QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Mrs B**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Northern Coroner
FILE NO(s):	2008/265
DELIVERED ON:	2 July 2013
DELIVERED AT:	Cairns
HEARING DATE(s):	26 June; 16 July; 17 August; 6 September; 10 -12 October 2012.
FINDINGS OF:	Kevin Priestly, Coroner
CATCHWORDS:	Inquest, involuntary patient, Mental Health Unit, Cairns Base Hospital, absconding and suicide, management of risk of absconding.

REPRESENTATION:

Counsel Assisting:	Ms S Williams i/b Office of the Northern Coroner
Queensland Health:	Ms S Gallagher, i/b Cairns & Hinterland Hospital & Health Service

Introduction

Mrs B was 52 years of age and resided with her husband, Mr B, near Innisfail. She had two adult children from an earlier relationship.

On the morning of 15 March 2008 Mrs B was found hanging by a rope in an undercover area on the northern side of the Cairns Showgrounds. Police and QAS officers were called and attended, confirming Mrs B was deceased. Police conducted a scene investigation and found a suicide note and a handbag containing printed instructions on how to tie a noose. A ladder was found nearby. Police also located a coke bottle and a bottle of Jim Beam. Police concluded there were no suspicious circumstances.

Mrs B absconded from the Mental Health Unit at Cairns Base Hospital at about 3.30pm on 14 March 2008, moments after a psychiatric review concluded she was at no acute risk of suicide. At 4.20pm, Mrs B purchased the rope and stepladder from a Bunning's store opposite the showgrounds. Her movements thereafter could not be established.

On 18 March 2008 Dr Paul Botterill conducted an autopsy and confirmed that death was due to hanging. He reported that testing for drugs and poisons showed the presence of a number of sedatives (diazepam, and metabolite, oxazepam, temazepam), and prescribed mood-altering treatments (olanzapine and quetiapine) at blood levels below the reported respective toxic or even therapeutic ranges. The blood alcohol level was 0.058% in road traffic terms. That level was not sufficient to significantly impair skills such as the creation and placement of a knot.

A Coroner is required to make findings about who, when, where, how and what caused a person's death. Although the present facts are sufficient to address most of these matters, further investigation was required about how Mrs B died. A Coroner may also consider what lessons might be learnt from a death with a view to preventing further deaths in similar circumstances.

The circumstances of the death of Mrs B give rise to issues about how the risk of absconding and suicide was managed. Her mental health history and management during the last admission requires closer examination.

Mental Health History

Mrs B had a long mental health history that included at least three attempts at suicide. There were a number of moves through her history. Her first mental health admission to hospital was in 1991 in Fremantle, Western Australia. There was a move to Broome in 1994. She first came into contact with mental health services in Queensland shortly after moving to Cooktown in 2001. She moved to Innisfail in 2003.

There were numerous admissions for psychiatric treatment with inpatient admissions from 1990 with various diagnoses, including:

- 3 to 6 December 1991 - Graylands Psychiatric Unit, WA
- 3-7 July 1994 - Heathcote Psychiatric Unit, WA- acute situational crisis
- 11-18 July 1994 - Fremantle Hospital Psychiatric Unit, WA - borderline personality traits
- 12 November to 16 December 1996 - Fremantle Psychiatric Unit, WA - chronic dysthymia, query major depression, borderline personality traits.
- 15 October to 3 November 1997 - Fremantle Psychiatric Unit, WA - major depression with severe agitation, generalised anxiety, and obsessional, narcissistic and borderline

personality traits.

- 17-18 December 1999 - Fremantle Hospital, WA - pseudosiezures, borderline personality and anxiety.
- 22 September to 16 October 2000 - Graylands Psychiatric Hospital, WA - recurrent depressive disorder, obsessional narcissistic and borderline personality traits, recurrent alcohol abuse.
- 11 September 2001 - Cooktown Hospital, Qld - outpatient review, Dr Hunter, Psychiatrist - recurrent depressive disorder and post traumatic stress disorder with differential diagnoses of manic-depressive disorder and personality disorder not otherwise specified.
- 10 -16 October 2001 - Cairns Base Hospital, Mental Health Unit - suicidal ideation, chronic dysthymia, cluster b vulnerabilities.
- 3-10 January 2002 - Cairns Base Hospital, Mental Health Unit - borderline personality disorder and major depression.
- 21-22 January 2002 - Cairns Base Hospital, Mental Health Unit - borderline personality disorder.
- 11-19 June 2003 - Cairns Base Hospital, Mental Health Unit - depression with suicidal intent and borderline personality traits
- 6-23 January 2004 - Cairns Base Hospital, Mental Health Unit - bipolar affective disorder and depressive episode.
- 3-31 July 2007 - Cairns Base Hospital, Mental Health Unit - recurrent major depressive disorder and borderline personality traits - Dr Achim Lider
- 20, August 2007 - Cairns Base Hospital, Mental Health Unit, day patient, ECT
- 3 September 2007- Cairns Base Hospital, Mental Health Unit, day patient, ECT

The Mental Health Unit

Before considering the more recent clinical narrative, the reader needs an understanding of the physical setting and operational practices of the Mental Health Unit at Cairns Base Hospital was Mrs B was assessed and treated in recent times. The evidence relevant to this aspect of the case is common with and was heard at the same time as the inquest into the death of Jonathon Saccu. The evidence is the same and the following paragraphs under this heading are identical to those appearing in my findings in that death.

The Mental Health Unit is situated at the south eastern corner of the hospital complex, adjacent to Lake and Kerwin Streets. The main entrance is located on Lake Street. As you enter the Unit, there is a hallway that gradually opens towards the body of the Unit. There is a nurse's station with reasonable line of sight of persons passing to and from the entrance. At night, the entrance is locked against entry but retains its exit capacity. It was through this entrance that Mrs B departed the Unit.

