QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of SPB**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
DATE:	9/12/2016
FILE NO(s):	2012/307
FINDINGS OF:	James McDougall ,Coroner
CATCHWORDS:	CORONERS: adequacy mental health assessment, admission under *Mental Health Act 2000,* discharge practices
Counsel Assisting:	Ms Rhiannon Helsen

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Background

SPB was 36 years of age when he took his own life. He resided with his family at Tugun. He had a significant and long-standing mental health history having been diagnosed with Paranoid Schizophrenia some 15 years before his death. He had received regular psychiatric and medical treatment in the community for his mental illness and poly-substance abuse. SPB also had a history of self-harm and attempted suicide, for which he had previously been hospitalised.

Sequence of events

On 23 January 2012 at 6:30 pm, Police were asked to attend the B's family residence as SPB was behaving violently towards his Father. SPB had reportedly become aggressive and threatened to kill his Father, before attempting to break down the bedroom door using a broken piece of wood as a weapon.

Upon arrival at the residence, Police found SPB to be intoxicated, behaving erratically, and talking incoherently. He became noticeably agitated upon seeing his Father, and told officers that he needed to kill him in order to stop his Father from killing other people. SPB had also made delusional demands for his Father to buy him and his 'girlfriend' a beach house, and indicated that he would receive insurance money in the event of his Father's death. Senior Constable TC subsequently spoke to SPB's Father, who advised him that he had grave concerns for his son, who was diagnosed with Paranoid Schizophrenia 15 years ago, and was currently experiencing an episode, which was worse than those he had previously. SPB's behaviour had reportedly become increasingly erratic the week leading up to the incident. He confirmed that SPB was a patient of the Currumbin Clinic, and was being treated by Consultant Psychiatrist, Dr MMcD. He requested that SPB remain in the Hospital mental health ward until he could make arrangements to have him admitted to the Currumbin Clinic. He was concerned that SPB was dangerous in his current state.

SPB was handcuffed and placed in a police vehicle awaiting the arrival of Queensland Ambulance Service ('QAS') officers. It was determined that he did not require any medical attention, and as such, he was transported to the Robina Hospital by Police. Upon arrival at the Hospital, Officer TC prepared an Emergency Examination Order ('EEO'). During this time, he was approached by an unknown doctor, who queried why SPB had been brought to the Hospital when he was intoxicated. Officer TC stated that he was of the opinion that SPB was suffering from a mental health episode and needed to be assessed. The doctor argued that, despite having not conducted any assessment, he was of the view that SPB was not mentally ill, just drunk. Nonetheless, Officer TC maintained his view that an EEO needed to be taken out, and continued to do so. He recalls that the doctor left the Hospital a short time after the disagreement, and did not appear to return. Extensive inquiries undertaken during the course of the coronial investigation have been unable to identify the doctor who spoke to Officer TC. Officers remained with SPB who continued to talk incoherently. At 9:33 pm, he was medically assessed by nursing staff for the purpose of being triaged, and provided an alcohol breath test, which produced a reading of 0.179. Officer TC explained to staff that SPB's Father was making arrangements to have him admitted to the Currumbin Clinic in the morning, and had asked for him to remain in the custody of the mental health unit until that time. He recalls a medical officer advising him that they could not guarantee SPB would be held for this period of time. Furthermore, a mental health assessment could not be conducted until SPB was sober. Officer TC asked that SPB's Father be contacted before he was released.

At 10:05 pm, with the assistance of security staff, SPB was moved to a safe room in the mental health area of the Emergency Department. He was monitored by way of 15 minute observations and through CCTV footage. At this time, as the EEO for SPB expired after a

period of 6 hours, it was decided that a Request and Recommendation ('R&R') for assessment, pursuant to the *Mental Health Act 2000,* should be instituted.

At 11:00pm, CC, a Clinical Nurse within the Acute Care Team, spoke to SPB's Mother and Father to seek collateral information about his presentation. She states that she was advised that SPB had been 'manic' for the past week, and his behaviour had changed significantly. He was reportedly more irritable, had been waking at unusual times, experienced extended blackouts and started making delusional comments primarily about his Father. It was unknown if SPB had been using illicit and prescription substances, although they suspected that he was regularly using Valium and Tramal. The events preceding SPB's admission to Hospital that evening were discussed. SPB's Mother and Father made it clear that they did not want him discharged home.

