OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Paul Andrew MEECH**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Hervey Bay
FILE NO(s):	COR/ 03 2095
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HEARING DATE(s):	03 – 07 April 2006
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, watch house supervision, mental illness, involuntary assessment and involuntary treatment order, management of mental illness.

REPRESENTATION:

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Queensland Police Service Union:	Mr Glen Cranny
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Findings of the inquest into the death of Paul Andrew Meech.

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The Coroners Act 1958 provides in s43(1) that after considering all of the evidence given before a coroner at an inquest the coroner shall give his or her findings in open court. What follows are my findings in the inquest held into the death of Paul Andrew Meech.

Introduction

Mr Meech had a history of relatively serious mental illness extending back at least 20 years. For periods it was relatively well controlled, often by lengthy admissions to mental health facilities. At other times, Mr Meech was dangerously chaotic in many aspects of his life. July 2003 was one such period. He was spiralling downwards with repeated incidents indicating increasing mania and psychosis. His brother and his regular treating doctor sought to obtain assistance for Mr Meech from the Maryborough Mental Health Unit (MMHU) and the Maryborough police also took him there after one of their numerous interactions with him.

Despite the claims of those around him that he urgently needed extended and intensive psychiatric intervention, Mr Meech was, in the last week of July, twice discharged from the MMHU after minimal treatment that did nothing to arrest his decline. On 1 August 2003, he was twice arrested by Hervey Bay police while engaging in deranged behaviour. On the second occasion, he was placed in the padded cell at the local police watch house where he was found dead less than three hours later.

These findings seek to explain how the death occurred, determine whether anybody should be committed for trial in connection with the death and recommend changes aimed at reducing the likelihood of similar incidents occurring in future.

The Coroner's jurisdiction

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

The basis of the jurisdiction

Although the inquest was held in 2006, as the death being investigated occurred before 1 December 2003, the date on which the *Coroners Act 2003* was proclaimed, it is a "*pre-commencement death*" within the terms of s100 of that Act and the provisions of the *Coroners Act 1958* (the Act) are therefore preserved in relation to it.

Because the police officer who first became aware of the death considered it to be "*an unnatural death"* within the terms of s7(1)(a)(i) of the Act, and as Mr Meech was in custody when he died, the officer was obliged by s12(1) to report it to a coroner. Section 7(1) confers jurisdiction on a coroner to investigate such a death and s7B authorises the holding of an inquest into it.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death.

The Act, in s24, provides that where an inquest is held, it shall be for the purpose of establishing as far as practicable:-

- the fact that a person has died,
- the identity of the deceased,
- when, where and how the death occurred, and
- whether anyone should be charged with a criminal offence alleging he/she caused the death.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proved.

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

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [1]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations,[2] referred to as "*riders*" but prohibits findings or riders being framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence.[3]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s34 of the Act provides that "*the coroner may admit any evidence the coroner thinks fit*" provided the coroner considers it necessary to establish any of the matters within the scope of the inquest.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s43(5)
[3] s43(6)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

applicable.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

Of course, when determining whether anyone should be committed for trial, a coroner can only have regard to evidence that could be admitted in a criminal trial and will only commit if he/she considers an offence could be proven to the criminal standard of beyond reasonable doubt.

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

The investigation

I turn now to a description of the investigation into this death. As soon as it was confirmed that Mr Meech was dead, the shift supervisor, Sgt Bennet, contacted the District Officer and other relevant senior officers. The acting officer in charge of the Maryborough Criminal Investigation Branch, Sgt Pope was detailed to investigate the matter. The cell was secured and photographed. The necessary watch house records were copied. All officers involved in the detention of Mr Meech were interviewed. An autopsy was undertaken by an experienced forensic pathologist.

More recently Mr Meech's medical records were obtained and an independent psychiatrist was briefed to provide an expert opinion.

I am satisfied that the investigation was sufficiently thorough and competently undertaken.

The inquest

Preliminary hearings and a view

The matter was initially reported to the local coroner. It became apparent that the inquest into this matter would be protracted. Lengthy matters impose significant burdens on single magistrate courts and I therefore agreed to a request from the Hervey Bay Coroner that I assume responsibility for the matter.

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[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[8] (1990) 65 ALJR 167 at 168

A directions hearing was held in Brisbane on 25 January 2006. Mr Rangiah was appointed counsel assisting. Leave to appear was granted to the two police shift supervisors at the material time and two watch house managers for the shifts in question. Leave to appear was also granted to the Commissioner of the Queensland Police Service (the QPS). The family were not separately represented but they attended the inquest and conferred with those assisting me throughout the hearing. A list of proposed witnesses and issues was published and a date set for the hearing in Hervey Bay.

Before the hearing commenced on 3 April, a view of the watch house was undertaken by the Court and those granted leave to appear. When the hearing commenced, the Fraser Coast District Health Service sought and was granted leave to appear.

Evidence was taken over the succeeding four days. 159 exhibits were tendered and 19 witnesses gave evidence.

The evidence

I turn now to the evidence. I can not, of course, even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Background

At the time of his death Mr Meech was 40 years old. For almost half his life he had suffered from moderate to severe mental illness that required on going attention and frequent admissions to mental health facilities. He had the benefit of a loving and supportive family, consisting of his mother and three siblings who provided him with assistance when they could. The Maryborough Hospital file records an incident in 1994 when his mother paid for an ambulance to take him to Toowoomba because she thought he would get better care there. It is clear that his mental illness at times made Mr Meech very difficult to deal with and the steadfast support of his family is admirable.

I shall say more about Mr Meech's mental health needs in the recommendations section of these findings. For now I simply note that in the weeks before his death he had a number of short terms admissions to the Maryborough Mental Health Unit (the MMHU) that seem to have done nothing to arrest his slide into full blown mania.

The last admission to the Maryborough Mental Health Unit

At about 4.30am on the morning of 29 July 2003, Maryborough police attended a local service station in response to a call from the operators that a man we now know was Mr Meech was acting aggressively there.

He was arrested for breaching the peace. He was making delusional claims and threats. For example, he told police that he could break the handcuffs

they had put on him and disarm and kill them in less than 30 seconds if he chose. He was taken to the watch house and released at around 8.00pm. Shortly afterwards he was seen by another officer who was leaving the station, standing on the roadway, yelling abuse at passers-by and forcing the traffic to drive around him. He was again arrested and lodged in the watch house where he again engaged in bizarre behaviour. When being taken to court he made more threats to police and claimed that he'd been held in a dungeon under a building in the city.

