OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Robert Joseph HENDERSON**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 1682/05(9)
DELIVERED ON:	3 September 2007
DELIVERED AT:	Brisbane
HEARING DATE(s):	14 February, 16, 17 & 18 April 2007
FINDINGS OF:	Ms Christine Clements, Deputy State Coroner
CATCHWORDS:	CORONERS: Inquest – Mental Health, death in care, involuntary treatment order in the community, monitoring, drug abuse, risk of non compliance with medication

REPRESENTATION:

Ms P Kirkman-Scroope of Counsel – appearing to assist the Coroner

Mr J Fraser of Counsel – representing the family; instructed by Richard Gray & Associates

Ms S Gallagher of Counsel – representing the Princess Alexandra Hospital, instructed by Minter Ellison Lawyers

Mr G Rebetzke – representing Ms Boodmowtee Ward, instructed by Roberts & Kane Solicitors

Mr Colin Strofield – representing the Commissioner of the Police Service

CORONERS FINDINGS AND DECISION

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

The Coroner's jurisdiction

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

The scope of the Coroner's inquiry and findings

3. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

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

5. 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]

6. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[2] However, a coroner must not include in the findings or any comments or recommendations, statements that a

[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s46

person is or maybe guilty of an offence or is or maybe civilly liable for something.[3]

The admissibility of evidence and the standard of proof

7. Proceedings in a coroner's court are not bound by the rules of evidence because section 37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

8. 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]

9. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

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

Introduction

11. Robert Joseph Henderson was born on 2 February 1974 and died on 11 July 2005 aged thirty one. His death was reported to police at the instigation of an unnamed Blue Nurse who attended premises at 6/131 Gladstone Road Highgate Hill. She was visiting an elderly resident, Ernest Hancock, who was in poor health. During the visit she observed a male person apparently deceased on the kitchen floor.

12. When police from the West End Station attended at about 8.30am on the morning of 11 July, they discovered the male deceased person still

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

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

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

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

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

[8] (1990) 65 ALJR 167 at 168

in that position on the kitchen floor. Mr Hancock was quite distressed and provided some information about the deceased person which was recorded in Constable Jan Webster's notebook. Mr Hancock knew the deceased person to be Robert Henderson. Other attending police officers were also able to recognise Robert from previous contact with him. He was formally identified by his father, Robert Henderson senior (Mr Henderson).

13. Mr Hancock told Constable Webster that the deceased, Robert had been staying in one of the rooms at the residence over the last few days. He said he had staggered into the house about 8.00pm on the previous evening, 10 July 2005. Mr Hancock thought he was drunk because he was staggering. Robert said he was going to sleep. Mr Hancock saw him lay down in the kitchen and go to sleep. He told the police officer he heard him snoring. The next morning when Mr Hancock got up he presumed Robert to still be asleep and so did not disturb him. When the Blue Nurse attended at about 8.00am to give Mr Hancock his injection, she saw Robert and said that it did not look like he was breathing. She called the ambulance. Ambulance officers attended and confirmed that Robert was deceased and then the police were called.

14. Mr Hancock told police he had known Robert for four or five years. Robert came and stayed with Mr Hancock because he was behind in his rent and he was looking for a new place to stay. On the previous day, 10 July 2005, Mr Hancock told police that Robert had arrived at about 6.00pm and then gone out for a couple of hours before returning home around 8.00pm, apparently intoxicated. During his absence Mr Hancock said two police officers had visited the house looking for Mr Henderson because he was wanted at the hospital. Mr Hancock understood this to be a psychiatric hospital. Mr Hancock did not know what medication Robert took but thought it was for his "nerves." He told the Constable that he did not know whether Robert used recreational drugs.

15. After the death occurred, the attending police officers noted there was a packet of Zyprexa Olanzapine on the fridge. Unfortunately, no further information was recorded, eg whether the medication was named for a particular person. The medication was not taken from the residence. Police officers who attended the scene also took photographs which included photos of the bedroom of Mr Hancock. These show a number of boxes and containers of medicines but there is no information to indicate whether or not they might have been the source of any of the medications revealed in subsequent toxicology tests after Robert's death.