The 38 bed Mental Health Unit comprises a Low Dependency Unit (LDU) consisting of 25 beds, a Special Purpose Unit within the LDU consisting of another 5 beds, and the locked Psychiatric Intensive Care Unit (PICU or high dependency unit) consisting of eight beds. There were three shifts; the early shift from 7am to 3.30pm, the late shift from 2.30pm to 11pm, and the night shift from 10.45pm to 7.15am. The overlaps allow for nursing handovers.

Dr Bayley is the Clinical Director of Cairns and Hinterland Mental Health Service. She started with Cairns Base Hospital in 1998 when the Unit moved into its current location. It then had 30 beds and averaged an occupancy rate of about 75%. She described the environment as spacious and therapeutic, an easy unit to manage. Dr Bayley started as Clinical Director in 2003

and reported that in 2004/2005 there started a trend of increasing numbers of patients, 'general emergency department presentations have gone sky high over the years and mental health presentations have consequently also gone up'. She said that the Unit now had 38 beds in the same footprint with occupancy rates of 106%. Dr Bayley told the court:

> We have a very difficult situation where we're managing trying to provide the best service we can to our patients who are ill with an under resourced system, so we have a number of patients awaiting beds in ED at any one time, and it's - it's regrettable. It's actually quite stressful now. So around about - a couple of years before Mr Saccu came in it started to get quite busy, and the staffing was - we were always trying to play catch-up with the amount of staff that we had. And it's also been incredibly difficult to get permanent, well-trained staff, you know, medical and nursing, in a regional area.

Patient security was managed by an escalating range of security measures from virtually absent in low risk situations (periodic visual observations every 30 minutes in an open unit) to very intense and strict in a high risk situations (constant visual observation in a locked unit). There are three levels of observations:

- category A – constant visual observations – one to one observations by special nurse appointed;
- category B – intermittent visual observation every 15 min; and
- category C - intermittent visual observation every 30 min.

The level of observation of each patient is reviewed on a daily basis.

The observations are conducted by nursing staff. A Clinical Nurse will allocate each nurse a specific time during their shift to complete and record visual observations of all patients over a two hour period. The nurse conducting the observations is required to identify each patient at least once within each period of observation, and then note at the end of that half hour period that they have conducted that observation.

Mr Sweeney, Director of Nursing, reported in his statement:

> Properly conducting the observation necessarily requires that the staff member identify the consumer the subject of the observation. Most consumers are photographed upon admission and a copy of the photograph is contained in the patient file. If a staff member is unsure about the identity of any consumer then that staff member can refer to the photograph for confirmation. Occasionally, a consumer will refuse to be photographed. In that event, the staff member conducting observations would be required to inspect the consumer's admission bracelet to confirm his or her identity.
>
> The conduct of observations is not intended to be a passive undertaking. Indeed, staff are encouraged to have interactions with consumers when performing the observations…

The mental health unit has CCTV cameras positioned at the front door, communal areas, courtyard and PICU. There are four monitors, two located on the wall of the nurse's station and two located on a wall in the PICU office. All monitors are divided into four sections to simultaneously show four different areas of the mental health unit on one screen. They are positioned so that they can be viewed only by staff members and not by the public or patients.

Recent Clinical Narrative

The admissions from July 2007 through to Mrs B's last admission in March 2008 require closer analysis.

Mrs B was admitted to Cairns Base Hospital on 3 July 2007. The following day Mr Lider, then Registrar, reviewed Mrs B with Dr Paterson as scribe. Detailed notes were made of that assessment. A detailed history was taken. Dr Paterson noted from Mrs B's history that she was chronically suicidal and that her most recent episode of agitated and depressed mood lasted 'from last year' to a recent trip to Thailand which she did not enjoy. She was 'chronically preoccupied' with suicidality and this could 'stray' unpredictably into action. Mrs B detailed past attempts at suicide. She also related a history of treatment that included anti-depressants that 'didn't help' and ECT that provided transient help. Mrs B reported thinking and rehearsing a murder suicide scenario – she wanted to shoot her husband then herself. The closest she had come to acting on the impulse was holding a gun in her hands. I note appropriate precautionary steps were taken in response to this disclosure. Mrs B fully understood her thinking was homicidal. It was noted that her judgement was rational and she understood right from wrong. There were no psychotic symptoms and she was noted as 'not actively suicidal'. A mental state examination was conducted and notes made of the results. There were no delusions or hallucinations reported. Another note was made about chronic suicidality. The assessment concluded with a plan for further investigation. There was an acknowledgement of a need to exclude treatment resistant depression. The presence of significant cluster B pathology was noted. The risk of suicide was assessed at medium 'in the setting of ? poor impulse control'. The risk of absconding was also noted. The entry concluded, "Monitor this patients level of risk carefully".

The next nursing entry after the psychiatric assessment was made at 1.40pm and noted Mrs B reporting, in the context of a discussion about a history of suicidal thoughts, she would 'love to just run out of the unit now and get a big knife and slash my wrists'.

On 5 July, there is another lengthy entry in Mrs B's medical records made either during or after Dr Paterson assesses her. More history about her childhood and relationships was elicited. This was presumably to further investigate whether the history supported a cluster B pathology (borderline personality disorder). A mental state examination was conducted. Reference is made to Mrs B not being 'actively suicidal'. The diagnosis of borderline personality disorder is noted.

The next nursing note refers to Mrs B reporting she wants to leave the unit, knows how to slip past the nurses station and guard. She will then buy a knife, go somewhere and finish it off. The nurse concluded her note with a risk assessment of medium for absconding and high for suicide.