The police concluded that Mr Meech was suffering from a mental illness and later in the morning they took him to the Maryborough MHU. He was there assessed and an involuntary treatment order was issued under the *Mental Health Act 2000* which compelled Mr Meech to remain at the hospital. A few hours later Mr Meech absconded from the hospital but returned within an hour and was readmitted to the mental health ward.

He was managed within the unit overnight while exhibiting bizarre behaviour. The next day this behaviour worsened and Mr Meech became aggressive and violent. In an effort to manage this, Mr Meech was, on a number of occasions, placed in seclusion.

The next day, 31 July, a psychiatrist re-assessed Mr Meech and concluded that he was not suffering from psychosis or any other mental illness and that his extreme behaviour was a result of alcohol or drug abuse. The psychiatrist therefore instructed that Mr Meech be discharged and that he not be re-admitted unless there was "*objective evidence of psychosis.*"

It is noteworthy, however, that even after the involuntary treatment order was revoked, Mr Meech was again detained in the seclusion room and administered sedation. During this time he was observed to strip naked, repeatedly masturbate, and tear sheets into strips which he placed around his neck. He was obviously not keen to leave the MHU as the police were called to remove him. Puzzlingly, the hospital records indicate that 10 minutes after this occurred Mr Meech again presented at the accident and emergency department of the hospital although there is no record of what transpired when he did so. Nor is it clear whether he was still at the hospital when the police arrived as the police records conflict with the hospital records in this regard.

First contact with Hervey Bay police

Mr Meech obviously then made his way to Hervey Bay as later on 31 July, at about 10.00pm, Hervey Bay police were called to a local shopping centre to deal with a man causing a disturbance and starting fights. They found Mr Meech lying on the ground, with an injury to his head. The police arranged for Mr Meech to be taken by ambulance to the Hervey Bay Hospital where the wound was treated.

About five and a half hours later, in the early hours of 1 August, the same officers were called to the hospital becuase Mr Meech creating a disturbance there. Hospital staff reported that he was trying to fight with the orderlies and

that he was banging his head against the walls. There was no discussion with staff at the hospital as to whether Mr Meech was in need of mental health care. Rather, he was arrested for disorderly conduct and wrestled into the police car. As the officers were removing Mr Meech from the waiting area of the hospital, he lunged forward and deliberately banged his head against the sliding glass entry doors.

On account of his violent behaviour, when he arrived at the watch house Mr Meech was placed into the padded cell but apparently, he calmed down and was soon after moved to a regular cell. This passivity was obviously short lived as soon after a new watch house keeper came on duty at 7.00am he was so concerned by Mr Meech's behaviour that he telephoned the Maryborough Mental Health Unit to seek advice as to whether Mr Meech should be taken to the unit. He made a note of the conversation in the watch house register that records that he was told that Mr Meech had been released from the MHU the previous day after having been assessed over three days. The notation continues, *"He is not mentally ill, he is anti social."*

Mr Meech's behaviour continued to fluctuate throughout the day. At its worst it he was ranting and incomprehensible. It involved him stripping off and stuffing his clothes down the toilet and making a swastika on the cell wall with faeces. At other times he was normally conversational.

Shortly after 5.00pm, Mr Meech appeared in court. Initially, he was so unruly that he was removed to a holding cell below the court where he was seen to be putting his handcuffed wrists into the toilet bowl. He was also seen to smash the handcuffs against the cell bars in an apparent deluded attempt to break them. When all other defendants had been dealt with, Mr Meech was taken back to court. He continued to act in a deranged manner but he pleaded guilty to the disorderly conduct charge on which he had been arrested at the Hervey Bay Hospital earlier that day and he was released from the watch house just before 6.00pm.

At about 6.00pm, an officer from the Hervey Bay Police Station went across the road to get some food from a chicken shop. He there came across Mr Meech whom he had not met before. The officer says that Mr Meech was rambling, slurring and largely incomprehensible, although he did understand Mr Meech to be accusing him of stealing his vodka. The officer did not engage with Mr Meech and they soon parted.

Shortly before 8.00pm, the Hervey Bay police received a call from an employee of a near by hotel advising that a man we now know was Mr Meech, was "*playing chicken* " with the traffic on the road outside the hotel, drinking alcohol and yelling obscenities at hotel patrons. About ten minutes later, another call was received informing that the same person was now removing his clothes.

Four officers attended the scene and Mr Meech was arrested. He violently resisted arrest and had to be restrained in the police vehicle to prevent him from assaulting the officers and damaging the car. When they arrived at the

watch house Mr Meech refused to get out of the vehicle and continued to make threats of violence against police. He was wrestled into the watch house. After being searched he was placed in the padded cell.

The assessment of any special needs he might have was not made on account of his violent behaviour.

The videotape from the cell monitor shows that Mr Meech was placed into the padded cell at 8.16pm. He can be seen pacing around the cell and apparently yelling out from some time. Almost immediately he removed all of his clothing, defecated and threw the faeces around the cell and smeared the walls and floor.

Soon after Mr Meech was seen on the monitor to soil the cell, the shift supervisor called the officer in charge of the station who was off duty to make inquiries about getting the cell professionally cleaned. During the conversation he described Mr Meech's behaviour causing the officer in charge to direct the shift supervisor to call the MMHU to see if Mr Meech should be taken there.

The shift supervisor complied with this direction. He asked the two people he spoke with whether they knew of Mr Meech. Both indicated they did. The second of these people told the shift supervisor that Mr Meech had been at the MHU recently and that he had been assessed as not suffering from any mental illness and that Maryborough police had been needed to remove Mr Meech from the MHU. As a result of being advised of this the shift supervisor gave no further consideration to having Mr Meech's psychiatric condition assessed.

For the next half hour after Mr Meech soiled the cell, the video tape shows that he paced around the cell or stood against the wall. At about 8.50 Mr Meech is seen to be crouching towards the back of the cell with his head resting against the wall. He raises himself onto all fours and then slumps back down on a couple of occasions. He then sinks onto his left hand side and on two occasions draws his legs right up to near his chest, writhing, and then subsiding into a foetal position. A minute later Mr Meech straightens his legs and moves no more.

Nothing then happened in the cell unit 11.00pm when the shift supervisor, who had started duty at 10.00, entered and quickly realised that Mr Meech was dead. The ambulance was called and arrived within a couple of minutes. They confirmed that Mr Meech was dead and left without attempting resuscitation. The investigation detailed above was then commenced.

