much to AW's progress because his psychosis had receded.

193. Dr Reddan was of the opinion it was not a coincidence that AW suicided on the day of the MHRT review. She considers AW had become demoralised.

Autopsy Report for AW

194. Dr O'Brien and Dr Williams have provided an Autopsy report. They found AW suffered extensive internal injuries and multiple fractures. The report concludes:

> *In my opinion the cause of death is multiple injuries due to fall from height. This is based on both the circumstances surrounding death, review of his medical record and post-mortem examination with associated testing.*
>
> ***Cause of Death***
>
> 1(a) Multiple injuries, *due to, or a consequence of*,

1(b) Fall from height."

195. The toxicology report confirmed a number of psychiatric drugs were detected in AW's system. Further, the sample was positive for cannabinoids. Alcohol was not detected.

Internal investigations conducted by Queensland Health in relation to SH

196. A PRIME incident report was completed immediately following the death of SH. Under the heading 'Incident Analysis' it describes the type of analysis as a Root Cause Analysis and says this commenced on 21 January 2010 but that it was stopped on 9 December 2011 due to a coronial investigation. Dr Crompton signed the Prime Report on 14 December 2011.

197. The Director General subsequently advised an RCA was not undertaken due to the Coroner investigating; an external review being undertaken; and Metro South Health Service District being advised that a claim under the *Personal Injuries Proceedings Act 2002* had been lodged.

198. The Obstetrics, Retrieval Services Queensland and Chair, Queensland Maternal and Perinatal Council also had conducted an external review. This report was not available and disclosure was denied due to privilege.

199. A Mental Health Mortality Report was completed by Dr Leggett on 28 May 2009.

200. Dr Crompton advised Patient Safety were responsible for completing the RCA process, which was a separate department within Queensland Health. There was a long delay in RCAs being completed at the time of SH's death. Dr Crompton said when he received correspondence from my office around December 2011 he discussed the situation with Patient Safety and it was agreed as the inquest was not too far away it would be preferable to receive the findings of the inquest as it would be a broader evaluation of what occurred. Dr Crompton advised he was never provided with the draft RCA or any information concerning the proposed findings of the RCA.

201. Neither Dr Leggett nor Dr Crompton was aware that the Obstetrics, Retrieval Services Queensland and Chair, Queensland Maternal and Perinatal Council had conducted an external review into SH's death. Neither could they provide any details as to what the review would have examined.

202. Dr Crompton conceded that given the RCA was not completed, there was no completed investigation into SH's death of which he was made aware.

Internal investigations conducted in relation to AW

203. A Mental Health Mortality Report was completed by Dr Hlincikova on 1 March 2010.

Root Cause Analysis

204. An RCA was commenced on 10 February 2010 and completed on 21 October 2010. However, Dr Crompton did not sign the RCA Report until 14 December 2011. On 5 January 2012, the Coroner was provided with a copy of the RCA report into AW's death.

205. The RCA concluded: "*There were nil identified direct root causes that could be identified by the team in the death of this young client. There were however a number of lessons learned*".

Lessons Learned

Lesson Learned statement One:

The client was admitted to the East Wing of the Mental Health Services for continuing management of his mental health. The proximity of the car park building to the Mental Health Unit provided the client with immediate proximity to a means of self harm (i.e. the car park is clearly visible from the East Wing Unit). The client also had knowledge that a self harm attempt from the car park building in the past, had ensured a lethal outcome.

Recommendation Number 1:

It is acknowledged that previous lobbying by Metro South Mental Health Services for the fencing of the private car park facility has been unsuccessful on a number of occasions thus far. It is recommended that the Metro South Mental Health Services escalate the negotiations to the Mental Health, Alcohol and Other Drugs Directorate to eliminate the risks identified.

Outcome Measure 1:

Escalation of negotiation to the Mental Health, Alcohol and Other Drugs Directorate.

Lesson Learned Statement Two:

The client was chronically moderate-high risk of suicide during his mental health history particularly in the context of his serious self harm attempt in 2009, but in the context of no plan (i.e. the client had a consistently high suicide risk, but when questioned about his intent did not state a plan of self harm). Recurrent abuse of alcohol impacted on his impulsivity and impeded his full recovery.

Recommendation Number 2:

It is acknowledged that substance misuse is a risk in Mental Health Service in-patient Hospital Units, with clear policies about the management of these practices in place. It is also acknowledged that these policies were instigated and followed in the management of this client. The Unit design does however create challenges in the monitoring of substances on the ward. It is recommend that any future re-design of the inpatient unit allow for a more design-specific, purpose built facility in an effort to reduce/manage clients who misuse substance in the hospital setting.

Outcome Measure 2:

In future planning, designs should allow for a specific purpose built facility that incorporates Mental Health risk reduction strategies.

Lesson Learned Statement Number 3:

The current adult inpatient unit accommodates both acute and chronic conditions from the ages of 18-65 years old. The Unit was designed for acute clients with an intended stay of 21 days maximum. In practise, clients are maintained far beyond that time. This client had a length of stay of 490 days. This exposure of a young client to adult clients with a long standing mental health condition, may have given the client potential insight into his likely long term future and may have adversely impacted on his hope for the future.