The following day, Dr Paterson discussed the case with Dr Stephenson, Consultant Psychiatrist and the decision was made to offer Mrs B ECT notwithstanding only 'transient help' last time.

Throughout these assessments, Mrs B remained on 'Cat B' observations.

The medical notes suggest that Mrs B settled on the ward when there was a treatment plan in place.

However, on the afternoon of 7 July Mrs B absconded. The circumstances of her return are not

noted other than she was brought in by ambulance to the Emergency Department, intoxicated (0.25) with lacerations to the left forearm. Dr Bates, Principal House Officer, reviewed Mrs B on her return to the Mental Health Unit. After noting the nature and extent of her injuries, he recorded the following entries under the heading suicidality:

> Acute
> Impulsive act
> Unable to explain thoughts apart from 'just wanted to get out of ward'
> Still agreeable to ECT on Monday
> Unable to assure safety

Mrs B was transferred to the Psychiatric Intensive Care Unit (PICU) as she remained a high risk of absconding and suicide.

The next nursing entry (8.30pm) records that Mrs B looked the nurse in the eye and said, "Next time I will do it right' and "If I get the chance tonight, I will do it right". She remained in PICU.

Mrs B was regarded as 'actively suicidal' the following day (8 July) in the sense that she expressed anger about her failed attempt at suicide. She remained in PICU on Cat B observations during the morning. However, in the afternoon, she was transferred to the Low Dependency Unit (LDU). The nursing notes of conversations with Mrs B suggest her thoughts remained on suicide. However, she also spoke in positive terms about ECT with an ECT maintenance program that might help with longer-term benefit.

Dr Bates re-assessed Mrs B on 9 July, his first opportunity since her absconding and he immediately canvassed the circumstances surrounding that event. He noted:

> Chronic unchanged suicidality, with history of acting out when admitted.
> Unpredictable suicidal gestures/attempts in setting of chronic fixation on suicide.
> Presently not actively suicidal.

He also noted:

> Monitor risk (high long term suicide and absconding risk – though latter is unpredictable – she is presently unco-operative).

Dr Bates noted he intended to discuss the matter with Dr Lider.

Although Dr Bates left Mrs B as Cat B in LDU, he concluded his entry with the note, " ? Threshold for PICU".

The entries through to 13 July contain references to continuing suicidal ideation including expression of details about manner of taking her life. A psychiatric review on that date refers to an unpredictable but chronic high risk of impulsive self-harm.

Dr Paterson reviewed Mrs B on 16 July and continued her Cat B observations until the risk changed. Over the following days, although there were occasional references to the term suicidal ideation, it was less frequent and not accompanied by any details about how. Further, Mrs B was allowed leave from the Unit for a group (escorted) walk. ECT treatments were continuing at that stage. By 19 July, assessment recorded Mrs B was not actively suicidal and her observations were reduced to Cat C, half hourly. The frequency of intermittent references to suicidal thoughts appears to significantly lessen in the following days. Mrs B was recorded as

enjoying visitors and walks on the Esplanade.

On 25 July, Mrs B is administered ECT number 7 and discharge planning is started. Suicidal ideation is denied. Mrs B was allowed home on weekend leave, returning on 29 July. Her final ECT was on 30 July and Mrs B was discharged home on 31 July. She was managed on discharge through Community Mental Health at Innisfail. Dr Paterson completed the discharge summary and reported the principal diagnosis was recurrent major depressive disorder with the additional diagnosis of borderline personality traits. The treatment plan included a high dose of Efexor and maintenance ECT.

On 29 September there was a change in medication. Mrs B later reported problems with hypersalivation, jaw movements, toothache and anxiety.

By December 2007, she reported she had stopped taking her medication, she was worn out and fed up with life. When asked about admission to hospital under an Intensive Treatment Order, she reported she would simply pretend that she was OK to get out of hospital.

In January, she saw Dr Van Meer, Psychiatrist, and reported continued symptoms with her mouth. By February, she was anxious, depressed and ready to try another medication. Dr Van Meer prescribed an anti-depressant, Escitalopram.

On the afternoon of 11 March 2008 Mrs B was transferred from the Innisfail Hospital to Cairns Base Hospital ("CBH") at the request of her Case Manager in Innisfail Community Mental Health for management of increasingly severe depressive symptoms and increased risk of suicide. Mrs B had earlier that day sought his help, knowing her mental health was deteriorating and concerned for her own safety.

At about 8:30 pm Dr Abeysundera, Psychiatric Registrar, assessed Mrs B in the Emergency Department and found she was suffered from depression with strong suicidal ideation. She was assessed as a high suicide risk if she returned into the community and at a high risk of absconding without leave. He recorded Mrs B as saying, "I have been struggling for a while", "I am going to hang myself", "I am not sad or depressed, I just wanna kill myself", and "If I get a chance I am going to sneak out and kill myself". She reported poor sleep for the past two months, poor appetite, weight loss, poor concentration and hearing voices for the past five days. A Mental Status Examination revealed strong suicidal ideation, auditory hallucinations, poor insight and judgment, and depressed mood.

In consultation with Consultant Psychiatrist, Dr Fritelli, a treatment plan for Mrs B was devised that included transfer to the Low Dependency Unit within the Mental Health Unit when a bed was available and psychiatric assessment for the purposes of an Involuntary Treatment Order. Anti-psychotic medication in the form of Amilsulpride was started and arrangements made for one to one nursing supervision pending transfer to the Mental Health Unit. There was a shortage of beds in the Mental Health Unit. When a bed might become available was not known. A nursing 'special' (one to one nursing supervision) was arranged to accommodate the risk of absconding pending the availability of a bed.