16. Information has been provided to the court indicating that Mr Hancock has subsequently died. I therefore rely on the information provided by Mr Hancock to Constable Webster as recorded in her notebook.

17. Autopsy examination of Robert confirmed that there were no physical signs of injury and no signs of any needle puncture marks. Dr Olumbe determined the cause of death to be mixed drug toxicity. Acute bronchopneumonia had contributed to the death. He explained that toxicology tests revealed the presence of a number of prescription drugs as well as the presence of cannabis. The prescription drugs found to be at levels in excess of therapeutic range and potentially in the fatal range were morphine, total morphine and alprazolam (this is prescribed as an antidepressant). In addition, other prescription drugs were found to be present within therapeutic range. These were diazepam, its by-product nordiazepam, olanzapine and lithium. No alcohol was detected.

18. The effect of the combination of these drugs suppressed respiration and caused unconsciousness. This would predispose the unconscious person to aspirate on vomitus, thus causing the acute bronchopneumonia which was evident as the reaction to the inhaled foreign material in the airways. The microscopically observed impact in the lungs was confirmation to the pathologist that Robert had survived for a period of time after initially falling unconscious due to the influence of the drugs.

19. There is evidence available to the inquest which may account for the presence of the therapeutic levels of diazepam (and its by-product) and olanzapine but there is no information available to explain the source or time of administration of the other drugs identified at autopsy.

The cause of death is due to mixed drug toxicity.

20. It is this inquest's task to determine the circumstances of Robert's death and whether there are any comments that might be made to help prevent a repetition of a death in similar circumstances or to improve public health.

Evidence from Robert's parents

21. Robert's parents gave evidence to the inquest. There were also extensive letters submitted prior to the inquest. They presented as caring parents who had supported their troubled son through many years of heartache. Robert lived with them until he was aged about 27 and problems of violence escalated.[9] Robert then had difficulties in maintaining accommodation. From time to time he would stay at unit 5, 131 Gladstone Road, Highgate Hill, which was the unit next door to Mr Hancock. He would also stay for short periods with his parents but this was no longer a long term option.

22. Mr Henderson expressed concern on several occasions that doctors had told him that his son was no longer schizophrenic and medication was withdrawn. I do not make any finding about this but simply note information from the treating psychiatrist and case manager that the

[9] Paragraph 7, statement Robert Henderson

nature of the illness can vary over time, sometimes requiring active intervention and medication when psychotic conditions are florid and at other times not requiring such treatment. However, I do note that there remains the insoluble difficulty of presentation at a particular time when a person may not be demonstrating symptoms but subsequently returns to his home environment and then becomes aggressive and violent. Robert's problems were exacerbated with the use of heroin. He had tried therapy via the subutex program under Dr Reese concluding at Christmas 2004. In 2005, his overall wellbeing declined with increasing use of alcohol mixed with drugs obtained via prescription.

23. In the period leading up to Robert's death his parents had been in contact with the Princess Alexandra Mental Health services via Robert's case manager, Phillip Williams. Summarising their evidence, they expressed their increasing concern that their son's behaviour was alarming. They told Mr Williams about Robert's increasing use of alcohol and their fears about other drug use. They considered their son to be in the worst condition they had seen him and wanted him to be returned to the mental health unit of the hospital for assessment and treatment. Mr Henderson's understanding of what he could expect for his son was that Mr Williams would arrange for him to be "secure" and that he would not have access to his own medication. Mr Henderson requested his son be held in a secure area for a couple of weeks to enable proper assessment.

24. I note that Mr Williams' explanation of what could be arranged used other language of "safety" within the hospital. Clearly what his parents wanted was to safeguard their son and they considered that if he were physically prevented from coming and going from the hospital at will, that he would be safer. The issue of course to be resolved is whether the parents' expectation of an appropriate treatment response could be met within the boundaries of appropriate and available psychiatric treatment. It is heartbreaking for parents of adults that they cannot intervene and direct treatment decisions and difficult for them sometimes to accept the treatment decisions made.