Recommendation Number 3:

It is recommended that a process be developed for young-adult clients who require a mental health hospital admission to be admitted to an age-appropriate, criteria-specific, facility that supports and provides age-appropriate interventions and networks.

Outcome Measure 3:

Future Planning

Lessons Learned Statement Number 4:

It is acknowledged in this client's case; that communication between Mental Health Service and interested family members (Mother, Sister, and Father) was complicated further by acute changes in the client's mental status. The client's consent for either inclusion or exclusion of family members in his care changed on a frequent basis. This was frustrating for family wanting information about their loved one, and hindered staff's ability to provide information to the family in periods of his care where the client requested that they not be informed.

Recommendation Number 4:

It is recommended that a care plan about communication with next of kin and other relatives is negotiated with clients when they are well. This agreed level of information about a client's care will then be used in cases where a temporary desire to have the family excluded or not informed about changes in their care is a symptom of the client's illness.

Outcome Measure 4:

Documentation of a client's wishes re communication plan should be incorporated into the clients' mental health plan, particularly in long term clients.

Improvements to the RCA Process

206. Dr Crompton agreed the RCA delays were not ideal. He advised that the completion of a RCA had been returned to Mental Health Services and that there is now a governance section, which includes patient safety. Dr Crompton said that they are now on schedule for the completion of a timely RCA.

207. In addition to Mental Health Services taking over the responsibility for the RCA process, Dr Crompton said he had implemented independent reviews of some critical incidents. This involved engaging an expert, for example a professor of psychiatry from interstate to investigate incidents. The process includes interviewing staff.

208. Dr Crompton agreed it would be helpful to obtain recollections from staff through a brief note following the unexpected death of a patient, as the longer time goes by, recollections change and may be modified by the thinking of others. He said this is why it was important to get the RCA completed as soon as possible.

209. Dr Crompton stated nursing staff were not interviewed for either RCA, which I do not consider ideal. I have been critical in a number of inquests about the quality, timeliness and process of conducting RCAs and do not need in this case to repeat the recommendations made as a result. It seems to be an endemic issue for Queensland Health.

Analysis of the Issues

The adequacy of the supervision of SH and AW whilst in-patients in the PAH, Mental Health Unit;

210. The supervision of SH and AW was through visual observations in an open ward. They were largely on 15 minute visual observations with occasional circumstances when they were on constant observations or in the AOA.

211. If nursing staff were concerned about a patient they had the ability to increase the observations and if necessary lock the doors to East Wing and/or seek to have the patient reviewed for transfer to the locked AOA.

212. When an involuntary patient absconds a resource intensive process required a number of persons to be notified if the patient is not located within one visual observation check.

213. SH and AW were frequently leaving the ward despite not being allowed unescorted leave. On a number of occasions the respective paperwork was completed for it to be sent to the Police for them to be returned, but on each occasion they returned by their own means.

214. Despite many previous absences without leave, AW and SH both appear to have left the ward shortly after they had been sighted for the preceding 15 minute visual observation.

215. The problem in both cases is not so much related to the adequacy of the observations regime as a principle. Given they were not on constant observations the observation process was adequate to the extent it recorded their absences as they occurred. The problem relates more to the fact that the ward was not a locked ward, they were not on constant observations and they were simply able to leave. That improvements can be made is undoubted and this is considered in the recommendations.

The enforcement of orders regarding specific leave requirements made pursuant to the *Mental Health Act 2000*, which were in place at the time of the deaths of SH and AW;

216. Involuntary patients are only allowed to leave when they have a LCTO.

217. There is a policy in place for when a patient absconds. Whilst it sets out specific requirements for notification, the evidence demonstrated there is some discretion by the nursing staff and the treating psychiatrist as to the steps required and it is a judgment call on how urgent is the matter after considering how high risk the patient is.

218. RN Morgan, the current Nursing Unit Manager, advised that due to the East Wing not being a locked ward it is very difficult to restrict patients who are not permitted to leave the ward from doing so. She states, "*The only way we are able to monitor the whereabouts of consumers is by undertaking visual observations*". The recently introduced non-smoking policy has made things more difficult. Absconding takes up nursing time to undertake searches, and complete paperwork.

219. Dr Crompton is of the view that, "*It is unrealistic and impractical to expect that patients can be prevented from absconding from an open ward*". He considers the only way to decrease the prospect of patients with restricted leave from

going outside the ward is to build a better and more suitable building. Further, he says the management of frequent absconding is through a behavioural management plan, the success of which is limited by the insight and co-operation of the patient, and also relatively limited by potential positive and negative consequences, which can be utilised.

220. Dr Motamarri says in making a decision to lock an entire ward, the team needs to balance the risk of the particular patient concerned with the risk to the other patients in the ward. He says it is contrary to mental health principles of least restrictive practices and to patients' rehabilitation to completely remove them from the outside world and is generally considered to be unlikely to prevent people from leaving if they decide to do so. Further, Dr Motamarri says locking wards is conducive to feelings of entrapment which lead to anxiety, anger and frustration.

221. Dr Leggett opines for many patients, locking them in a ward is completely inappropriate from a therapeutic perspective and is likely to cause exacerbation of behavioural problems.