On 4 August a comprehensive autopsy was undertaken on Mr Meech's body by Dr Ashby, an experienced forensic pathologist. She found no evidence of trauma or injury that would explain Mr Meech's death. The minor injuries that he was found to have were consistent with having been caused during the struggles and scrapes described earlier in these findings. She found blood tinged froth in the larynx, trachea and bronchi consistent with an asphyxial event. This was consistent with the enlargement of the spleen and petechial

haemorrhages in the upper eyelids, the neck, the lungs and the scalp. These findings led Dr Ashby to conclude that asphyxia was the primary cause of death.

Toxicology results that showed a blood alcohol level of .289% led Dr Ashby to suggest that a seizure resulting in laryngospasm and involuntary contraction of the thorax could have been the mechanics of death. After watching the video tape of the cell monitor, Dr Ashby suggested that the straightening of the legs by Mr Meech at 8.51 was probably the agonal event. In her report and in evidence Dr Ashby discussed the possibility of Mr Meech's violent and aggressive behaviour being explained by hypoglycaemia caused by a falling alcohol level. She was not aware of an alternative explanation for that behaviour which has received considerable attention at this inquest, namely Mr Meech's mental illness, nor that Mr Meech had engaged in similar behaviour when he had been in custody for many hours and could not be intoxicated. I am therefor disinclined to consider hypoglycemias played any part in the death.

Findings required by s43(2)

I am required to find, so far as has been proved, who the deceased was and when, where and how he came by his death.

As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, I am able to make the following findings.

Identity of the deceased – The deceased was Paul Andrew Meech

Place of death – Mr Meech died in the Hervey Bay police watch house in Queensland.

Date of death – He died on 1 August 2003.

Cause of death – Mr Meech died as a result of asphyxia caused by a seizure resulting from severe alcohol intoxication. An underlying significant condition that contributed indirectly to the death was bipolar affective disorder.

The committal question

Section 41(1)(a) of the 1958 Act provides, so far as is relevant, that if in the opinion of the coroner the evidence taken at the inquest is sufficient to put a person upon trial for manslaughter, the coroner may order the person to be committed to trial for the offence.

Section 303 of the Criminal Code provides "*that a person who unlawfully kills another under such circumstances as not to constitute murder is guilty of manslaughter"*. So far as is relevant, s285 of the Criminal Code provides that if a person has a duty to supply the necessaries of life to another because the

second person is detained, the first person is responsible for the consequences of any failure to supply those.

In this case, when Mr Meech was being held in the watch house, Sergeant Witt or Constable Elder or perhaps both had charge of the deceased by reason of his detention in the watch-house. It was the duty of those officers to provide the deceased with the necessaries of life.

In *R v Nielsen* (2001) 121 ACrimR 239, the Court of Appeal expressed the view that failure to provide medical assessment and treatment for a person displaying schizophrenic symptoms amounted to a failure to provide a necessary of life.

I have accepted that when he was in the watch-house the deceased's behavior was consistent with his experiencing the manic phase of Bipolar Affective Disorder. However it was not the direct effects of that disease which killed him but rather the asphyxia brought on, probably, by severe intoxication.

There was very little prospect that anything the officers could have done would have saved Mr Meech once the seizure that precipitated the asphyxia occurred.

I am satisfied that neither officer could reasonably have known that Mr Meech was in need of emergency attention and can not therefore be held liable for it. They held an honest and reasonable belief that Mr Meech was merely intoxicated and that he would recover spontaneously as his body metabolized the alcohol he had consumed. Therefore, I consider that no properly instructed jury could lawfully convict the officers of the unlawful killing of Mr Meech. Accordingly I find that no person should be committed for trial in connection with the death.

Preventive recommendations – riders

Section 43(5) of the Act prohibits a coroner from expressing any opinion on a matter outside the scope of the inquest except in a rider which is, in the opinion of the coroner, designed to prevent the recurrence of similar deaths. I pause to note the power given to coroners is not limited to the making of riders aimed at preventing deaths in identical circumstances in future. Therefore in my view, the fact that this death may have occurred in almost unique circumstances or in circumstances where it could not have been prevented does not deprive me of the authority to make riders aimed at other watch house deaths that could occur in similar circumstances.

This case raises a number of issues which warrant attention from that perspective.

The assessment and supervision of Mr Meech in the watch house

Assessment of medical needs

So far as is relevant to this matter, Chapter 16 of the QPS Operational Procedures Manual (the OPM) provides that the officer admitting a prisoner to a watch house must assess whether he/she requires any medical attention. If so, the officer must take steps to ensure that it is provided. The watch house register has pre-printed forms on which this assessment is to be recorded.

In this case, the watch house keeper at the time Mr Meech was admitted said that he did not make or record any such assessment because of Mr Meech's violent resistance when he was brought in. He was given a pat down search and wrestled into the padded cell; the officers then using their best endeavours to extricate themselves without injury.

Thereafter, Mr Meech was assumed to be intoxicated and nothing more, so no medical attention was sought. In making this assessment the officers relied on the advice they had twice on that day been given by staff at the MMHU to the effect that Mr Meech was not suffering from any mental illness. I consider that they were entitled to rely on that advice and to assume the person proffering it was competent and authorised to do so.

I am of the view that the officers actions and presumptions were reasonable in the circumstances and indeed to the extend that they related to Mr Meech being drunk, they were borne out by the blood alcohol levels found at autopsy. They were wrong when they assumed that he did not require any medical attention but this is a vexed question that could not be solved by those officers on that night, nor this inquest today. It is a fact that very drunk people can not be safely held in a watch house. However, it is unclear how officers can determine when that dangerous state has been reached and equally unclear as to what they can do with such people if the risk is recognized, having regard to the violent and aggressive behaviour many people exhibit when so affected.

Inspection of Mr Meech in the watch house

Another aspect of this matter that requires some consideration is the adequacy of the supervision of Mr Meech while he was in custody on the night of his death.

So far as is relevant to this matter Chapter 16 of the OPM provides that the officer in charge of the watch house is to ensure that each prisoner is inspected at intervals of no greater than one hour to determine whether the prisoner may be in need of medical treatment. Officers are directed by the OPM to observe the prisoners' physical appearance and to pay particular attention to any prisoner who is apparently intoxicated to ensure that is not masking the symptoms of a serious medical condition. They are also instructed to ensure that a sleeping prisoner is breathing comfortably and

appears well. The OPMs provide that *"inspections are to be conducted personally irrespective of whether or not video monitoring equipment is installed."* The instructions are duplicated and simplified in standard operating procedures developed for the Hervey Bay watch house by the local watch house manger.