25. In this case there was probably a misunderstanding by the parents of what could be offered to their son. It was simply not within the realms of Mr Williams' authority to make treatment decisions. That was an area for the psychiatric registrar or psychiatrist. Mr Williams was appropriately trained to perform his role as case manager which includes making initial assessments of a person's mental state, risk of suicide or committing acts of violence against other people, or the risk of absconding.

26. I note Mr Williams' concession in evidence that he did remember the father telling him he was worried his son would abscond, although he did not think he had documented this.

27. Overall Mr and Mrs Henderson appeared to have been able to access members of the treating team fairly readily in order to communicate their concerns. Mr Williams took a period of entitled leave during his role as case manager. This meant that between about 28 June and 4 July the duty officer from a different team was the person with case responsibility for Robert.

28. I do note that it was during this period that Mr Henderson indicated his extreme concern. There was a response and a decision was made to revoke Robert's permission to remain within the community whilst subject to an Involuntary Treatment Order. An order was made that he be returned for assessment to the hospital. That was achieved and Robert was returned to the hospital on 9 July 2005.

Information from the hospital

29. Robert was a long term patient of the Princess Alexandra Hospital Mental Health Unit. The hospital record commences in October 2001 and includes references to outpatient and inpatient treatment including admissions to the Ipswich Hospital and periods when he was subject to Involuntary Treatment orders pursuant to the *Mental Health Act*. Most of his care was received in the community from the West End Community Mental Health Service under the supervision of consultant psychiatrist Dr Geoff Leong. The medical history indicates a diagnosis of schizophrenia and continuing problems with abuse of prescription and illicit drugs as well as alcohol.

30. I refer both to Dr Leong's statement[10] for a summary of Robert's treatment as well as the medical record.[11] Dr Leong outlined the regime of mental health care that is now in operation in Queensland pursuant to the Mental Health Act. To paraphrase the intention of the legislation, the aim is to provide necessary treatment within the least restrictive manner which is appropriate to the patient's condition. Most treatment is offered in the community. Indeed, this even potentially includes the directive care provided under an Involuntary Treatment Order. Dr Leong explained that inpatient care at the Princess Alexandra Hospital was in either the East or West wing of the Ward Adult Acute Psychiatric Unit (WAAPU). There is a separate area of that ward called the Acute Observation Area which is a closed (locked) ward to accommodate patients with a significant risk of suicide or aggressive behaviour. These patients are under constant observation of nursing staff. Observation levels in the east and west wings are determined as a clinical decision in accordance with hospital[12] policy. There are also two seclusion rooms but these rooms can only be used in accordance with the Mental Health Act, namely to protect a patient from imminent physical harm or when there is no less restrictive way for their safety or the safety of others.

[10] Exhibits B3, B4, B5
[11] C1, C2, C3, C4
[12] GL-2 annexed to statement of Dr Leong at paragraph 8, exhibit B3

31. Dr Leong's evidence was that patients who are likely to be placed in the closed ward, (that is, the acute observation area) are those at "high risk of absconding and engaging in behaviour which would be harmful to themselves or others. A person with a high risk of suicide or aggression may be placed in the closed ward or the acute observation area."[13]

32. I accept Dr Leong's evidence that this decision is to be made on the basis of bed availability, appropriateness of placement in such a closed ward with other patients and whether this placement is likely to facilitate treatment and is the least restrictive option to deliver treatment. However, I will remark on this issue further with reference to the case manager's evidence and completion of risk assessment forms.

33. Once Robert and his family moved to Brisbane most of his care was delivered in the community via the Continuing Care North Service which is part of the community based mental health care offered in association with the Princess Alexandra Hospital. The method of service delivery is via a team based case management program. The teams are comprised of multi-disciplinary members trained in psychiatric assessment. Their primary qualification might be as a psychiatrist, psychiatric registrar, psychologist, nurse, social worker, occupational therapist or in another related discipline.

34. Ultimately, counsel for the Henderson family, Mr Fraser raised the issue whether such assessment was the best model and raised the preference for more specialist and qualified assessment by doctors trained in the psychiatric field. I will consider this later.

35. Dr Leong, the treating consultant psychiatrist, only saw Robert on two occasions between October 2001 and July 2005. On other occasions, Robert was seen by other members of the team. The last occasion Dr Leong physically saw Robert was in December 2004 when an Involuntary Treatment Order was sought. Dr Leong reviewed Robert and signed the order which was confirmed subsequently by the Mental Health Review Tribunal in February 2005.