222. Dr Crompton and RN Morgan advised unless the patient is on constant observations the only way to monitor a patient on an ITO with leave restrictions on the East Wing is through 15 minute visual observations.

223. Dr Crompton, the Executive Director of Mental Health says the East Wing is not locked because:

    a. the current philosophy of recovery within mental health adopts a least restrictive practice for mental health patients;

    b. it is more difficult to reintegrate patients into society from a locked environment;

    c. patients who are in units which are continuously locked express the view that they feel caged in and may experience a loss of freedom/control;

    d. relatives and friends need to be "swiped" in; and

    e. a locked unit does not stop people escaping. It may in fact create a reason for patients to want to abscond if they feel caged and trapped. It may also escalate other behaviours such as aggression.

224. Both AW and SH had a habit of absconding from the East Wing despite their LCTO's. Their absences were noted and given the past history there was an expectation they would return. The usual practice was that after two observations periods being missed the absconding procedures would be put in place. An earlier implementation of those procedures would have made no difference in these cases as SH and AW both took their lives within a few minutes of leaving the ward.

225. The evidence supports absconding from the ward is a frequent if not daily event for multiple patients and is ongoing. It is certainly apparent the PAH acute wings were not suitable for long term rehabilitation clients such as AW and the building is unsuitable to adequately manage the supervision of patients who frequently abscond. A more suitable building is required for those patients. Notwithstanding the practical difficulties in preventing patients absconding from

this facility, given any new facility is some time off, it is still incumbent on PAH to review the circumstances surrounding leave entitlements and the monitoring of patient's leave. This is dealt with in the recommendations.

AW's use of and access to alcohol and drugs whilst an in-patient in the PAH Mental Health Unit;

226. On 24 September 2009, a behaviour management plan was developed for AW which was based on a PRIME audit. At the time there was only one incident concerning alcohol. The management plan did not address AW's alcohol usage.

227. The evidence shows, AW's increased intake and reliance on alcohol commenced in or around the end of October 2009. This continued to significantly escalate at the end of December 2009, beginning of January 2010. From 31 October 2009 to 10 January 2010, AW was intoxicated on eight occasions.

228. Dr Reddan was of the view AW would have benefited from a much more structured behavioural program with more clear boundaries and consequences for specific, identified behaviour. Further, Dr Reddan raised the issue of AW's access to money to purchase the alcohol.

229. Although it may be that management of alcohol and drugs in an open ward is difficult, AW's alcohol problem needed to be more actively managed. He came to the East Wing with a history of abuse of illicit drugs and became an alcoholic.

The steps taken by the PAH to negotiate the erection of safety barriers at the Buranda car park;

230. In February 2004, the Director General of Health established a Committee to undertake a review of fatal mental health sentinel events. The review was over the two year period 2002 to 2003. As a result of the review, the report 'Achieving Balance: Report of Queensland Review of Fatal Mental Health Sentinel Events' was produced.

231. Of those deaths reviewed, 26% (six) were as a result of jumping from a height. In four cases, patients had jumped from the hospital car park. One of the recommendations of the report states, "*The Princess Alexandra Hospital Health Service District reopen negotiations with the private owner of the multi-storey car park with a view to estimating the costs of erecting suitable barriers and, if necessary, contributing to the costs involved*".

232. As a result of the review, the implementation of the nine key recommendations was tasked to a steering committee over a four-year period. The relevant recommendation in relation to the car park is key recommendation 6 'Remove potential means of suicide wherever possible by implementing searching procedures in accordance with the *Mental Health Act 2000* and correcting potential structural factors in all inpatient mental health units and their immediate environment'. There is no reference to the Buranda car park in any subsequent Achieving Balance Updates.

233. Limson Investments Pty Ltd purchased the Buranda car park on 21 August 1991. Mr Limbada, a representative for the car park owner, says he recalls discussions being held with the PAH in 1993 to see if anything could be done to prevent suicides. He says ideas included bolstering security at the hospital to prevent patients from leaving the premises unauthorised, as well as erecting

barriers. Mr Limbada says he is not aware of the document 'Achieving Balance: Report of Queensland Review of Fatal Mental Health Sentinel Events' nor that any actions have been undertaken in relation to the recommendation.

234. On 5 January 2012, the Director General of Health advised that Metro South Health Service District had previously lobbied for the Buranda car park to be fenced but this has been unsuccessful on a number of occasions. He advised the then Minister for Health, had been briefed on the risk relating to the privately owned car park.

235. Subsequent to the correspondence from the Director General, the PAH has investigated this issue further and has provided additional information. I do not intend to detail the steps that have been taken, which have been set out in submissions. I am satisfied PAH has made genuine attempts to have the private car park owner enclose the car park. Unfortunately, the car park owner does not see it as its responsibility to install barriers to the car park to prevent future suicides. This is reprehensible on its part given that further lives are likely to be lost.

236. The new PAH multistorey car park on the PAH campus meets all the relevant standards and mental health legislative requirements.

237. Dr Reddan says that most mental health units or services become aware of what could be described as self-harm or suicide "hotspots" around them. She identifies the car park as such a hotspot and urges some structural alterations to the car park.