In addition to these hourly inspections watch house managers must also physically inspect all prisoners at the beginning and at the end of each shift.

From the time Mr Meech was placed in the padded cell at about 8.15 until he was found dead at about 11 o'clock, no officer entered his cell or opened the cell door. The only inspections consisted of observing him on the monitor that was in the corridor outside his cell and another in the sergeant's office in the police station. The clarity of the picture on these monitors is poor. While this mode of monitoring a prisoner may be adequate when he or she is moving about, when a prisoner is prone and still, it does not enable the viewer to determine whether the prisoner is asleep, unconscious or dead. It obviously does not comply with the OPMs or local SOPs. The evidence of the senior officer of the Property and Facilities Branch of the QPS is that the monitor is only intended to be used to check the location of the prisoner before opening the door.

The watch house keeper who was on duty when Mr Meech was first placed in the padded cell said he did not enter the cell to inspect the prisoner because he was concerned of the health risks posed by the faeces Mr Meech had spread over the cell. He could not explain why, when he could see Mr Meech lying prone, he didn't open the door to check from the doorway that Mr Meech was at least breathing.

The officer appointed as watch house keeper from 10 o'clock onwards, was instructed by the shift supervisor not to enter the cell for the same reason with the added concern that Mr Meech was naked and she was a female. The shift supervisor also pointed out that the door to the padded cell was quite heavy and he considered that the female officer might not be able to close it quickly if the prisoner sprung up when she opened it to observe him.

These concerns can readily be accepted as reasonable and valid. The watch house keeper who finished his shift at 10 o'clock and the shift supervisor who commenced duty at that time were aware that Mr Meech had been still, on the floor of his cell, for about an hour. They reasonably assumed he was sleeping and it was decided that he would be left sleep for another hour before being woken and moved to a normal cell at 11o'clock. He was seen to be in a position that would minimise the risk of positional asphyxia.

We now know that plan had a fatal flaw, but as I have said it is unlikely that strict adherence to the OPM would have prevented the death. That doesn't mean that in other similar circumstances death would be unavoidable, nor does it mean that the practice adopted by the officers on this night was appropriate. There were four officers on duty in addition to the shift supervisor. It was open for him to arrange for two of the male officers to

attend at appropriate intervals to at least open the cell door to inspect Mr Meech. Even had this not saved Mr Meech's life, it certainly would have avoided the macabre situation whereby Mr Meech lay dead in his cell for two hours before those holding him became aware of his demise.

There is a full time watch house manager who is responsible for the training and supervision of watch house staff. At the time of this incident, even though both watch house keepers had relatively recently undergone custody training, it seems their knowledge of appropriate procedures was inadequate: one didn't even know of the existence of SOPs for the watch house.

Recommendation1 - Inspection of prisoners

I recommend that all operational police be reminded of the need to physically inspect prisoners in accordance with the requirements of the OPMs and the SOPs.

Recommendation 2 – Inspection of prisoners in the padded cells

I recommend that the watch house managers be directed to develop and implement procedures for the inspection of prisoners in padded cells that will enable inspections to be undertaken in all circumstances that may exist in their respective watch houses.

The watch house facilities at Hervey Bay

The invidious position the watch housekeepers found themselves in when determining how they could keep watch over Mr Meech raises the question of whether the design of the padded cell is adequate for its purpose. In particular, it raises the issue of whether the inability to see into the cell with sufficient clarity to make the necessary assessments of a prisoner's condition without opening the door should be remedied.

The evidence of the senior officer of the Property and Facilities Branch of the QPS is that there is now in use in new watch houses, a padding that allows doors to be fitted which include a strip of glazing to allow an officer to see into the cell and a two piece door which can allow the top section to be opened with minimal chance of the prisoner escaping.

Recommendation 3 - Review cell doors

I recommend that the Property and Facilities Branch urgently review the doors on all padded cells to determine whether they should be replaced by doors that allow officers to visually inspect prisoners.

The response of the Maryborough Mental Health Unit

The statutory framework

Before considering in detail the adequacy of the response of the MMHU it may be helpful to refer to the statutory framework under which a person thought to be suffering from mental illness can be compelled to undergo assessment and or treatment.

A request for assessment for a person may be made by an adult who reasonably believes that the person has a mental illness of a nature or to an extent that involuntary assessment is necessary and who has observed the person within 3 days of making the request (s.17). A request for assessment is accompanied by a recommendation for assessment by a doctor or authorised mental health practitioner who has examined the person within the preceding 3 days (s.19(1)). A person for whom these assessment documents are in force may be taken to an authorised mental health service by an ambulance officer or health practitioner (s.25(1)).

An alternative procedure for assessment of a person is an application for a justice examination order to a magistrate or justice of the peace (s.27(1)). A justice examination order authorises a doctor or authorised mental health practitioner to examine the person to decide whether a recommendation for assessment should be made (s.30(1)).

A third procedure for assessment of a person is that a police officer or ambulance officer may make an emergency examination order (s.35(1)) in circumstances where because of the person's suspected mental illness there is imminent risk of significant physical harm being sustained by the person or someone else (s.33(b)). The person must be taken to an authorised mental health service for examination to decide whether assessment documents for the person should be made (s.34). On the making of the emergency examination order the person may be detained for not longer than 6 hours for examination by a doctor or authorised mental health practitioner (s.31(1)). In that period a recommendation for assessment can be made by a doctor or authorised mental health practitioner.

When assessment documents are in force for a person, the person may be detained in an authorised mental health service for assessment for the assessment period (s.44(1)). When the assessment documents are produced the person becomes an involuntary patient (s.44(6)). The initial assessment period is for no longer than 24 hours, but may be extended to 72 hours (s.47).

As soon as practicable after the person becomes an involuntary patient, an authorised doctor for the authorised mental health service must make an assessment of the patient to decide whether the *"treatment criteria"* apply to the patient (s.46(1)).