Overnight, SPB's demeanour was reportedly settled and co-operative. At 5:40 am, Nurse CC assessed SPB. His blood alcohol level at this time was 0.082. Whilst he was co-operative during the assessment, he reportedly had intermittent eye contact and seemed distracted at times. There was no evidence of psychomotor agitation or retardation. SPB was said to be guarded during the assessment, however, stated that he had been using Valium the previous evening, and had consumed 10 beers. He minimised the level of aggression reported by his Mother and Father, and claimed that it was merely a heated discussion over family finances. He stated that he was remorseful for what had happened, and denied any intent or plan to hurt his Father. During the course of the assessment, SPB did not express any suicidal ideation or any homicidal thoughts. He denied hearing voices, and presented as euthymic. As such, Nurse CC could not identify any acute mental health concerns. It was determined that he should remain overnight, and be reviewed by the Psychiatric Registrar.

At around 8:00 am on 24 January 2012, Psychiatric Registrar, Dr SM, conducted a mental health assessment of SPB. He claims SPB was cooperative, and his speech was normal in rate, tone and rhythm. His mood was said to be euthymic with normal and appropriate mood reactivity. He denied having any persecutory, homicidal or suicidal thoughts, and was reportedly quite remorseful about the events leading up to his presentation at Hospital. He was observed not to be responding to any abnormal perceptions and denied any command hallucinations. Dr SM concluded that there were no acute symptoms indicative of the need for SPB to be admitted. As such, he was discharged with information about temporary accommodation. In terms of follow up treatment, there was a plan to contact SPB again to reassess his mental state and the need for further engagement with the Acute Care Team. SPB's parents and his private treating Psychiatrist were informed as to the above findings.

According to Dr SM, he did not discuss SPB's presentation, assessment and proposed care and treatment with any other medical staff or consultants, as he formed the view that SPB had no acute psychiatric symptoms. He found that SPB's presentation was as a result of his high level of intoxication, which lead to his threatening behaviour. Given SPB had an appointment with Dr MMcD on 27 January 2012, and did not have any acute psychiatric symptoms, which required monitoring or treatment aside from his current medications, Dr SM was of the view that he should be discharged.

According to SPB's Father, he was contacted by staff at around 6:00 am on 24 January 2012, and advised that it was likely SPB would be released following an assessment. He advised that he did not want SPB attending the family residence, and requested that he remain at the Hospital or be discharged to the Currumbin Clinic. At 8:30 am, he was advised that SPB was to be discharged and could be collected from the Hospital.

According to SPB's treating Psychiatrist, Dr MMcD from the Currumbin Clinic, he was contacted by Dr SM on 24 January 2012. He was advised that SPB had an event the previous evening and was intoxicated and violent at home. Dr MMcD expressed the view that SPB required admission under the *Mental Health Act* for the purpose of assessment and risk

management, and that it was uncharacteristic for him to behave this way at home. He was informed that SPB was to be released.

At around 10:00 am on 24 January 2012, SPB was discharged from the Hospital and provided with a cab charge voucher by staff, who also called a taxi to collect him. A Gold Coast Cab subsequently picked him up at 9:52am, driving him to Bunnings Warehouse in Burleigh Heads, where SPB purchased a rope. He was subsequently dropped at an address in Currumbin, which is next to Currumbin Wildlife Sanctuary, and a short distance from his family residence.

At around 12:30 pm that day, a staff member leaving Currumbin Wildlife Sanctuary saw SPB hanging from a tree in Alex Griffith Park. Police and the Queensland Ambulance Service ('QAS') were called. He was pronounced deceased at 1:30 pm.

Autopsy

An external only post-mortem examination was performed by Pathologist, Dr DL on 25 January 2012.

External examination revealed the presence of a rope around the neck with an underlying ligature mark rising from apparent suspension point beneath the right ear. The appearance are consistent with those seen in hanging. Old healed scars, consistent with being self-inflicted, were present on both wrists and forearms.

Toxicological analysis of samples taken at autopsy detected the sedative drug diazepam, and its breakdown products, as well as the anti-psychotic drugs Olanzapine and Zuclopenthixol, all at levels within the reported therapeutic ranges.

The cause of SPB's death was found to be hanging.

Mental Health History

SPB had suffered with paranoid Schizophrenia for around 15 years. He had reportedly experienced a number of episodes of psychosis during this time, which caused him to behave erratically and sometimes violently. He also suffered from poly substance abuse, which included amphetamines, cocaine, codeine and benzodiazepine. He was managed by way of high doses of depot medications Zuclopenthixol Decanoate, supported with Olanzapine orally. Since 2004, SPB had been in receipt of a Disability Support Pension.

According to SPB's Father, he had tried to take him own life on a number of occasions. This included attempts to gas himself in the family carport, self-harm and an overdose of medication. As a result, he had been admitted to various Hospitals on a number of occasions as a mental health patient, and for treatment of substance abuse issues.