238. Dr Crompton is of the view that even if Queensland Health had the funds to pay for enclosing the car park, it would require ongoing maintenance, which would need to be budgeted for. Additionally, he says there is the issue with Queensland Health being required to pay for the installation of protective measures around other publically or privately owned facilities such as the shopping centre, Ipswich Road, the Story Bridge and the Dutton Park railway station.

239. Dr Leggett says the car park has accumulated a bad history and has achieved a symbolic cultural significance as a place of death for patients of the acute mental health service as well as others in the community. He is of the view the car park should have barriers put up to prevent people from jumping.

240. SH's father took photographs of the car park seven days following SH's death. They show a number of barriers placed sporadically around the perimeter of the building. Mr Limbada has advised Telstra installed the barriers in 1998 to protect their telecommunications equipment from vandalism. He says the barriers were only installed in areas where Telstra had telecommunications equipment and where there was a risk of vandalism. The barriers were erected at Telstra's costs. The barriers to the car park have not altered since SH's death.

241. In oral evidence, Mr Limbada recalled there have been nine to ten deaths since his company has owned the car park. He said his company generally does not have any involvement with the hospital following a death. Mr Limbada said the cashier from the car park usually rings QPS and security at the hospital when there has been an incident. The cashier is present from 6am to 11.30pm Monday to Friday and 12 to 8.30pm on weekends.

242. Mr Limbada does not recall any discussions with the hospital after 1993 when the matter of the safety barriers was raised with him. The evidence would suggest this is not an accurate representation of the facts. He does remember some discussions in 2005 concerning closing the air bridge due to renovations at the hospital. He does not recall these discussions including anything about safety barriers for the car park. Mr Limbada said he has never obtained a quotation for installing barriers on levels 5 to 7. Mr Limbada said the closure of the air bridge in 2005 due to renovations at the PAH affected 30% of his revenue. However, in response to a suggestion that the air bridge be closed again, he said it would not affect his revenue, as people would cross over Ipswich Road

243. Mr Limbada confirmed he has never had an audit/risk assessment completed under the *Workplace Health and Safety Act 1995* but does a check list for his insurance company every year. Further, he has not made any enquiries with the Brisbane City Council about undertaking rectification work to the car park to install safety barriers as he left this to the responsibility of the PAH.

244. Mr Rebetzke, of Counsel has made an interesting and persuasive submission that the continued failure by the company to properly manage exposure to the risk by the installation of preventative barriers is a breach of the *Workplace Health and Safety Act 1995* and is arguably an offence. The risk is not only to those persons with a psychiatric illness who use the car park as a means to take their own lives, but the risk is also to the company's employees, customers and to those who are passing by.

245. I intend to refer the findings from this inquest to Workplace Health & Safety Queensland.

The adequacy of the relevant Princess Alexandra Hospital policies and procedures

Supervision of Patients

246. RN Morgan advised if a patient goes missing, the usual practice is:

   a. Nursing staff will ask other team members if they know the whereabouts of the patient;

   b. If the patient cannot be located, the nurse in charge is notified whilst a more thorough search of the surrounds is completed;

   c. The patient is contacted on their mobile phone and their next of kin is contacted;

   d. The patient's psychiatrist or on call registrar is notified and a decision is made about what steps should be taken, depending on the perceived risk;

   e. If high risk, security is notified and conducts a search of the grounds, if low risk, the psychiatrist may give the patient a further 10-15 minutes to return to the ward before security and the paperwork for the police is completed;

   f. The Emergency Department is notified and a PRIME report commenced (usually staff have heard back from security at this time);

g. Depending on the discussions with the psychiatrist, if the patient has not returned within the allocated time a 'Return to Authorised Mental Health Service' form is completed by the allocated nurse in charge, signed by a medical practitioner, and faxed to the QPS Command Centre (there can be a delay in having the form signed by a doctor); and

h. The QPS then becomes responsible for returning the patient to the ward.

247. RN Morgan estimates staff would usually complete at least one or frequently more 'Return to Authorised Mental Health Service' forms a day and often a number of times in relation to the same patient. Further, she advises that since PAH became a smoke free environment on 1 July 2012, the number of patients absent without leave and the time spent searching for patients has increased. This is due to there being no designated smoking area on the hospital grounds and patients being directed to go down to Ipswich Road or Cornwall Street to smoke. She states, "*There is quite a large area to search and searching takes nursing staff away form their other clinical duties within the ward for much longer periods"*.

248. The PAH Policy 'Missing Patient (Unauthorised Absence)' of January 2005 indicates if an involuntary patient is missing and not located within one visual observations check, security conduct a search of the grounds and buildings. The secondary action is for the nurse to contact the nurse in charge of the shift, the after hours nurse coordinators (who will notify the ADON and Executive Director of Medical Services) psychiatry registrar, any relevant third party where safety may be an issue, and police.

249. The PAH Policy 'Missing Patient (Unauthorised Absence)' of October 2009 is in effect the same but adds additional persons who are to be notified. Instead of police, it states the Dutton Park Police, the Warrant Bureau, the Police Communications and Princess Alexandra Hospital Mental Health Act Delegate, the Emergency Department Mental Health Team, and the Mental Health Triage.