The *"treatment criteria"* are all of the following (s.14(1)):

"(a) the person has a mental illness;

(b) the person's illness requires immediate treatment;

(c) the proposed treatment is available at an authorized mental health service;

(d) because of the person's illness -

(i) there is an imminent risk that the person may cause harm to himself or herself or someone else; or

(ii) the person is likely to suffer serious mental or physical deterioration;

(e) there is no less restrictive way of ensuring the person receives appropriate treatment for the illness;

(f) the person -

(i) lacks the capacity to consent to be treated for the illness; or

(ii) has unreasonably refused proposed treatment for the illness."

It is fundamental that the person must have a *"mental illness"* if the person is to be treated as an involuntary patient. That expression is defined as *"a condition characterised by a clinically significant disturbance of thought, mood, perception or memory"* (s.12(1)). However, a person must not be considered to have a mental illness merely because, inter alia, the person takes drugs or alcohol or the person engages in antisocial behaviour or illegal behaviour (s.12(2)).

An authorised doctor for an authorised mental health service may make an involuntary treatment order for a patient if satisfied that the treatment criteria apply to the patient (s.108(1)). If an involuntary treatment order is not made at the end of the assessment period , the patient ceases to be an involuntary patient and the doctor must tell the patient that the patient is no longer an involuntary patient (s.48(1)). However, the person may continue to be a patient as a voluntary patient (s.48(2)).

If the involuntary treatment order was made by an authorised doctor who is not a psychiatrist, the patient must be examined by an authorised psychiatrist within 72 hours (s.112(2)). The psychiatrist must revoke the order if not satisfied that the treatment criteria apply to the patient (s.112(5)). The

psychiatrist must confirm the order if satisfied that the treatment criteria apply to the patient (s.112(6)).

If the category of the involuntary treatment order is in-patient, the patient may be detained in the patient's treating health service. A treatment plan must be prepared for the patient and the patient must be treated as required under the treatment plan (ss.110, 115). Regular assessments of patients are then required to be carried out as required under the patient's treatment plan (s.116).

Seclusion of an involuntary patient in an in-patient facility of an authorised mental health service may be authorised by a doctor or, in urgent circumstances, by the senior registered nurse on duty (s.150). Seclusion means the confinement of the patient at any time of the day or night alone in a room or area from which free exit is prevented (s.148(1)). Seclusion may not be authorised unless the doctor or nurse is reasonably satisfied that it is necessary to protect the patient or other persons from imminent physical harm and there is no less restrictive way of ensuring the safety of the patient or others (s.151). Seclusion must be authorised by written order (s.153).

Mr Meech's mental health history

In order to assess the adequacy of the response of the MMHU to Mr Meech's needs it is necessary to provide some detail of his medical history.

It appears that between 1984 and December 1994 Mr Meech had 11 admissions to various hospitals for treatment of his mental health. The early admissions were for a period of one month. Subsequent admissions decrease in duration from three weeks to two weeks and then there are a number of one week admissions.

On each occasion he was diagnosed with and treated for bipolar affective disorder (BPAD).

He also attended a psychiatric out patients clinic at the Maryborough Hospital commencing August 1991 to April 1994. His attendances were on average monthly but there were some periods when he did not attend.

From April 1997 to July 2003 Mr Meech appears to have been managed by either his general practitioner Dr Michael Monsour or other hospitals or local doctors in the towns where he was staying.

Dr Monsour's treatment

In May 1998 Mr Meech began to receive monthly intramuscular injections of depot Haloperidol (Haldol) in addition to some other medications including Cogentin and Lithium Carbonate from Maryborough General Practitioner Dr

Monsour with who he seems to have established a reasonably productive therapeutic alliance.

From May 1998 until January 2001 Mr Meech received virtually monthly depot Haldol and he appears to have remained relatively well.

Dr Monsour's records then contain a gap between January 2001 and March 2002. Mr Meech returned to the practice at this time for two further injections of Haldol (March and May) but only 100mg was given thus reducing the dose by 50mg.

There is a further gap in the records between May 2002 and June 2003. A further injection of Haldol is given on 10 June but only of 50mg.

On 19 July he again represented to the practice. Schizophrenia is noted as well as *"nerves playing up, insomnia and distressed".* He was advised to seek admission to the Fraser Coast Mental Health Unit.

On 25 July 2003, the last occasion Dr Monsour saw Mr Meech, the notes reveal he was *"manic++"*. He was provided with a letter and a Recommendation for Assessment.

Dr Monsour's statement to police indicates that Paul was *" … extremely manic and I felt he was a danger to himself. In this state he was likely to do anything."*

Meech's interaction with MMHU during July 2003

In the three weeks preceding his death, Paul Meech attended Maryborough Base Hospital on 11 occasions. On some visits he was seeking treatment for minor injuries or alcohol abuse. On a number of other occasions he was seeking sedatives or sleeping tablets and/or seeking admission to the MMHU.

Each time he presents to the A&E his previous diagnosis of BPAD or variations thereof are included in the summary.

Assessment on 25 July and day leave

There is then a break of some ten days before he again presents to the A&E department at 3.30pm on 25 July with the letter of referral and recommendation for assessment signed by Dr Monsour. In the letter, Dr Monsour states that Mr Meech appears manic at present and that he has a past history of schizophrenia. He notes that he is currently on Lithium (200mg bd) and that he feels he may need admission.

There is also a Request for Assessment form signed by his brother Alan James Meech and dated 25 July 2003. In the reasons section of that document Alan recorded that Paul was "hyperactive, irational (sic). Not sleeping"

An assessment was undertaken by Dr Alexandre who recorded a previous history of bipolar affective disorder and polysubstance abuse.
Dr Alexandre also noted that Mr Meech's speech was pressured, he had a euphoric mood and fatuous affect. He had marked flight of ideas. In his statement to the inquest Dr Alexandre states that he didn't get the impression Mr Meech was in a delirium or confusion and that he had ingested alcohol or drugs to the extent which would have resulted in that state. He also had partial insight so he was aware that something was going on but he didn't appreciate he was unwell.

Dr Alexandre formed the impression Mr Meech was hypomanic and that he was potentially psychotic but not necessarily under the effect of drugs. He didn't consider Mr Meech was suffering from a schizophrenic psychosis or that he was having delusions. His diagnosis was hypomania and he queried whether it was in the context of bipolar affective disorder and or secondary to either illicit or prescribed substance abuse.

Dr Alexandre concluded that it was appropriate to admit Mr Meech for assessment so he duly completed the Recommendation for Assessment form and noted the assessment period commenced at 4.30pm for 24 hours.