From 2009, SPB received regular treatment from Consultant Psychiatrist, Dr MMcD from the Currumbin Clinic. Despite being given high doses of psychotropic medication, Dr MMcD noted that SPB continued to live with low grade psychotic phenomena, which took the form of persecutory ideation and sometimes elaborated into broader delusional material, which included themes of surveillance and reference from media sources. At times, SPB could also experience auditory phenomena, which were commentary in command. He also struggled with benzodiazepine dependence during his treatment history. Although attempts to have him slowly withdraw from this drugs were attempted, he would often end up taking more medication when distressed in combination with excessive alcohol use.

In March 2010, SPB was admitted to the Gold Coast Hospital for treatment of self-inflicted wounds to both forearms. He had reportedly been feeling depressed in the weeks beforehand, and after a disagreement with his Mother, had grabbed a knife from the kitchen and gone to

the beach where he cut his wrists before walking into the ocean. He subsequently decided he didn't want to die, and drove himself to the John Flynn Hospital for treatment. He was subsequently transferred to the GCH for surgical treatment of his wounds. SPB was discharged with further follow up care to be provided by Dr MMcD at the Currumbin Clinic. It was noted that this impulsive act was likely as a result of his mental illness in combination with ongoing substance abuse.

In February 2011, SPB was admitted to the Gold Coast Hospital following an overdose of 20 Diazepam tablets, 50 Zolpidem tablets, speed and alcohol. He claimed that he was not trying to commit suicide, but rather just wanted to sleep. He was subsequently admitted to the Currumbin Clinic in April 2011 for treatment for a number of weeks.

In November 2011, SPB took an overdose of medication, which was intended to manage strong feelings of anxiety, rather than to end his own life. He attended a 24 hour clinic at this time and was provided with 10 Tramadol 200 mg slow release tablets, which he consumed after drinking 10 alcoholic drinks. SPB subsequently had a seizure and was taken to the Tweed Hospital by his Mother.

Dr MMcD last saw SPB on 16 December 2011. He expressed the view that SPB was approaching a reasonable mental state for his long-term presentation. His psychotic phenomena were not as evident, although he remained in active addiction to alcohol and benzodiazepines.

Expert report, Psychiatrist Dr JP

On 28 April 2014, Psychiatrist, Dr JP, who is the Medical Director for Metro North Mental Services, provided an expert report in relation to this matter.

Dr JP's response to the questions specifically posed in relation to SPB's admission and discharge from the Robina Hospital in January 2012, are as follows:

I. *Was the assessment conducted by the Robina Hospital adequate and appropriate, particularly in relation to the documentation around commencing the Request and Recommendation for Assessment, and subsequently ceasing both assessment provisions?*

Dr JP notes that upon presentation to the emergency department of the Robina Hospital, SPB was briefly triaged and clinically examined by Nurse LJ. There are no records to suggest that he was assessed by emergency department medical staff. Dr JP expressed significant concern about the initial assessment of SPB by the emergency department staff, who was triaged as a Category 4 patient. Dr JP is of the view that such a categorisation, which applies to mental health patients who are cooperative and 'semi-urgent', was a 'significant underestimate' of his needs. Dr JP does acknowledge, however, that the assignment of triage categories is outside her area of expertise.

Dr JP confirms that the actions taken by staff in seeking a Request and Recommendation for Assessment, just within the 6 hours stipulated for an EEO, was reasonable, given SPB's intoxication and recent mental health history.

In relation to the assessment undertaken by Nurse CC at 5:00am on 24 January 2012, Dr JP notes that SPB's mental state, as recorded, suggests that he was possibly minimising his symptoms. She highlights that in order to effectively determine a diagnosis and appropriate treatment by way of an assessment of a patient pursuant to the *Mental Health Act,* it is necessary to weigh up all of the information available, not just the patient's presentation at the time of interview. Dr JP is of the view that SPB's mental state, in combination with his history from his family, was highly suggestive that he was acutely psychotic for the week prior to his

presentation to hospital. In this case, Dr JP notes that a better explanation as to SPB's aggression was that his consumption of alcohol had a disinhibiting effect, which resulted in him acting on his psychotic symptoms.