250. Despite this policy it was generally not followed in practice. Dr Leggett states, "*when I am contacted about a missing patient, I make an informal subjective risk assessment. If a patient is high risk, an Authority to return is faxed immediately after a short but thorough search of the unit. However, with a low risk patient who is known to wander off for a cigarette, there is a little room for judgement and discretion. Efforts are made to contact the patient and/or their family. Staff members and Security will look around the hospital ground and smoking areas, now outside the hospital grounds*".

251. RN Tepairi said in oral evidence that 15 minutes was a short amount of time and that it could take that long to search the ward. She said that if the patient was not assessed as high risk it was common to allow 30 minutes as the patient may be out buying cigarettes. Further, RN Tepairi advised it was possible to have several frequent absconders on a ward and that patients can abscond more that once per shift.

252. RN Morgan acknowledged the current practice on the ward concerning absconding patients is inconsistent with the policy and that it is difficult for nursing staff to follow the policy. The policy did not reflect the practice at the time of AW and SH's death and does not reflect current practice.

Alcohol and Drugs

253. Alcohol and Drugs are not permitted on hospital grounds. There is a sign at the main entrance of the ward that stipulates this. Upon admission to the ward patients are advised that drugs and alcohol are prohibited. This is also made clear in the Consumer Orientation booklet. During the admission process a patient's belongings are searched. After admission it is difficult for nursing staff to keep track of other items brought in by the patients or their visitors.

254. RN Morgan states, "*As many of the consumers in the East Wing of the Mental Health Unit have drug and/or alcohol problems, managing the use of those substances in an open ward is incredibly difficult particularly when a consumer's friends or families visit and can bring prohibited items into the East Wing of the Mental Health Unit without staff knowledge*".

255. If a visitor is found to be supplying drugs or alcohol they are asked to leave and can be banned from the ward. If staff members have reasonable suspicion that a patient has consumed drugs or alcohol, staff can search a patient's belongings. Two staff must be present during the search and if any contraband is found, it is reported to the nurse in charge. RN Morgan says a physical search does not occur on a frequent basis with no more than a dozen each year.

256. The policy at the time of AW's death and the current policy both indicate that a patient is informed they will be breathalysed if alcohol consumption is suspected and may subsequently be discharged. In AW's case this was not possible as he was on a Forensic Order. The policy also states, "*All consumers with alcohol co-morbidity will have an up to date recovery plan that includes referral to Dual Diagnosis services, regular risk screening and management of alcohol whilst an inpatient*".

257. In the last six weeks of AW's life his dependence and consumption of alcohol significantly increased. Whilst there was a referral to dual diagnosis there was no structured behavioural management plan instigated, including investigating where and how AW was obtaining alcohol.

258. Accepting there are practical difficulties to stop alcohol being brought into the ward, AW's consumption of alcohol was very significant. The continual breaches meant he was possibly never going to be able to satisfy the requirements of the MHRT and this needed to be addressed for his future. It was not.

The adequacy of the patient handover between staff on the East Wing

259. Evidence was heard that unless there was a specific concern about a patient their leave status was not generally handed over to staff. It was confirmed there is not a single updated document (that contains details for all patients) in existence that a nurse is able to access, to establish whether a patient is voluntary or involuntary nor the leave requirement for each particular patient.

260. RN Morgan advised that since the deaths of SH and AW a typed handover sheet is being used. Whilst this has the involuntary and voluntary status of the patient is recorded, it does not set out a patient's leave restrictions.

261. Nursing and administration staff were not provided with pertinent information at the commencement of their shift and had to go to a separate folder in the unit to establish what leave entitlement a patient could or could not have.

Nursing responsibilities when a patient threatens suicide

262. RN Tepairi said it was sometimes common for patients to threaten to jump off the car park. She was of the opinion a doctor should always be notified in these cases. She felt this action was warranted even if the nurse thought it was an empty threat.

263. Acting CN McKenzie said the Nurse in Charge expects a nurse to inform them of any threats of suicide and could not think of an exception to this. He said even if the nurse thought the threat to be a hollow threat or said in anger, the patient needs to be assessed. He said he would seek a review by a psychiatrist, review the chart, and establish the context in which the threat has arisen in order to determine if the patient's mental health is deteriorating.

264. Dr Reddan and Dr Smith were of the opinion that if a patient makes a threat, the patient should be assessed. This did not occur in SH's case and it should have. Dr Reddan's opinion was nobody will ever know if such an assessment would have made any difference in the outcome for SH.

The appropriateness of accommodation for forensic order patients

265. Dr Motamarri believed that as AW became well, staying in hospital was counter productive and that it was countering the effects of his treatment. This was particularly in relation to AW's frustration, which became difficult to manage as an in-patient.

266. Dr Motamarri explained that AW's legal status was dictating his treatment and there were limited options. One alternative was placement in a medium secure unit, such as The Park. At the close of oral evidence, Dr Motamarri was asked to provide an additional statement concerning The Park.