At 5.10am the nursing notes reveal that upon waking Mr Meech was loud, hypervigilant and intolerant if his requests were not met immediately. He was pacing the unit and was unable to settle and his agitation appeared to be increasing. He was given 10mg of diazepam at 4.50am.

A further nursing note recorded at 7.00am states that he was threatening to fight staff however he settled within a short period.

At 10.30am the next day he was seen by Dr Kluver, the then director of psychiatry. The date of the entry is *"27 July"* but this appears to be an error and should be 26 July. Dr Kluver noted that Mr Meech was requesting discharge. He was happy to have slept 5 hours last night. His speech was noted to be pressured but there were no clear psychotic symptoms. Dr Kluver was able to negotiate day leave with him as an alternative to discharge.

Mr Meech returned as a voluntary patient at about 5.00pm on 26 July.

At 9.00pm a nursing entry records that Mr Meech was noisy, intrusive and hostile initially but settled quickly. He was noted to be expansive and grandiose at times and overly friendly with female co-patients. He was noted to have disorganised conversation much of the time and was using a lot of street jargon but at other times was quite calm and able to conduct sensible conversations. He as also observed to be talking to the radio and television (the USA weather pattern channel).

There is a note at 9.10pm where a conversation at 6.30pm with Dr Alexandre is recorded. The doctor is advised that Mr Meech wishes to leave the unit. Dr Alexandre provided instructions that he may leave. A phone call with Dr

Kluver then occurs at 9.00pm. Dr Kluver instructs that Mr Meech may be readmitted should he represent.

As there was no decision made on 27 July 2003 to either continue Mr Meech's assessment or place him under an involuntary treatment order, Dr Alexandre completed the Patient Ceased to be an Involuntary Patient form at midday on 28 July 2003.

At 10.45pm Mr Meech again presents to the A&E department requesting an x-ray of his collar bone. He also advises that he has just been released from the police station and is cold and hungry and has no-where to go. The A&E chart notes his other diseases/disabilities as "manic, scitz, bipolar, chemical imbalance".

At 11.00pm the nurse notes that he became verbally abusive, demanding admission to the MHU. When told he had to wait, he threatened to break down the door and break into the MHU. Police and security were notified.

Assessment and admission 29 - 31 July 2003

Mr Meech's next contact with the hospital is at 9.30am on 29 July when he is brought to the A&E department by police. He has been in custody overnight and the police advise he is a risk to himself and being a disturbance to the community. Mr Meech states that he wants to eat and he wants admission to the mental health unit.

The police have in their possession an Emergency Examination Order form dated 29 July 2003 and signed by the applicant Senior Constable Shane Coles from the Maryborough police station. The order notes that he had been taken into custody and released on three occasions during the night/ morning of 28/29 July 2003. His mood was noted to vary between calm to very agitated. His speech was rambling and sometime incoherent. He made threats of violence towards police and believed he has superhuman strength. *"I can snap handcuffs, can disarm and kill a police in less than 30 seconds".*

The order notes that while he was in the watch house he removed all of his clothes and scrubbed the walls and floor of the cell with them. Within seconds of being released from custody he was walking in front of traffic. He was due to due to appear in court and when transported there became angry, tense, and threatened violence. He also talked of dungeons under buildings that he had been held in.

He is then assessed at 9.45am by Dr Lip. Mr Meech wanted to know what nationality Dr Lip was and whether he was a dragon. He was also noted to be rambling on and hyper-excited. Dr Lip considered that he should be assessed so he completed a Request for Assessment form wherein he notes: *"Brought in by police – risk to himself and community. Hyper-excitable and rambling in speech. Aggressive."*

It appears that Mr Meech is then assessed by Vicki Kilbourn, an authorised mental health practitioner and she completes a Recommendation for Assessment form. The form indicates that he is mood elevated, very irritable, pressured speech and hasn't slept. He has been wandering from place to place. He stated that when he turned the television on at Cooladi he saw a sentence on it referring to him irrespective of the channel.

The form states that he is at risk of self harm inadvertently engaging in risk taking behaviour and has poor insight.

Mr Meech is again referred to Dr Alexandre at the mental health unit.

Mr Meech was still mood elevated but rather than a happy mood he was irritable, agitated and dysphoric. His thought form was abnormal but it wasn't as clear cut as it had been previously. His conversation was still moving from topic to topic but he was unsure if it was flight of ideas or something else. He also noted he had labile affect.

Dr Alexandre noted he seemed cognitively intact so his level of consciousness was not obviously impaired. His diagnosis was basically the same as it was on 25 July 2003 and that was that he was mood elevated, possibly as part of bipolar affective disorder and he queried whether it was secondary to substance abuse.

Dr Alexandre considered Mr Meech required a longer period of admission to determine his usual level of functioning and the aetiology of the disorder. He thought the only way to achieve this was to admit him under an Involuntary Treatment Order (ITO). He then duly signed the order at 11.15am.

Dr Alexandre notes on the form that Mr Meech had previously been diagnosed with bipolar affective disorder and that he was currently elevated and irritable in mood, suggesting hypomania. He considered the illness required immediate treatment which was available at the mental health unit. He notes that untreated it was likely he would suffer further deterioration.

He noted that Mr Meech had recently been seen walking in traffic in a disorganised fashion so he appeared to be a danger to himself. Due to his mood elevation there was no less restrictive way of ensuring treatment and he lacked the capacity to consent to treatment.

Dr Alexandre ordered 30 minutely observations, Olanzapine at night and regular Clonazepam.

Mr Meech was then admitted to the ward and was to be managed in the open ward or in the High Dependency Unit (HDU) as required. The nursing notes indicate that he was abusive, swearing, pacing ++ and hostile however he was compliant with admission process.

At 12.00pm he was noted to be still pacing but not as abusive.

At 2.20pm he was noted to be demanding ++ wanting phone calls and cigarettes. He was abusive to staff and others. When he continued to demand cigarettes and was advised that there were none of the ward, he proceeded to leave the ward, jump the fence and abscond.

An entry is then made by Dr Karin Fuls noting that Mr Meech had absconded over the fence and a requirement and authority to return had been completed. The requirement form is signed by Dr Fuls at 2.30pm. The form notes that it is necessary to complete his treatment as he is mentally ill and will deteriorate if not treated.

A nursing entry then appears in the records at 3.10pm which notes that Mr Meech had returned to the ward at 3.00pm. He was escorted to the HDU in accordance with Dr Fuls orders. He was given 2mg of Clonazepam at 3.20pm.