36. Dr Leong is a long serving psychiatrist with Queensland Health and clearly committed to his profession. It is unfortunate that the demands for mental health treatment are so great that a long term patient such as Robert would only be seen by the supervising consultant psychiatrist twice between 2001 and December 2004.

[13] Exhibit B3, paragraph 11

Details of contact between Robert, his family and the mental health support team.

37. The lead up period of contact with Robert prior to his death commenced from a referral by court liaison officers back to the Princess Alexandra Hospital team. This occurred on 22 June 2005. He was allocated a case manager, Phillip Williams who met with Robert for the first time on Friday 23 June 2005. The meeting was at Robert's accommodation at the time and also included a psychologist from the team. The notes record that Robert had just been evicted. He was at his parents' home with his girlfriend and his father was also present. He was seeking other accommodation. There was a discussion of previous experiences that had affected him. Robert was noted to be appropriately dressed but living in a very messy environment with apparent signs of damage. He was distracted during the visit but showed some indicators of restricted affect. Mr Williams' impression was that he was suffering from current social stressors against a background of known schizophrenia and recent criminal charges. The most pressing matter was his need to stabilise accommodation. He was booked in to see a psychiatrist on 28 July at West End and weekly home visits were planned.

38. On Wednesday 28 June, Mr Williams saw Robert again. He had information for Robert about accommodation but Robert indicated he had already arranged a flat that morning. Information about emergency accommodation was provided and Mr Williams also explained that he would be away for a week. This was also explained to Robert's father.

39. Robert told Mr Williams that he was noncompliant with his medication but that he would recommence taking his medication. He denied experiencing any symptoms of worsening mental state. Mr Williams appears to have written his notes up later that day and confirmed that Robert was subject to an Involuntary Treatment Order. The recorded plan was to check his recent psychiatric history, book a review with a doctor as soon as possible, identify the accommodation Robert had indicated and liaise with the team about these matters.

40. Mr Williams denied providing him with any medication at this visit.

41. Robert was then seen by other members of the team until 2 July when Mr Williams returned from holidays.

42. The next entry is on 29 June. Ruth Hills, the psychologist in the team, received a phone call from Mr Henderson. Mr Henderson told her that Robert's girlfriend had dumped him at their place. Robert was upset with the girlfriend and was angry. He was making threats to bash the girlfriend and his mother. Mr Henderson said his son needed to go to hospital. Mr Henderson was concerned due to the history of violence and he believed his son was deteriorating mentally. The psychologist advised him to contact the police to arrange for Robert to be taken to

hospital or for a Justice Examination Order. Mr Henderson doubted that the Dutton Park Police would help him but at 1.50 that afternoon he spoke with the social worker from the team, Kay Rees, and told her that the police were to attend at about 2.00pm. Mr Henderson wanted the team to know that he considered Robert's girlfriend a bad influence who encouraged Robert's increased use of alcohol. He wanted assurance that Robert would not be discharged from hospital. The psychologist told him she would pass on the father's mobile telephone number to be advised if possible. She also clarified to Mr Henderson that it would be the triage team at the hospital, not the community team who would see Robert at hospital and that Mr Henderson needed to give his information to that team.

43. Mr Henderson rang again at 2.30pm wanting to check whether his son was at hospital. Ms Rees confirmed she had contacted triage and posted information on the white board. She stated that the hospital team would see Robert when he arrived and that Mr Henderson's mobile number had been passed on. Mr Henderson said his son was due in court the next day.

44. The next day, 30 June 2005 there were several phone calls between the psychologist Ms Hills and Mr Henderson. He told her that the police had attended at Robert's place but did not consider it was necessary to take him to hospital. They came back within half an hour when they discovered he had allegedly failed to appear in court on 28 June. Mr Henderson said however, that his son had appeared in court that day and had been granted bail. Mr Henderson hoped to be able to resolve the eviction problem his son was facing and thought the mental health issues could wait until Monday when the regular case worker, Mr Williams returned.