267. Dr Motamarri has advised that The Park has medium and high secure units and caters for patients who have chronic mental illness. The aim of the facility is to assist with the rehabilitation process for chronic mental illness. He says from his experience that there is a long waiting list of about 12 months or more. Dr Motamarri explained the entertainment and leisure activities are very limited at the PAH and not conducive to rehabilitation. The medium secure unit at The Park is more open, has grassed area, has case workers to take patients into the community and offers rehabilitation programs.

268. Dr Hlincikova had previously worked at The Park. She advised that it was more conducive to rehabilitation, it was secure and therefore patients and visitors were searched on arrival, which reduced the problem of alcohol and drug misuse. Further, she advised there were greater rehabilitation resources, which included more staff, psychologists, occupational therapists and a number of different therapies. She believed AW would have met the criteria for medium security but acknowledged there was a waiting list due to the large catchment area The Park is required to cover.

269. Dr Crompton was of the opinion a medium secure unit would have been more appropriate for AW but said The Park supports a population of 1.75 million with only 25 to 30 beds available at any one time. Dr Crompton advised that the PAH mental health facility was not designed for long periods of stay and said

the average length of stay was between 10.9 and 12.9 days. His preference would be for Forensic Order patients to be placed in a more suitable facility and that the 2nd stage of the Mental Health Plan was for a Medium Secure Unit in Metro South. Dr Crompton said he is unsure what will now occur with these proposed plans due to the recent changes which have occurred in Queensland Health.

270. Dr Reddan is of the opinion there should be more interaction between The Park and Mental Health Services when arranging the swapping of patients to encourage wise use of an expensive resource and that the Director of Mental Health needs to look into this. She considers AW would have benefited from The Park in the few months when he was psychotic, which may have enhanced his recovery and facilitated his transfer back to PAH for graduated leave.

271. The evidence supports a finding that the length of AW's stay in the acute mental health unit was counter productive to his recovery. There may have been difficulties given the orders of the MHRT and the resources available to them but interaction and engagement with the MHRT and The Park may have resulted in other options being considered for AW at an earlier stage in his hospitalisation.

272. Subsequent to the completion of the evidence at the inquest I requested PAH provide me with further information concerning The Queensland Plan for Mental Health 2007-2017. The plan recognises that access to the right care and support at the appropriate time is important for people living with mental illness.

273. A secure mental health rehabilitation unit (SMHRU) located at the PAH was not funded under stage one of the plan. The SMHRU for Metro South was identified as a high priority initiative in stage two in the preliminary evaluation conducted in 2010. This was intended to be included in the funding submission to the Queensland Government. It is understood that the evaluation study initially considered an option on the Princess Alexandra Hospital site although alternative sites within the Metro South Health Service District including a unit at Redland Hospital, Logan hospital and QE2 hospital were also identified.

274. Whatever is the case the East Wing was totally unsuitable for rehabilitation needs for AW. The only other suitable facility was The Park, which simply did not have sufficient beds to cover the whole population for the district. A medium secure unit was incorporated in the Queensland Plan for Mental Health for the district. It matters not whether it was at one particular hospital or another. What is important is that the facility is provided.

275. However it is understood Queensland Health has not yet been invited to provide a funding submission for stage two. That should be progressed as soon as possible.

The appropriateness of accommodation for female psychiatric patients following the birth of a child

276. Dr Leggett addressed the issue of the lack of access to a Specialised Mother and Infant Care Unit for public patients. He indicated such units allowed for patients with mental illness to care for their newborn babies with a high level of assistance and supervision with the necessary medical care for the babies and specialised therapeutic attention to attachment problems.

277. Dr Leggett was of the opinion that what occurred with SH was not optimal and that she is likely to have required more assistance and supervision with bonding and infant care following such a traumatic separation as occurred.

278. Dr Leggett also raised the issue of the suitability of the unit generally having regard for the safety of young vulnerable women, given the unit was mostly populated by males, many on Forensic Orders, some with a history of aggression and violent offences. He considered the unit was a sub optimal therapeutic environment, particularly for a patient with a polysubstance abuse history.

279. Dr Crompton advised he is only aware of one Mother-Infant Unit which is at Belmont Private Hospital. He also thought there could be one at Prince Charles Hospital. Dr Smith advised there was such a unit at St John of God Hospital where he consulted. The idea of such units is for a nurse to remain in the room with the patient and her baby to supervise the interactions.

280. Dr Crompton said there have been other mothers who have been transferred from the PAH Mental Health Unit to the Mater to give birth and then return. He recalls one occasion where it was negotiated that the mother could stay at the Mater with a staff member from the PAH. He explained it was difficult to organise as PAH was separate to the Mater and there were difficulties in staffing and establishing responsibilities between the two organisations.

281. SH's mother advised that she and SH thought SH would be staying at the Mater after the birth of the baby and were surprised when she was transferred back to the PAH within hours of the birth. Dr Smith said this would have been a psychological blow to any mother. It is difficult to establish whether having some further time with her baby prior to transfer back to the PAH would have made any difference in the circumstances of this case.

282. It is noted that initial planning for stage two implementation of The Queensland Plan for Mental Health 2007-2017 identified the need to establish specialised mother-infant inpatient mental health units across Queensland. During a cost benefit analysis of the proposed health service expenditure a 14 bed facility at the Prince Charles Hospital was supported. That at least should be progressed as soon as possible.