Dr JP concluded that the assessment conducted by the Robina Hospital staff of SPB was adequate, she notes, however, that there was insufficient and inadequate formulation of the findings. Nurse CC made the diagnosis of alcohol misuse and intoxication, noting that SPB had Schizophrenia, which was historically drug induced, and that he was currently denying acute psychosis. Dr JP notes that Nurse CC's dismissal of SPB's history of Schizophrenia as due to drug use was not supported on the information documented. Furthermore, a patient's denial of psychotic symptoms is not a sufficient basis to refute that the patient is actually psychotic, particularly in SPB's case, where he was reportedly guarded and had deteriorated over the period of a week. Dr JP notes that this diagnosis seems to have guided SPB's subsequent management, which was based only on a cross sectional assessment that appears to have taken precedence over the collateral information from his family, his history of schizophrenia, and ongoing prescription of high dose antipsychotic medication. Dr JP is of the view that Nurse CC and Dr SM did not give sufficient credence to the collateral information provided by SPB's parents, particularly in relation to the risk he posed to others, and the possibility of serious mental or physical deterioration. Furthermore, Dr SM's explanation as to the basis for SPB's presentation as one based in psychodynamic theory of parental envy, poor coping skills, acting out defences and unwillingness to take personal responsibility, was not sufficiently supported by the information available.

Dr JP noted that the decision to remove an involuntary assessment order should be based on the patient no longer meeting the criteria, and neither Nurse CC nor Dr SM demonstrated a sufficient basis to support the removal in SPB's case.

II. *Was the treatment provided sufficient given SPB's mental history and presentation on that date and on the following date when released? And, given SPB's medical and psychiatric history, was it appropriate for the Robina Hospital to release him on 24th January 2012?*

Dr JP notes that SPB's history of Schizophrenia and the information from his family about his behaviour in the week before the incident, suggests that he had a relapse in psychosis. The cause of this relapse was not clear. She is of the view that there was sufficient information in the medical chart, from police and his family to determine that SPB was suffering from a relapse in his psychotic illness and was acting on his psychotic beliefs. Generally, in such a situation, admission to hospital would be warranted to allow for further assessments to be undertaken in an environment where substance use, adherence and psychological stressors were more readily controlled. This assessment would then allow for the most appropriate treatment to be determined. Dr JP notes that in this case, there does not appear to have been any consideration of admitting SPB in order to further explore the situation.

In Dr JP's opinion, the decision to discharge SPB should not have occurred without discussion and guidance from the Consultant Psychiatrist on call. She notes her surprise that SPB was discharged in light of the requests for admission made by his Mother and Father and treating Psychiatrist.

III. *Was the risk management plan and follow up arrangements formulated by the Robina Hospital adequate and appropriate in the circumstances? Was the communication of the matter sufficient?*

Dr JP is of the view that SPB's risk management plan was inadequate as the risks had not been clearly elucidated prior to his discharge. She notes that when considering discharging a patient from the emergency department after being brought in by police or ambulance, good clinical practice is to obtain the agreement and support of his carers, in this case SPB's

parents, and his private Psychiatrist. Dr JP is of the view that the actions taken in this case, particularly the plan to discharge SPB to an unknown friend's residence, was not adequate management given the recent acute crisis. Relevantly, despite these shortcomings in the formulation and subsequent management, Dr JP stated that there was little indication that SPB was at acute or imminent risk of suicide. The greater risk appeared to be the aggression towards his Father and further deterioration of his mental state in the absence of definitive treatment.

IV. *Any other issues you believe are relevant to the investigation?*

Dr JP notes that whilst there were deficiencies in the assessment and subsequent management of SPB, it is not possible to suggest that a more detailed and thorough assessment involving the Consultant Psychiatrist would have detected the elevated risk of suicide in this case. As such, whilst it is possible that had SPB been admitted to hospital on 24 January 2012, he may not have suicided, it should be noted that suicide is also more likely during admission or shortly after discharge.

Gold Coast Hospital and Health Services review

Following SPB's death, the Gold Coast Health Service District ('GCHD') conducted a Human Error and Patient Safety ('HEAPS') review of the circumstances surrounding his admission and discharge from the Robina Hospital shortly prior to his death.

As a result of this comprehensive review, the following recommendations were made:

a. Prior to the EEO being revoked, SPB was placed on a Request and Recommendation to allow further time for clinical staff to assess him and consider whether he required admission under an Involuntary Treatment Order or whether he could be discharged.

It was recommended that Registrars make contact with Consultant Psychiatrists to discuss decision making process when patient/clients on EEO, including cases where the EEO progresses to a Request and Recommendation order; and when Request and Recommendation orders are ceased in the Emergency Department.

b. Although collateral information was obtained from SPB's family, it is not clear whether the information provided by his private Psychiatrist was received prior to the development of the discharge plan and SPB's discharge from the Emergency Department.