45. On 1 July, Mr Henderson spoke with Ms Hills. He said that Robert's girlfriend had returned. He said his son had consumed half a dozen rum and cokes and was now incoherent, frothing at the mouth and apparently responding to voices aggressively. Robert's accommodation ended on the Sunday and his response was to become intoxicated. Mr Henderson said his son was not taking medication and that he was concerned about threats of violence and the risk of self harm. Ms Hills noted she had difficulty in obtaining a clear picture of the situation from Mr Henderson and therefore could not gauge Robert's mental health. She understood that Mr Henderson was quite anxious about Robert coming to their house. He felt he and his wife might be unsafe and unable to cope. Ms Hills noted the stressor events, of the eviction, court appearance, unstable relationship, drunkenness, non compliance with medication, reported actual and threats of violence and apparent psychotic symptoms and considered the most appropriate course appeared to be to revoke his leave under the current Involuntary Treatment Order. This would allow assessment in hospital and stabilisation of medication.

46. Ms Hills rang Robert to obtain details including an alleged attempt to strangle the girlfriend two days previously, threatening and abusive behaviour to his parents and being enraged in the morning and evening of 30 June. Mr Henderson alleged his son had shaken his fist at his mother and sworn at them. There was an allegation of a history of carrying weapons. Mr Henderson also told Ms Hills that there had been several recent suicide attempts noted as attempted overdoses.

47. This information was used to complete the "Authority to return patient to authorised mental health service" document which was signed by Dr Leong and dated 1 July 2005. A "request for police assistance" document was completed as well as a document with "additional information to accompany authority to return patient to authorised mental health service". The document summarised the information recorded by the psychologist, Ms Hills that day. It included information for risk to others in the categories as follows:-
    - history of violence;
    - physical violence in the last month;
    - threats or verbal aggression in the last month;
    - history of weapons use; and
    - past major property damage.

48. In the risk to self category it was stated he was a current risk and had a past history of three attempts in the last two months.

49. Mr Henderson is then recorded as having spoken by phone with the triage section of the hospital repeating that his son needed "depo" medication as he was non compliant with medication. He left his mobile phone number.

50. Robert was brought to the hospital by police on 2 July. A note is recorded at 9.30am. Robert agreed to stay and so the police were not required. The note continued that he did not appear to be intoxicated or out of control. He was annoyed he had to come in but did not resist. There were details of his problems with the real estate agency and acknowledgement that he had hit the neighbour. The intake person noted he was not psychotic and not taking drugs at this time.

51. Discussions were held with Robert. The plan was to report back to the team with progress on his accommodation. The immediate plan was to stay in a motel with Deb, his girlfriend. He did not want any contact with his father.

52. He was then reviewed by Psychiatric Registrar Dr Slavica Jelesic-Bojicic at 11.00am on 2 July. There is a detailed note of the assessment which commences:

    "Thirty one year old man on disability support pension under community involuntary treatment order with diagnosis of schizophrenia

complicated with medication non compliance, poor insight and alcohol abuse."

53. The note continued to record recent stressors including two nights in the watch house, problems with the real estate agent and a flatmate and a requirement to report twice weekly to police. He denied any positive symptoms of psychosis. Although he appeared distracted he was otherwise appropriate in response and manner at the assessment. He denied suicidal thoughts or plans. He acknowledged that alcohol was a bad influence. He was willing to take his medication.

54. The Registrar's impression was there was no evidence of paranoia or psychosis. Robert demonstrated reasonable insight into his current social problems. He was willing to stay in contact with the team. The risk screen form completed by the Registrar at the time summarised that Robert was in the medium risk category for suicide and high risk for violence.

55. The plan was to discharge him home over the weekend. The mobile team was notified to assist if required. He was given some medication immediately, Olanzapine 10 mg and Valium. He was to call that afternoon to provide contact details for the girlfriend with whom he would stay. He promised not to consume alcohol. He was willing to see his case manager to discuss accommodation. He understood the need to report to the police as per the bail requirement. The next review by his treating doctor was set for 28 July. His presentation did not suggest urgent intervention was required. He was co-operative.