Conclusions

283. These deaths have identified a multitude of complex and difficult issues. The investigation initially focused on the adequacy of the observations and supervision of SH and AW whilst they were the subject of Involuntary Treatment Orders and Forensic Orders. The inquest has revealed there are significant practical difficulties arising from the physical layout of the East Wing, and given it was an open unit this made it difficult to enforce orders that were meant to prevent SH and AW from leaving the ward. The evidence is that they both left the ward frequently but then returned.

284. The evidence supports a finding in relation to SH that more should have been done after she gave birth and particularly on the day she took her own life. She had a long-term serious mental illness. She had recently given birth to a child who had been removed from her within 3 hours of the birth. No-one considered that she might be susceptible to or be suffering from post-partum depression or psychosis or that her immediate removal from her baby would induce the same. She was returned to a different hospital to where the baby was being cared for.

She had a realistic expectation she was going to be released from hospital and that she and her mother were going to care for the baby. There was evidence of deterioration in her condition. There had been a recent change in medication. She was told that her expected discharge from hospital was to be delayed. She was angry about this. On the day of her death she told two nurses of a threat to jump off the Buranda car park. She had been a frequent absconder from the ward notwithstanding her leave orders required escorted leave and she was on a 15 min observation regime. No-one conducted a risk assessment that day and she was not reviewed by a psychiatrist or mental health nurse. Even with the benefit of hindsight it is surprising no-one thought to join all of these dots together and, consider escalating these issues.

285. What would have occurred as a result of any escalation or review is uncertain, but it should have been undertaken. It may have resulted in SH being placed under constant observations, which could have prevented her from leaving the ward on that day. It may have been as simple as opening up a dialogue between mental health staff and SH, which changed the course, at least on that day.

286. AW had been very unwell when he first entered the acute unit. To some extent his psychosis had receded but he was the subject of a Forensic Order which limited the options for the treating team until the order was changed. He remained in the acute unit for 462 days. The East Wing was an unsatisfactory physical and treatment environment for a young man such as AW. The average stay in the acute unit was 12 days. AW should have been treated much earlier in a medium secure unit which provided better rehabilitation facilities and was appropriately secure to prevent patients absconding. It would have been hoped, although it is difficult to be absolute about this, that rehabilitation in a more suitable facility could have seen his introduction to community treatment well before the day of his death. The only such facility was The Park but it was difficult to access this unit given it catered for a large population.

287. Although AW's psychosis abated during his stay at the unit, he became an alcoholic. As the East Wing was not a locked ward, staff appeared to be powerless to prevent him from frequently absconding and in the latter part of his stay, obtaining alcohol. This breached his Forensic Order in a number of respects. As a result the treating team was unable to obtain the necessary changes to the Forensic Order to permit his treatment in the community, where the treating team believed further improvement in his mental state and living skills would be best achieved.

288. Although the East Wing was an unsuitable environment for AW's appropriate rehabilitation, it is evident that given he was remaining there, something had to be done and more structured behavioural programs should have been implemented to assist in AW's alcohol problem. They were vaguely considered but not to the extent required to make any real progress.

289. On the day of his death AW was showing signs of anxiety and distress. He was to appear before the Mental Health Review Tribunal that afternoon and he would have been well aware it was unlikely there would be any change. It was not a coincidence that he took his own life that day in that context. I accept the signs were not sufficient to predict AW was going to take his own life that day, but earlier rehabilitation at a suitable facility and a more structured behavioural program may have meant he would not have been put in that position.

Findings required by s45

290. In accordance with section 45 of the *Coroners Act 2003* ('the Act'), a coroner who is investigating a suspected death must, if possible, make certain findings.

291. On the basis of the evidence presented at the inquest, I am able to make the following findings:

The Death of SH

a. the identity of the deceased person was SH;

b. SH died as a result of suicide by jumping off the Buranda car park after suffering a prolonged mental illness. On the day of her death she had threatened this very event. She should have been reviewed by mental health staff as to her risk of suicide given her other vulnerabilities, but was not. There is no evidence of suspicious third party involvement directly into her death;

c. the date of her death was 25 April 2009;

d. the place of her death was the bottom of the Buranda car park located at 250 Ipswich Road, Woolloongabba, Brisbane;

e. the cause of death was:

   i. chest injuries, due to, or a consequence of;
   ii. fall from height.

The Death of AW

a. the identity of the deceased person was AW ;

b. AW died as a result of suicide by jumping off the Buranda car park after suffering a prolonged mental illness. He had been treated in the acute East Wing for 462 days and was under a Forensic Order. The East Wing was an unsuitable facility for the treatment of a young man on a long term basis. He was anxious about his unlikely prospects of release from this facility as he was to appear before the Mental Health Review Tribunal later that day. It was in that context that he made a decision to take his own life;

c. the date of death was 2 February 2010;

d. the place of his death was the bottom of the Buranda car park located at 250 Ipswich Road, Woolloongabba, Brisbane;

e. the cause of death was:

   i. multiple injuries, due to, or a consequence of;
   ii. fall from height.

Recommendations in accordance with s46

292. Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to:

a. public health and safety,

b. the administration of justice, or

c. ways to prevent deaths from happening in similar circumstances in the future.