At about 8:35am the next morning (12 March), Dr Pollard, Consultant Psychiatrist, and Dr Walker, reviewed Mrs B. A mental state assessment was undertaken, with a full personal and mental health history being recorded. Dr Pollard concluded that Mrs B was a high risk of suicide and required she be admitted for stabilisation and further assessment. Dr Pollard noted that Mrs B presented with escalating suicidal ideality on a background of mood symptoms – she was

angry irritable, depressed, and self hating; but seemed more in keeping with a mixed affective state in the context of a longitudinal history of mood and behaviour disturbance since her mid 20's. He also noted that Mrs B expressed overt suicidal thoughts and had a history of acting out on the same. He admitted her for stabilisation and treatment under an Involuntary Treatment Order ("ITO"). She was started on Quetiapine, an antipsychotic to calm her. Amilsulpride was stopped. Upon transfer to the Mental Health Unit, Mrs B was to be placed on Category B observations. However, a bed had not yet become available.

From 3:00 pm, Registered Nurse Wilson was assigned to carry out special one on one observation of Mrs B. At 6:00 pm RN Wilson took a 30 minute rest break. At 6:15 pm Mrs B left the ward without permission. At about 6:45 pm, her absence of discovered and an Authority to Return was faxed to the Police Service. This document alerted police to the absence of Mrs B. It sought their assistance in finding her as well as authorising her detention and return to the Unit.

At about 8.10pm Police officers returned Mrs B to the Mental Health Unit reporting that she was found at a local Hotel. Dr Abeysundera returned to Emergency and reviewed Mrs B about 10pm. She was then asleep and he didn't wish to wake her since she had settled. The nursing notes record that Mrs B had a histrionic reaction on her return to hospital.

At about 1:30 pm on 13 March, Mrs B was transferred to the Special Purpose Area within the Low Dependency Unit of the Mental Health Unit. Clinical Nurse Eric Atkins completed the necessary paperwork and conducted a clinical review including a risk assessment, mental state examination and individual care plan. Significantly, CN Atkins recorded that Mrs B had impulsive thoughts about killing herself and she planned to buy a rope to hang herself. CN Atkins completed the admission process and settled Mrs B on the ward. At 3.30pm, he noted Mrs B showered shortly after admission, slept and category B observations had started.

At 8.30pm CN Atkins noted:

> "8.30 pm. Hears male voices saying derogatory things, "she's useless/no good", also saying she should kill herself. Feels impulsive and cannot guarantee her safety. Bleak outlook on future, can't see beyond today. Able to recognise that she has been at this point before and 'recovered'. Has rested on her bed all day. Poor diet but taking fluids. Category B observations in Special Purpose Unit area. Given information on Involuntary Treatment Order on Mental Health Tribunal process."

CN Atkins made these notes as part of his handover to the next shift and was not further involved in the care of Mrs B.

At 7am on 14 March Registered Nurse Lucy Juler started work in the Mental Health Unit. Mrs B was one of a number of patients allocated to her care for the duration of her shift, to end at 3.30pm.

RN Juler became concerned about the wellbeing of Mrs B, in particular, her worsening suicidal ideation with plans of hanging herself. She reported her concerns to Dr Beth Campbell who, along with Dr Lider, Consultant Psychiatrist, reviewed Mrs B starting about 3pm.

At about 3.15pm RN Juler made notes in Mrs B's medical records about her observations during the shift. Dr Lider and Dr Campbell had not taken the medical records with them into the interview with Mrs B. In her statement, RN Juler transcribes her notes (with interpretations in italics) as follows:

> "Nursing - reports intense suicidal ideation, worsening since yesterday, has plan of hanging self but states has not acted on this as yet. *[i.e. not tried this at all).* Cannot guarantee safety, would not seek support from staff if needed *[I recall Ms. B stated this)'* Expressing hopelessness and helplessness re: her situation, particularly as she has "tried lots of different treatments and nothing has helped". States began feeling suicidal on Sunday/Monday in response to a difficult work situation, and perception of the world/others being very negative - stated had not felt suicidal for 4/12 *[i.e. previous 4 months).* Describes self as "surviving" life, has lived with depression for 16 yrs, and that life is no longer worth living. Perceives she has a very poor quality of life. Dr Campbell aware and is to f/v *[i.e. I had informed Dr Campbell of my observations of Ms. B during my shift and that she was to review Ms. B. I recall that I had also informed the Team Leader, I'm unable to recall who the Team Leader was on this day).* Mrs B had breakfast but declined lunch - states "I cannot eat anything at all - helping self to fluids. Commenced on food chart. *[i.e. commenced monitoring what she was eating).* High risk of suicide/ DSH *[DSH is an acronym for deliberate self harm].* Became tearful very briefly, but on the whole affect is incongruent with speech content, appearing calm and 'matter of fact' when describing experience."

At the conclusion of the interview with Mrs B, Dr Campbell discussed with Dr Lider his impressions and wrote a synopsis of the assessment in the medical records. She showed a copy to Dr Lider and he accepted the note as accurate.

Based on that note, Dr Lider reportedly considered Mrs B had chronic suicidality, ongoing risk, and borderline personality disorder with narcissistic traits. During the examination, Mrs B told Dr Lider that she has "planned a suicide – hanging and had written note (to family)". She expressed ongoing inability to guarantee her safety.

Dr Lider concluded that Mrs B's behaviour was not significantly different to that observed in outpatient clinics and other admissions. Dr Lider recalled Mrs B's presentations in November 2007. He considered she was not at acute high risk of self-harm. Mrs B's medication was adjusted and the plan was for her to remain in the Unit under an ITO on Category B observations.

By 3:30 pm Mrs B had absconded and her medical file noted she was absent without permission.

Between 3.30 and 5pm the Acting Team Leader for that shift took steps to confirm the absence of Mrs B and when confirmed, completed the necessary paperwork. Dr Nentjes, the on call Consultant Psychiatrist, attended the unit about 5pm and authorised police assistance in finding and returning Mrs B. Police were faxed an Authority to Return.