At 7.00am on 30 July Mr Meech is noted to be walking about the unit in a hostile and threatening manner. He is reported to be slamming doors and wearing only a towel around his waist which he then removes and is naked apart from a top. He is recorded to be very angry and verbally threatening. He is then administered 1mg of Clonazepam at 7.30am with no effect.

He continues to stalk the unit so he is placed in the HDU with the assistance of the hospital orderlies. He is then administered 10mg of Midazolam at 8.30am.

Mr Meech continues to be abusive and threatening so is placed in seclusion at 8.35am by order of the senior nurse. Dr Fuls is informed of the situation at 8.40am. The seclusion order indicates Mr Meech is aggressive and he is kicking and throwing furniture and threatening staff.

At 8.45am he is noted to be tearing a bed sheet into strips and wrapping it about his head ninja style. He is placed on constant observations at 8.50am. At 9.00am he is noted to be urinating on the floor. At 9.20am he is observed to be asleep on the bed.

At 10.15am Dr Fuls orders further seclusion due to his physical aggression and being uncooperative. The seclusion order states he is *"acutely psychotic with physically aggressive behaviour"*. The order is to end at 10.15pm.

Dr Fuls makes a further seclusion order at 5.00pm on 30 July to expire at 5.00am on 31 July. The reasons noted in that order are that he is physically aggressive at present and uncooperative. He requires seclusion to protect himself and others from physical harm. Dr Fuls notes there is no less restrictive way of ensuring his safety.

The nursing note which follows indicates he wakes at 12.45pm. He is recorded as banging on the door and beating at the window. He is noted to remain unsettled and still possibly aggressive and uncooperative. Dr Fuls is informed. Fifteen minutely observations are maintained.

Dr Fuls then notes in the record that Mr Meech does not appear to have perceptual disturbances, a formal thought disorder or abnormal thought content. He is irritable and aggressive with a loud voice. She notes he has some provocative behaviour and does not respect personal boundaries. She queries if his presentation is a substance induced condition. She orders the continuation of benzo sedation and seclusion as required.

A further entry by Dr Fuls notes when Mr Meech is taken out of seclusion for a smoke he refuses to return and is aggressive. She orders Olanzapine 10mg stat dose and Olazapine 5mg tablets as required. He is to be managed in seclusion as required.

A nursing note at 9.30pm records that Mr Meech was released from seclusion at 4.00pm for a coffee and cigarette and then could not be persuaded to return without a *"show of numbers"*. At 5.00pm he is given dinner and at 9.00pm he is allowed out of seclusion. He is returned at 9.30pm but again needed a show of numbers and *"lots of encouragement".* He continued to bang on the door and windows. He also stripped off his clothes and masturbated. At 10.00pm he is noted to be a little more settled but still masturbating.

At 3.45 am on 31 July 2003 Mr Meech was released and returned to seclusion but again commenced banging on the doors. It was negotiated that he could have 2 cigarettes and he was to have his Olanzapine. At 4.35pm he was escorted out of seclusion by two orderlies and given 5mg of Olanzapine and 2 cigarettes. A phone request was made to Dr Ting requesting authorisation for further seclusion commencing 4.45am. He was then escorted back to seclusion where he is recorded to have promptly settled.

There are then two further nursing entries where he is reported to have been threatening to staff whilst out having a cigarette and observed to have been banging his head against the window.

These entries are followed by notes made by Dr Fuls. She records that he is currently aggressive and uncooperative. However according to Dr Fuls there is no formal thought disorder, no delusions and no perceptual disturbances. She queries whether his admission presentation is due to substance abuse. Dr Fuls then revokes the Involuntary Treatment order and notes the chart that Paul to be discharged. He is only to be readmitted if there are objective signs of psychosis. Dr Fuls signs the declaration to revoke the ITO on the basis that she is not satisfied the treatment criteria did not apply. The time recorded on the form is 8.45am.

A nursing note is then recorded stating Mr Meech had been in seclusion since 8.30am. He was returned to seclusion at 8.45am. He is observed on the monitor to remove all bed clothing and tear the sheets and place them around his neck. He is also noted to be standing at the window masturbating.

The final entry in the records for Maryborough indicates he is given his clothing and escorted from the unit with the assistance of police at 12.45pm.

Ten minutes later there is a phone call to report that Mr Meech is in A&E and demanding his clinical file.

Critique of clinical decisions

The question this history raises is whether Mr Meech should have been discharged from hospital on 27 and 31 July 2003.

Dr K Dr Kluver provided a statement to the inquest and gave evidence indicating that he first saw Mr Meech on 27 July. In evidence it was established that this date was incorrectly recorded and it should have been 26 July. Mr Meech had been requesting discharge because his primary goal of obtaining a good night's sleep had been achieved. Dr Kluver considered that it would be very difficult to justify involuntary detention of Mr Meech because he didn't meet the treatment criteria in the Mental Health Act.

Dr Kluver stated that in view of his numerous presentations to the emergency department and the limited period of time he had been in hospital, he negotiated with him to have day leave as an alternative to discharge. Dr Kluver stated that he recalled the interview and clearly remembers the objective was to prolong Mr Meech's voluntary admission because at that point he did not meet the criteria for involuntary detention. Dr Kluver considered that he had no grounds upon which to extend the assessment period or to institute an involuntary treatment order under the provisions of the *Mental Health Act 2000.*

Dr Fuls also provided a statement and gave evidence at the inquest. Dr Fuls concluded that on the information available to her Mr Meech suffered from alcohol dependence with the abuse of multiple other substances, such as cannabis and prescription medication. She made repeated references to his aggressive, violent and abusive behaviour resulting in the necessity for Mr Meech to be managed in seclusion. She considered Mr Meech exhibited the characteristics of someone with an antisocial personality disorder. In Dr Fuls opinion there was inadequate evidence on the last admission to support the presence of a psychotic disorder such as schizophrenia or a mood disorder such as BPAD.

In evidence Dr Fuls stated that Mr Meech was displaying 'problematic behaviour' on the ward which placed others at risk. She considered that Mr Meech's ability to negotiate or manipulate to meet his needs, such as cigarette's etc, indicated voluntary behaviour which is inconsistent with a presentation of mania. Dr Fuls gave evidence that clinicians need to work with the boundaries and confines of the Mental Health Act and because the Act doesn't refer to behaviours his presentation did not meet the treatment criteria. Accordingly, if a patient is aggressive and not mentally ill, then the appropriate people to deal with this is the police.