293. Ms Zerner provided a comprehensive and thoughtful list of recommendations that could be considered. I have also had the benefit of the other Counsels' submissions on these matters. In particular, Ms Callaghan has responded on behalf of the State of Queensland and Metro South on a number of the recommendations that impacted on it and broad agreement on Ms Zerner's suggested recommendations was reached. I am grateful for Metro South's consideration of and approach to the recommendations. There is disagreement with any proposed review of the no smoking policy. I accept that position. The policy needs to consider special management for the cohort of mental health patients who are not permitted unescorted leave and smoke, but otherwise there are not sufficiently good reasons to abandon it as a substantive policy.

294. Ms Callaghan also noted that the Queensland Mental Health Commission Bill was introduced to Parliament in November 2012, which includes proposed amendments to the *Mental Health Act 2000*. The proposed amendments include provisions to enable monitoring of a patient's location while on limited community treatment for those on forensic or classified orders. I agree with Ms Callaghan's submission that there may be strong policy reasons why any expansion of monitoring provisions should not include patients on involuntary treatment orders in an open ward environment.

Metro South Mental Health Service

295. It is therefore recommended that Metro South Mental Health Services:

(1) Communicate with the Chief Psychiatrist in relation to the current policy for missing consumers (unauthorised absence) seeking advice as to whether this policy should be altered (anticipating that any change to the current policy may be linked to a review of the *Mental Health Act 2000*). In the meantime Metro South is to undertake a review of its current procedures in relation to implementing this policy with particular reference to strategies to assist in the management of repeat absconders, the management of the no smoking procedures within the service and the current escalation processes;

(2) Conduct a three month trial of the provision of a leave book or register to be signed by each patient who is leaving the ward to ascertain whether any such changes modify patient behaviour and the capacity of staff to monitor and support the missing persons procedure;

(3) Undertake a review into possible technological aides which could be used to assist staff in managing repeat absconders in an open ward environment (that is, providing some form of intermediate supervision between AOA/constant observations and an open ward environment);

(4) Continue the clinical transformation process which is committed to the development and implementation of strategies to identify and manage the deteriorating patient with respect to their mental and physical health. I note that this process is well advanced and it is expected that a report will be provided to Metro South in early 2013. I welcome the offer of being provided

a copy of the report and regular advice as to its implementation and training of staff;

(5) It is noted that Metro South is awaiting the implementation of a journey board system providing online details with respect to a patient's admission status, expected date of discharge, Mental Health Act status and frequency of visual observations. Pending implementation the Director of Nursing will be requested to utilise a photographic identification process for patients with the requirement that this be connected to the handover sheet for each nurse, which document is also to include leave entitlements.;

(6) Ensure any scheduled MHRT reviews are entered on the current whiteboard system and ultimately on the proposed journey board;

(7) Review the practicality of providing reception staff with a copy of the visual observation photo board so they are aware of which patients can or cannot leave the ward;

(8) Ensure there are specific individual behavioural management plans for excessive alcohol and drug use by those patients, who cannot be discharged. Such individual plans may include the clinical team implementing a structured program of searches, regular breathalysing, and limiting the patient's access to money (where there is a legal entitlement to do so);

(9) Seek agreement by way of an MOU or similar agreement between Metro South Health Services and the Mater Hospital concerning the management of female psychiatric patients giving birth to promote mothers being able to stay with their baby for a reasonable period after the birth of a child;

(10) Queensland Health is conducting in 2013 a review of the Mental Health Mortality Report. During that process Queensland Health, as well as Metro South should review the practical and legal implications for the inclusion of written statements from medical and nursing staff caring for the patient at the time of the death (to assist the RCA process and any subsequent investigations such as a coronial inquest).

Stage 2 Queensland Plan for Mental Health 2007-2017

(11) It is recommended the Queensland Government progress Stage 2 of the Mental Health Plan to provide a Medium Secure Unit for Metro South Mental Health Services; and

(12) It is recommended the Queensland Government progress Stage 2 of the Mental Health Plan to include the development of a Specialised Mother and Infant Unit for public psychiatric patients.

Buranda Carpark

296. It is recommended Limson Investments Pty Ltd install appropriate barriers to the Buranda car park in attempt to prevent future suicides from the car park.

297. A copy of these findings will be provided to the chief executive of Workplace Health and Safety Queensland pursuant to section 48(2)(b) by way of information in which I reasonably suspect a person has committed an offence.

Exercise discretion of the Coroner to refer hospital staff in accordance with s. 48(4)

298. Section 48(4) of the Act gives a Coroner discretion to refer information about a person's professional conduct to the relevant professional disciplinary body if the coroner reasonably believes the information might cause that body to inquire into or take steps in relation to conduct.

299. I agree with the submissions of Ms Zerner that the circumstances leading up to these two deaths do not warrant the referral of any treating staff to any Health Practitioner Board.

This inquest examined in much detail the circumstances of the deaths of SH and AW and my condolences are offered to their family and friends. I have not forgotten this investigation also considered the deaths of ST and WF and my condolences are expressed to each of their family and friends.

John Lock
Brisbane Coroner
25 January 2013