Management of the Risk of Absconding and Suicide

With the benefit of a better understanding of the clinical narrative, a number of issues arise:

- The and reasonableness of the assessment of Dr Lider, in particular, the level of observations;
- The opportunity for better monitoring of the entrance to the Unit.

However, before addressing these substantive matters, a few preliminary matters need to be

addressed.

Although there were differences of opinion between treating psychiatrists in the past as well as between Drs McVie and Bayley as reviewers, they agreed the priority on admission of Mrs B was to treat the symptoms with a view to moderating acuity and stabilising her as soon as possible. Whether Mrs B suffered treatment resistant recurrent major depression or a personality disorder or a combination of both, initial attempts to manage her on medication in a supportive and safe environment were reasonable and appropriate. Her response to medication might have been different depending on her condition, but at the early stages of admission, no immediate alternative course was available.

As Dr Bayley described, both conditions can give rise to acute suicidality and require close observation for different reasons.

Dr Pollard explained that although he thought Mrs B's history suggested a diagnosis of a major depressive disorder, she was experiencing increasing suicidality and felt unsafe. It was more important to treat the mood symptoms whether as a component of a depressive disorder or personality disorder.

There was a consensus amongst Psychiatrists about the meaning of 'chronic' and 'acute' risk of suicide. However, occasionally the term 'high' was used in relation to risk. The relationship between 'acute' or 'chronic' with 'high' was not clear. Some practitioners referred to risk as high without reference to acute or chronic. I exclude any mention of nursing assessments, which involved the use of templates and assessment tools which use scales of low – medium – high and adopt uniform terminology. However, I would have thought an integrated approach would lead to consistent use of understood terminology between nursing staff and clinicians.

In the context of Mrs B, Dr Pollard would use the terms acute and chronic. For a client with a long history of suicidal behaviour and thinking, he would use the term 'chronic risk'. For periods of escalating thoughts and preoccupation with suicide prior to admission, he would use the term acute risk. As to the use of the term 'high' risk, Dr Pollard explained that he intended to convey there was a substantial risk of suicide. Dr Campbell expressed a similar understanding. However, some clinicians appeared to use the term 'acute' in a context that suggests a meaning similar to 'high'.

There is room for greater consistency and uniformity amongst nurses and clinicians. However, those differences did not contribute to any confusion in the present circumstances.

The Assessment by Dr Lider

There is an important introductory remark that must be made at this point. The mere fact of Mrs B absconding immediately after the assessment of Dr Lider does not mean his assessment of risk was wrong. It was an assessment of risk and even low risks may eventuate. However low the risks of absconding and suicide, it remained a possibility.

The basic clinical narrative was addressed earlier in my findings. It will be recalled that Dr Lider assessed Mrs B. Although he concluded she had chronic suicidality, was an ongoing risk, had planned a suicide and was unable to guarantee her safety; her presentation was similar to earlier presentations and she was not an acute, high risk of self harm. She was to remain in the LDU under category B observations.

Dr Campbell played a minimal role in the review of Mrs B. Dr Lider, as the Consultant Psychiatrist, conducted the assessment. Dr Campbell referred to Dr Lider as the principal decision maker. In evidence she reported her role as more akin to a scribe for Dr Lider except she didn't have the medical records with her. She completed an entry in the medical record at conclusion of the assessment, which Dr Lider sighted and approved without modification or addition. The entry contains the final impression and does not contain any detail about recent history (since the last psychiatric assessment) including the circumstances surrounding the recent absconding. Nor does it include any detail about a Mental Status Examination. Dr Lider gave evidence to the effect that the elements of a Mental Status Examination were taken into consideration during the interview with Mrs B. He did not articulate his observations relevant to the mental state examination for Dr Campbell to note. In the course of his statement dated 25 November 2001, Dr Lider reported on the nature and extent of his examination based on reference to the note made by Dr Campbell and did not specifically refer to a Mental Status Examination. However, in evidence and during examination about the thoroughness of his examination, Dr Lider was adamant that a mental state examination was conducted, as it was a standard practice. The other omission from the entry relevant to this assessment is any reference to the circumstances of the earlier absconding. Dr Lider gave evidence to the effect that he did not inquire of Mrs B about those circumstances, how she felt and what prompted her to abscond. He considered that information to be of limited value.

In the absence of detailed notes of the assessment, there is no opportunity to compare and contrast how Mrs B presented on this assessment with presentations in earlier admissions which are substantially more detailed in the medical records. We are left only with the final impression or conclusion of Dr Lider.

In a broad sense, Mrs B's presentation on this occasion was similar to earlier admissions. However, that broad comparison does not assist with any understanding of acuity at the time of her last assessment.

During the admission in July 2007 Mrs B absconded from the Mental Health Unit and on return with self inflicted wounds to her arm, was placed in the PICU for a day or so until she settled. Two days later, Dr Bates canvassed the circumstances of her absconding; assessed Mrs B was still a high long term risk of suicide and absconding. Although she had been transferred to the LDU, he queried the threshold for admission to the PICU. The risk of suicide and absconding was closely monitored over the following week. Clearly, Dr Bates thought there was a question mark about her proximity to the threshold for admission to PICU in light of the continuing high level of risk.

The absence of Mrs B's medical records during Dr Lider's assessment raised a concern about whether the full history of her admission was available to Dr Lider and considered before concluding his assessment. According to the evidence of Dr Campbell, the file was retrieved and the entries made in it with Dr Lider after the interview with Mrs B. Neither had any clear recollection of the extent to which the file was considered. This is understandable given the passage of time.