56. On 4 July, his case worker, Mr Williams was back at work after leave. A case review meeting was convened with the team, although it is not clear which members of the team were present. There was concern about continued contact from the parents and risk of violence. It was decided a hospital admission would be advisable to review and fully assess Robert. An interview was held with Robert that day at 3.30pm at the Annerley clinic. Robert told Mr Williams he now had accommodation in Mt Gravatt and would provide the address. He said he was taking his Alanzapine (Zyprexa) and valium that had been prescribed by Dr Jelesic-Bojicic on Saturday, 2 July. He was communicating well with the case worker including good eye contact. He was calm in manner and was no longer stressed due to accommodation worries. Robert denied auditory or visual hallucinations. He denied any thoughts or ideation of suicide.

57. Mr Williams thought Robert's overall presentation was good. His impression was that Robert was complying with his medication, was not displaying any positive symptoms and not apparently a risk to himself or to others. The plan was to continue with twice weekly contact and his father was notified. I accept these notes as indicating the way in which Robert was presenting at the time.

58. On 5 July, Mr Williams saw Robert again. He appeared to be much the same, although tired. There were no other risks noted. Accommodation remained an issue to be resolved in the long term and arrangements were made to solve that issue.

59. By 6 July, a case management entry was made stating there had been multiple phone calls from Mr Henderson. He reported that Robert was at Mr Hancock's place at 131 Gladstone Road, Highgate Hill. He was concerned about Robert meeting his bail obligations. There was a plan formulated that he stay overnight with a friend at Holland Park and obtain a Centrelink payment.

60. The next day, 7 July, the father again telephoned with concerns that Robert was drinking and was still at 131 Gladstone Road. He believed his son was unwell and aggressive. Mr Williams spoke with Robert and thought he was irritable because of problems with his girlfriend. It was decided that if Robert could not meet the following conditions up until Friday (of being compliant with medication and not engaging in aggressive behaviour with his parents) then he would have to return to hospital. A temporary arrangement was made for him to stay at his parent's house.

61. On that same day, 7 July, there is a note in the records that twenty 10mgm Olanzapine tablets were supplied. Other evidence indicated that this was a week's supply of tablets (at the prescribed rate of three tablets per day). There is no further detail, although evidence at the inquest indicates that it was Dr Nelligan who issued the tablets. His practice was to issue tablets where there was a known history of mental illness and previously prescribed medication. He would issue tablets to the case worker to provide to the patient.

62. The next entry by Mr Williams on 8 July records Robert had left the house early that morning. According to his father, he was irritable and had been drinking.

63. Mr Williams was clearly concerned about the continuing problems being reported and he discussed the case with Dr Leong. A decision was made that Robert needed to come to hospital. A bed was booked and his leave was to be revoked. The forms were completed but Robert could not be located. The Morningside Police were notified of the authority to return him to the hospital. Dr Leong signed the "authority to return" together with the additional information document which detailed escalating violence over three weeks, disorganised and irritable behaviour and a requirement to report to Dutton Park Police. It concluded, "can become agitated and aggressive". A request for police assistance was signed on the basis the involuntary treatment order was being changed from community based to in-hospital treatment.

64. The risk screen form that Mr Williams completed on 8 July 2005, is contradictory. The overall impact of the form must be considered to be

in the patient's interest as its aims were to facilitate Robert's immediate return to hospital. The form is however inconsistent in recording a low risk of suicide when in fact the detail suggested that Robert should have been designated as a medium risk.

65. In addition, the risk nominated for absence without approval was ticked as low when the detail revealed it to be within the high range.

66. Counsel for the family rightly criticised this error but it cannot be said that this error led to any particular result or consequence. When Robert was brought to hospital in accordance with the initiating action of Mr Williams, he was independently assessed by the Psychiatric Registrar, Dr Martin. Mr Williams has experience and skills in making initial assessments to indicate when a patient should be brought to the attention of a doctor. He did this. Mr Williams was not the person to recommend or decide whether a patient be placed in a secure or open ward. That decision was to be made by the admitting doctor. The reality is that the decision is always made in the context of whether beds are physically available at the time.