Both Dr Kluver and Dr Fuls gave evidence that at the time they interviewed Mr Meech he was not displaying forms of thought disorder to warrant further detention under the provisions of the Mental Health Act. Although the medical records received under summons by this office contained a good mental health history, neither of the doctors appeared to have read it.

To assist consideration of this issue, my office obtained a report from Adjunct Professor Joan Lawrence who was requested to provide an evaluation of the management of Mr Meech's condition by the MMHU. I was greatly assisted by Dr Lawrence's report and the evidence that she gave.

In Dr Lawrence's opinion there is no doubt Mr Meech suffered from a severe condition of Bipolar Affective Disorder which would be regarded under current DSM-IV terminology as Type 1, with primarily manic episodes. Dr Lawrence considered that there was extensive documentation within his medical records to evidence this condition.

Dr Lawrence reports that there were regular indications Mr Meech was frequently non-compliant with his maintenance medication and he acknowledged and admitted regularly abusing alcohol and marijuana which clearly aggravated or exacerbated his mental illness. Dr Lawrence reports that when the illness itself begins to develop, patients often tend to commence use and abuse of substances in an effort to ameliorate the symptoms and distress that the illness episode causes.

Dr Lawrence concedes that whilst making allowance for the inherent difficulties in managing a patient such as Mr Meech, even when a diagnosis was made of a manic episode in a BPAD, the substance abuse that was comorbid was given unnecessary weighting in the management decisions. She explains that Mr Meech was consistently treated as an intoxicated person with obnoxious behaviour, as opposed to a mentally ill person who was comorbidly substance abusing.

She opines that Mr Meech's patterns of behaviour in the 3-4 weeks prior to his death are all consistent with manic behaviour plus intoxication but repeated efforts by Mr Meech himself, his general practitioner and his family to have him admitted and obtain necessary, lengthy treatment for his condition in a secure and safe environment failed.

Dr Lawrence notes that even when he was given admission to the MMHU under an order, he was permitted day leave the following day which she considered counterproductive to efforts to detoxify him in order to establish any underlying diagnosis of psychosis. When he was displaying behaviour which put him at risk to others and in the community, and warranted involuntary detention, he was again discharged prematurely while those behaviours were clearly still manifest and the risks to both himself and the community continued.

After Mr Meech was admitted appropriately under an ITO on 29 July for a properly diagnosed manic condition his treatment in Dr Lawrence's opinion was inadequate, insufficient and incomplete.

In Dr Lawrence's opinion the evidence clearly demonstrates that Mr Meech was shuffled between police and the hospital in an attempt to get control of his behaviour. She concludes that regrettably in this instance the victim became Paul Meech himself.

Dr Lawrence disagrees with the clinical determinations of both Dr Kluver and Dr Fuls and rejects their suggestion that an assessing psychiatrist can only have regard to the symptoms observable at the time the assessment is made. She advocates for a more longitudinal assessment informed by history provided by those with knowledge of the patient

While I of course I must give due weight to the opinions of the two experienced clinicians involved in the treatment of Mr Meech, I consider his prior diagnoses, his conduct, before and after his discharge – indeed his conduct right up to his death makes it much more likely that Dr. Lawrence's opinion is correct.

MMHU response to the death

After the death of Mr Meech, the MMHU conducted a critical incident review that generated a number of recommendations. However, that process did not involve any assessment of the soundness of the clinical decisions that resulted in Mr Meech being discharged and to that extent it was inadequate. I am aware however that since this death, Queensland Health has introduced a new incident management policy that causes sentinel events to be reported and requires a comprehensive root cause analysis to be undertaken. I am confident that the new policy, if properly implemented will address this deficiency.

Conclusions and recommendations

In the weeks before his death, Mr Meech made numerous, sometimes desperate attempts to get help for the mental illness that was dominating his life. He went so far as to attempt to break into the Maryborough Mental Health Unit and on the occasion of his final discharge he was so reluctant to leave police were called to evict him. I readily accept that those who made the decisions that denied him the treatment the evidence clearly shows he urgently needed believed they were constrained by the provisions of the *Mental Health Act 2000* from acting in any other way.

Drs Kluver and Fuls say that they consider they can only have regard to the symptoms displayed at the time they are making the assessment the Act requires and that previous assessments and aberrant behaviour before and after can not be taken into account. Dr Lawrence disagrees and says that a more longitudinal assessment, informed by the knowledge that a patient does not recover overnight from mania brought on by affective bipolar disorder,

must be undertaken. She is adamant that if this approach was adopted in relation to Mr Meech, he would have been kept at the MMHU for a number of weeks. Consequently he would not have been in the Hervey Bay watch house on the night of 1 August 2003. As Dr Lawrence also said, in a case like this, there are no guarantees. However, Paul Meech deserved to be given a better chance to recover by being treated for longer at the MMHU.

The Mental Health Act gives greater attention to the human rights of patients than have some earlier regimes. However, to deny a patient treatment that he, his family and his doctor are crying out for on the basis that to provide it would infringe his human rights is preposterous.

Mental illness is not a crime. Sufferers should not therefore be dumped on the police just because their illness makes them objectionable, aggressive or even violent. Mental health experts can administer drugs that moderate these effects and have facilities to monitor and treat other medical problems that may arise. Police do not have the necessary knowledge or capacity to appropriately deal with these challenges. A poignant comment by Senior Constable Arthur resonated. She said "*the hospital was asking us to remove him so we had no other option than to take him to the watchhouse*.

It is not fair to the mentally ill, their families or the police officers involved to expect police to try and cope with these issues. It is not in the public interest to have seriously ill patients simply discharged from watch houses onto the streets when the minor offences the patients usually commit have been dealt with by the courts.

Recommendation 4. - Review of the Mental Health Act provisions

I recommend that the Director of Mental Health seek legal advice as to whether the Act should be interpreted in the restrictive manner contended for by the treating psychiatrists in this matter.

If the advice is to the effect that those clinicians took an unnecessarily narrow view of the relevant provisions, the advice should be circulated to all mental health staff. If the advice is to the affect that their interpretation is correct, the Director of Mental Health should consider seeking to have the Act amended so that mentally ill people are not denied the treatment they need when they are not able to adequately assess those needs because of their illness.

This inquest is closed.

Michael Barnes
State Coroner
7 April 2006