In response to the opinion of Dr McVie, Dr Lider told the hearing that there was the opportunity to put Mrs B on a 'one to one nursing special'. However, he did not consider there was a need for that level of observation. Further, Dr Lider told the hearing that PICU was not an appropriate environment to treat a depressed patient. The PICU was a place for very aggressive or very agitated patients suffering from either psychosis or antisocial behaviour. It was accepted that at the time of Mrs B's assessment, admission to PICU was not an option. The issue is whether or

not a one to one nursing special should have been arranged.

Dr Lider was also asked questions about his use of terminology to express the risk of suicide and absconding. He described acute as actual, immediate and direct risks, the 'here and now' or immediate symptoms of a mental illness. In contrast, chronic risks are persistent over the long term and not normally treated in hospital but in the community. He concluded an acute risk requires acute treatment.

When Dr Lider was asked what he would expect to see Mrs B demonstrating before regarding her as at an acute risk of suicide, he responded by reference to examples. A patient admitted to the Emergency Department continuously expressing a wish to die, unable to react to anything else, fixated on their wish to die and their own thoughts. Their problems are secondary. He also referred, by way of another example, to a patient in the Intensive Care Unit who has overdosed and questions why doctors didn't let them die.

Dr McVie, Consultant Psychiatrist, conducted a review of the clinical management of Mrs B by reference to the medical records and prepared a report which was admitted into evidence. Dr McVie expressed a preference for a diagnosis of treatment resistant recurrent major depression or a bipolar type II affective disorder. She thought that Dr Lider's conclusions and entry in the file shortly before Mrs B left the ward were, retrospectively, clear evidence of error of judgement. Dr McVie expressed a preference for close observations (1:1 or placement in a High Dependency area of the ward) for the first few days of admission until response to medication could be established or ECT could be recommenced.

As to the reference to an error of judgement, Dr McVie expresses an important qualification, namely hindsight.

Dr McVie concluded her review as follows:

> "In summary, the file information is consistent with Ms B having suffered with a severe mental illness for the last 17 years of her life, commencing at age 35. The main features were recurrent suicidal ideation, depressed mood, hopelessness, low self esteem, poor concentration, sleep disturbance, agitation and in later years intrusive thoughts, a belief her husband and family would be better off without her, and (although most assessment specified no psychotic features), there were clearly documented auditory hallucinations in her last admission. At times, possibly during exacerbation of her illness, she displayed borderline personality features, notably self harming, irritability and she was considered impulsive. Though her suicidal behaviours were often described as impulsive, there appears to be considerable thought and planning associated with them. There is no documented history of personality dysfunction prior to age 35 making a primary diagnosis of borderline personality disorder less likely. There is also a history of obsessional personality traits, which often are associated with depressive illness and can predict poor prognosis. Through my retrospective analysis, I would prefer a diagnosis of treatment resistant recurrent major depression or a bipolar type II affective disorder. Ms B's history and her documented interactions with mental health staff suggest an above average intellectual function, with some evidence of selective disclosure of symptoms. I think it highly likely she was bordering on psychotic, at least during her last admission if not on previous occasions. Her self-medication with alcohol to alleviate her anxiety is clearly documented but does not seem to have been given the prominence it required in terms of association with risk of suicide."

It is important to note the references to considerable thought and planning associated with Mrs B's suicidal behaviour, her above average intellectual function and capacity for selective disclosure of symptoms.

As to the level of observations, Dr McVie reported:

> "Having regard to Ms B's complete history, her very recent absconding from the ED (and being found consuming alcohol), her absconding on day 4 of the admission in July 2007, the intensity of her suicidal ideation, the comments to the case manager that she did not expect to come out of hospital this time, the "new" symptom of derogatory auditory hallucinations, the presence of a collection of symptoms which would be consistent with a DSM IV diagnosis of Major depression, and the fact she had been off medication for several months, I would have preferred her to be on close observations (1: 1 or in the High Dependency area of the ward) for the first few days of admission until response to medication could be established or ECT could be recommenced. I note Ms B was purported to have been on 1: 1 observations in the ED under a "nurse special" (Dr Bayley's report …). It is not clear how she was able to abscond in this situation."

Dr McVie placed considerable reliance on the observations of RN Juler in concluding that there was significant evidence of acute suicidality. She also gave evidence that she would have explored with Mrs B the circumstances of her earlier absconding.

Under cross-examination, Dr McVie agreed with the suggestion that the clinician who examined Mrs B was in a better position to asses her condition and acuity of symptoms.

Understandably, the opinions of Dr McVie were challenged. Dr Bayley, Clinical Director and Consultant Psychiatrist, Cairns and Hinterland Mental Health Service undertook a review of the clinical management of Mrs B and provided a report to the court. In her report dated 17 November 2008, Dr Bayley explained that on admission to the Mental Health Unit at Cairns Base Hospital, there is the option of admission to the locked Psychiatric Intensive Care Unit (PICU) or the open Low Dependency Unit (LDU). The PICU has eight beds and has a higher nurse to patient ratio compared with LDU. All patients admitted to the CBH PICU are automatically placed on Category B Visual Observations. The Cairns and Hinterland Mental Health Service policy is to use admission to the PICU only as a last resort when all other less restrictive treatment options have been tried. Only very ill and high risk patients are generally admitted to the PICU. Most patients prefer to be on the LDU for reasons of personal freedom and sense of therapeutic empowerment. Deciding when to admit patients to PICU or LDU requires constant assessment and balancing of respect for patients' civil liberties, trying to help them take personal responsibility for their behaviour, and treatment; versus the need to keep them safe and secure in a potentially unpleasant locked environment.

Dr Bayley reported that admission of Mrs B to the PICU would have been considered but LDU admission was preferred in her situation to attempt to treat her in the least restrictive way and to engage her in a positive therapeutic alliance. Further, it would have been counterproductive to Mrs B's mental health to nurse her in a cramped locked environment with highly psychotic and disorganized fellow patients.