The importance for clinicians to ensure that all relevant collateral information was received prior to a client's discharge from the Emergency Department where practicable was reiterated. Details of the communication/collateral information and barriers must be clearly documented in the patient/client medical record.

These recommendations were endorsed by the Gold Coast Hospital and Health Services ('GCHHS') and implemented by way of the introduction of new procedure PRO1485, titled *'Discharge from Mental Health Community Teams'* ('the Procedure'). The Procedure, which was introduced in July 2015, is mandatory, and applies to all of the GCHHS MHSS Community Mental Health Teams.

Relevantly, the Procedure specifically stipulates the following measures:

- ***Section 3 - Procedure for discharge****:* It was noted that involving consumers, their families and or carers in discharge planning was an essential element of successful consumer outcomes. At section 3.1.1. states that, *'It is imperative*

that discharge be planned in partnership with the consumer, family carer, (where feasible) relevant Primary Health Care and other Mental Health Care providers and that the consumer, families, carers and health care providers are informed of the process of re-entry into the service…'

- ***Section 3.1.2 – Risk Management and Discharge planning:*** Risk management planning is an essential component of a safe and successful discharge of the consumer. Section 3.1.3, which relates to Clinical decision making in relation to discharge, notes that *'All discharges from Mental Health Community Teams where ever possible should be subject to a multidisciplinary team review including a consultant psychiatrist and the allocated case manager/care co-ordinator. Additionally, all community continuing care teams' clinical case reviews should be confirmed with the treating psychiatrist'.*

- ***Section 3.1.5 – Discharge Planning Documentation:*** The procedure requires that discharge planning documentation is to be completed utilising CIMHA *Case Review* Form and the *End of Episode/Discharge Summary* form if discharging from a community mental health team, and CIMHA Progress note if discharging from ACT. Section 3.1.6 stipulates that discharge plans include, but are not limited to, reasons for discharge, clear discharge plan including the mental status of the consumer, a risk management plan, progress whilst under the care of the Team, current and previous medications, links with private providers, a copy of the plan and capacity assessment.

- ***Section 3.2.2- ACT ED discharges*** are required a minimum, prior to leaving the emergency department, to have also been:

    - *Discussed with a mental health* –Consultant Psychiatrist if:

        - The consumer presented to ED on an EEO/ including an EEO that lapsed. *The procedure specifically states that all clients under an EEO need to be discussed with a Consultant, even if the EEO has lapsed prior to the client being assessed.*

        - Consumer was on a forensic order.

        - Consumer on a Request and Recommendation.

        - Consumers presented to ED following significant attempts at Self harm/suicide.

        - Consumers presenting frequently to the ED.

        - Consumers felt to be at high risk or overly complex.

    Additionally, Mental Health Registrars are required to discuss consumers who present to the Emergency Department with a Consultant Psychiatrist if (i) they are a First year Mental Health Registrar; or (ii) Second year Registrar.

Conclusion

SPB was 36 years of age when he took his own life by way of hanging. He had a significant mental health history, having been diagnosed with Paranoid Schizophrenia 15 years prior to his death. He had received ongoing and regular psychiatric and medical treatment for his

mental illness, as well as polysubstance abuse. This included regular engagement with Dr MMcD from the Currumbin Clinic. It is clear that SPB had a significant mental health condition, which caused him to experience episodes of acute psychosis, during which he could become delusional, violent and suffer from persecutory ideation. He had previously self-harmed and attempted to take his own life, in the context of his mental illness.

Clearly, there were a number of shortcomings in the findings and subsequent management of SPB by mental health staff at the Robina Hospital. Unfortunately, it seems that an unsupported diagnosis of alcohol misuse and intoxication was made, which effectively dismissed his long-term schizophrenia as drug induced, and guided his subsequent management. I agree with Dr JP's view that SPB should have been admitted for further assessment and risk management considering his mental state and mental health history as provided by his family and Dr MMcD.

Despite the shortcomings identified in relation to the formulation and management of SPB by the Robina Hospital, it is clear that there was little indication that he was at acute or imminent risk of suicide. Furthermore, as Dr JP notes, it is not possible to suggest that a more detailed and thorough assessment of SPB would have been able to detect the elevated risk of suicide, which also may not have been prevented had he been admitted to Hospital. Since SPB's death, a review has been conducted by GCHHS, the recommendations of which have been implemented by way of the introduction of a new discharge procedure. I am satisfied that this procedure sufficiently addresses the clinical concerns arising in this matter. Accordingly, I do not propose to hold an inquest in relation to SPB's death, and close the coronial investigation.

I close the investigations.

James McDougall
Coroner
Coroners Court Of Queensland
Southern Region
23 November 2016