Within the LDU there is a Special Purpose Area ('SPA') comprising a 5 bedroom area sectioned off from the rest of the LDU by a separate entrance. It allows high patient visibility and is close to the LDU nurses station. It is used to nurse the elderly, adolescent or vulnerable and fragile patients.

According to Dr Bayley, Dr Lider's placement of Mrs B in SPA on 15 minute observations was a clear indicator that whilst it was not thought Mrs B was at extreme, immediate risk of suicide, she needed more attentive nursing to ameliorate the instability of her mental state.

Dr Bayley reported on the balancing exercise applicable to Mrs B:

> "All psychiatrists practicing in acute mental health inpatient units will agree managing the suicide risk of patients with Borderline Personality Disorders is one of the most challenging situations faced in clinical practice."Overdo" the external control and the patient becomes regressed and more suicidal. "Under-do" the external control and the patient is at risk of impulsive self harm. Managing patients with psychotic symptoms as a consequence of Schizophrenia is, by contrast, much less clinically challenging.
>
> Many Psychiatrists advocate not managing patients with Borderline Personality Disorders as MHU inpatients. They argue that patients with Borderline Personality Disorder should be managed only in an outpatient setting. Other psychiatrists argue that patients with Borderline Personality Disorders should only be managed with extreme long-term inpatient admissions in specialist units.
>
> In contemporary Australian clinical psychiatric practice most would adopt the middle ground approach as was done by Dr Lider for Mrs B: aim for short admissions for containment of distress, management of affective symptoms, encouragement of patient taking personal responsibility for emotions and behaviours, and at engaging in appropriate longer term outpatient therapy.
>
> Psychiatrists also often have to tolerate risk with patients such as Mrs B, to allow a positive long term therapeutic outcome. Hence, Dr Lider took the 'middle ground' approach with regards external control of Mrs B during her last admission."

Dr Bayley concluded that Dr Lider's assessment and management plan was well within the limits of normal Australian clinical, psychiatric practice.

In addition to her reports, Dr Bayley gave evidence at the inquest after hearing the evidence of other witnesses, particularly the circumstances of her earlier absconding and the observations of RN Juler. She said she was of two minds about whether her assessment and management of Mrs B would have been any different to Dr Lider. However, she conceded that the notes of RN Juler were relevant to the assessment of suicidality. If she saw the same features as RN Juler, she might have put Mrs B on closer observations. However, as a note of caution, Dr Bayley reported that it was not unusual for different clinicians to see different mental health symptoms and for differences in presentation between nurses and clinicians. Dr Bayley reported she also would probably have explored the circumstances of the earlier absconding, as that information might have been relevant to risk of suicide.

It will be recalled from the clinical narrative that Dr Pollard assessed Mrs B in the Emergency Department and planned for Cat B observations on transfer to MHU. He explained that although Mrs B struggled to maintain control of her symptoms, direct supervision can be intrusive and damaging. In patients with a history of acting out their distress, they can regress, becoming more difficult and risky to themselves. Dr Pollard considered it part of the negotiation on admission to get the client to talk about how they feel and then the doctor has to make a judgement call. He said that Mrs B had a history of increasing self harm when hospitalised, a

warning that hospitalisation was itself an environment that increased her self damaging behaviour.

Dr Pollard was informed of the circumstances of Mrs B earlier absconding and asked to comment on the benefit of investigating with Mrs B why she absconded. He told the court that the incident confirmed the unpredictable and impulsive nature of her behaviour; and it would be helpful to find out why she left and to document it. Although, he said 'sometimes the whole picture can get lost the next morning'.

There are a number of features of Mrs B's presentation that would tend to cumulatively suggest that she was at a high risk of suicide at the time Dr Lider assessed her. However, the treating and reviewing Psychiatrists were particularly mindful about the need to create the most therapeutic and least restrictive environment in order to moderate self harming behaviour.

I also have serious doubts about whether Mrs B presented in the same manner to Dr Lider as she did to RN Juler. Her absconding from the Mental Health Unit was immediately after the assessment. She is variously reported as demonstrating considerable thought and planning associated with suicidal behaviour and capable of selective disclosure of symptoms. It seems to me entirely plausible that she had insight into how serious her condition had become and was selective in her disclosure during the assessment, ensuring the level of observations did not change and interfere with any plans to opportunistically abscond.

It is precisely these sorts of situations where the opportunity to intervene falls back onto the monitoring of the entrance to the Unit.

Monitoring the Entrance

The analysis of the evidence and findings from that part of this inquest that was heard jointly with the inquest into the death of Jonathon Clarence Saccu is the same and is recited in the following paragraphs.

The question of monitoring the entrance to the MHU is not without its difficulties.

There is a degree of sensitivity amongst mental health clinicians and advocates when dealing with restrictions on patients. Dr Bayley told the court:

> … we're trying to create a therapeutic environment, not a prison, and that's something that we often struggle with, but to - it is a state-wide Queensland Health policy which I've had expressed to me by the Director of Mental Health in Queensland - Aaron Groves is in the substantive position but currently on leave - that his opinion and ethos is that we try and have open units where possible to promote recovery and treatment in the least restrictive alternative in a hospital - you know, rehabilitative setting rather than a locked away setting…
>
> Although the issue returned to monitoring the entrance as opposed to locking it, Dr Bayley emphasised that the senior clinicians and nursing staff had discussed this issue for a very long time and whether it was locked or closely monitored, there was an overriding concern about how that might impact therapeutically on patients like Mr Saccu who suffered acute episodes of fear and anxiety about being locked up, patients who ultimately had to be transitioned back to the free environment within the community.

Dr Bayley earlier stated:

> It's difficult because this is a hospital. We're trying to create a therapeutic environment for people. It's not a prison. And, you know, we try and help people take personal responsibility for themselves as much as we can, try to keep them safe and well within a pleasant environment, in the least restrictive ways. It - it's - it's a difficult balancing act.
>
> As an example of a necessary but therapeutically unsatisfactory arrangement, Dr Bayley referred to the occasional presence of security officers.
>
> … when we've had a number of people that we are worried about but we don't have room in PICU, we've put a security guard on the door, and that's just awful to have security guards standing at the door. It's just such an awful thing to - awful message. You know, the security guard can be as friendly as you like but having a security guard standing at the door is - changes the whole tone of the place.

During discussion in evidence, Dr Bayley raised a number of considerations relevant to the question of monitoring. She reported that there was no universal position about the wisdom of monitoring amongst academics, clinicians, consumers, carers or various advocacy groups. Although there are construction standards for mental health facilities, the issue of monitoring is not addressed. She thought psychiatrists were divided, some thinking it was a great idea while others considered it dreadful. The issue had a polarising effect. Dr Bayley thought that when you drilled down through layers of attitudes and perceptions, it's not as clear cut as she first thought.

Dr Bayley reported that due to architectural changes necessary to increase the bed capacity by 2, it was necessary to relocate and create a new entry and entrance. It was more suited to closer monitoring.

From 2012, access to the Unit was monitored through a reception facility Monday to Sunday from 7am to 9pm. The Unit is not accessible (entry or exit) for patients or visitors outside of these hours. The access doors have a camera phone on the exterior to allow communications with the Unit. The interior also has a camera phone so staff may view the area inside the door before it is opened. Staff will activate the door to permit entry or exit on request of the patient or visitor. All patients are signed in or out of the facility in compliance with their inpatient status.

Three administrative positions were created and this has assisted in ensuring that the new entrance is monitored. Dr Bayley noted that this architectural change was a matter of necessity for other reasons and co-incidentally facilitated better monitoring of the entrance. However, the desirability of monitoring remained a vexed issue. She also expressed concerns about whether the persons monitoring the exit should be administrative or nursing staff. Nursing staff through their training and interaction with patients on the ward are likely to have better relationships with patients, particularly those at most risk of absconding. However, it seems to me that an administrative officer at a reception like facility near the entrance will have immediate access to nursing staff if required.

When redeveloped in 2014 the MHU will expand from 38 to 50 beds. Access to the current Low Dependency Unit is planned from the Esplanade. Patient and visitor access in and out will be staff monitored at the entrance.

Further, Dr Bayley reported a discussion with a colleague working in psychiatric facility that

moved to a closed doors approach. It did not result in a reduction in the number of persons absconding. They just found other ways of absconding.

Dr Bayley was not aware of academic studies or literature reviews that considered whether therapeutic aspects of an otherwise open mental health unit were compromised or adversely impacted by monitoring of the entrance.

There is a need for consistent policy of statewide application about the desirability for managing and monitoring the risk of absconding through the physical layout of mental health facilities. Although the appropriate treatment of patients and intermittent visual observations may mitigate the risk of absconding and suicide, the physical layout and monitoring of the entrance presents a further opportunity to mitigate that risk. It should not be left to the managers of each facility to decide what is appropriate. There needs to be a carefully considered and researched best practice that is implemented statewide.

Required Findings (s.45 Coroners Act 2003)

Who died: Mrs B

When she died: Between 14 and 15 March 2008

Where she died: Cairns Showgrounds, Mulgrave Road, Cairns

What caused her death: Hanging due to depression

How she died:

1. Mrs B had a long history of mental health when on 11 March 2008, she sought the assistance of her Case Manager with Community Mental Health at Innisfail with deteriorating health. She was transferred and admitted to Cairns Base Hospital.

2. She remained in the Emergency Department until a bed became available in the Mental Health Unit. In the meantime, she absconded and self harmed, an attempted suicide before being returned by police.

3. On 13 March, Mrs B was transferred to the Special Purpose Area within the Low Dependency Unit of Mental Health Unit and placed on category B observations every 15 minutes.

4. There was no immediate improvement in her condition and during 14 March, the mental health nurse monitoring Mrs B became concerned about her condition and requested psychiatric review and assessment.

5. Dr Lider, Consultant Psychiatrist, in conjunction with Dr Campbell, assessed Mrs B and found she was not an acute high risk of suicide.

6. Immediately after that assessment, Mrs B absconded from the Unit.

7. On the morning of 15 March 2008 the body of Mrs B was found hanging from rope in an undercover area at the Cairns Showgrounds. Investigations revealed that late on the afternoon of 14 March she attended the nearby Bunnings store and purchased the rope and a stepladder.

8. There were no suspicious circumstances surrounding her death. Mrs B died due to suicide.

9. The clinical assessment and decision making during the assessment of Dr Lider was reasonable and appropriate including the level of observations upon which Mrs B was placed. Moderation of the self harming behaviour required that Mrs B be treated in the least intrusive and restrictive immediate environment in terms of level of observations.

10. However, the very nature of this therapeutic regime requires physical safeguards such as more stringent monitoring of the entrance to prevent involuntary patients leaving without permission.

11. I am satisfied with the changes made to the physical layout and staffing of a co-located reception and nurses station will substantially mitigate the risk of absconding and suicide.

Comments/Recommendations

I recommend that Qld Health or the Director of Mental Health investigate and develop a statewide policy about preferred options for managing and monitoring the risk of absconding, including through the physical layout and staffing of reception like facilities at the main entrance to Mental Health Units as a guide to the construction of new Units and the modification of existing Units.

Coroner Kevin Priestly
Cairns
2 July 2013