67. It was 9 July when Robert was brought to hospital. The emergency department records for 9 July are somewhat unsatisfactory. A nursing observation sheet has minimal information recorded at the top of a page. It states, *"brought in by police on ITO….absconded from WAAPU several days ago. On arrival compliant, looks unkempt."*

68. The entry regarding absconding from WAAPU does not seem to match up with other information, and it may simply be a misinterpretation of the various decisions and documents detailing what had happened with Robert during that preceding week. There may be material missing from the emergency department record for 9 July or it may be that the documents are simply incomplete and do not record sufficient information. There is a record of a medical assessment by the emergency department which indicates he is in a satisfactory medical condition to be admitted to the ward. I cannot identify any document or record of the following:

    a. an assessment of his mental state in the emergency area;
    b. an indication of assessment of level of risk of absconding;
    c. a resultant recommendation for the level of observation or placement in the psychiatric ward;

69. There is a repeated suggestion that Robert absconded twice from the emergency department. In Dr Leong's statement[14] dated 26 September 2005 he states:

    "9 July 2005

[14] B4, page 2

The patient was brought to the emergency department of PAH. He was noted to have absconded on two occasions from the department."

70. A statement from the case manger, Mr Williams, dated 12 July 2005 includes on the second page the following:

"On the morning of 11 July 2005 Mr Henderson senior phoned the case manager to notify him that Mr Henderson junior had absconded three times from the inpatient unit over the weekend and that he was currently missing. The case manager phoned the mental health ward, ambulance and emergency departments to attempt to locate Mr Henderson junior."

71. A type written section of notes from the emergency department, [15] again gives little information.

72. It indicates he left the emergency department at 8.35pm. At 21.15 hours there is an apparent nursing entry in the chart indicating Robert was admitted to the ward. It reads:

"Admission of 31 year old male. History of schizo affective disorder. Returned from AWOL (absent without leave) by police. Has been to accident and emergency for assessment medical clearance. Admitted on involuntary treatment order and fifteen minute observations. Has been drinking throughout the day. Given as required Diazepam- 10mg and he has retired."

73. This may simply mean that his permission to remain in the community on an involuntary treatment order had been revoked and he was ordered to be returned to the hospital. He had been medically assessed in emergency and cleared for admission. Significantly, he was admitted to the ward on fifteen minute observations. It was noted he had been drinking throughout the day and he had been given 10mg of Diazepam and gone to bed. I cannot locate any document to indicate he was seen by a psychiatric registrar or psychiatrist either in the emergency department or in the psychiatric ward on the night he was returned to hospital.

74. The emergency department records [16]indicate on the first page that he *"needs mental health assessment, on involuntary treatment order, has bed in WAAP (the adult psychiatric ward)"* The emergency department entry commences at a triage time of 19.22.

75. At 7.26 pm (19.26) there is a typed entry recording that the emergency Registrar Deborah Wenham saw him. The diagnosis is typed as: *"mental and behavioural disorder, substance abuse and harmful use multiple drug abuse"*. A handwritten entry in the emergency notes

[15] C2
[16] C2

recorded at 8.00pm (20.00) records a physical examination and results. He was awake, alert and co-operative. There was nothing physically out of the ordinary. There is an observation which queries drug influence. He was fit for admission.

76. The next entry in the chart is made on 10 July 2005, the day he absconds from the ward.

77. It is recorded at 10.00am by the Psychiatric Registrar, Dr Martin that Robert was admitted following revocation of a Community Involuntary Treatment Order due to non adherence with treatment and abuse of alcohol. He had absconded prior to being reviewed by the Registrar. It was noted he had not been reviewed by either the consultant or the four hourly registrar. Again, the note records:

"I believe he has absconded twice from emergency during admission process."

78. Dr Martin noted the fax authorising Robert's return to hospital and an order for one on one observation or transfer to the acute observation area. Significantly though, the note continued that this area was full and she was unable to move a patient out at the time of the entry.

79. An urgent review by the psychiatric registrar was ordered for his return. The notation read: *"await team review if doors are closed when returned".* His family was to be notified of his absconding.

80. ***It is on this admission, given the benefit of hindsight, that Robert should have been assessed by a psychiatrist or registrar much sooner than was planned. The lead up to this admission and the concern expressed by his family which was recognised by his case worker in initiating his return to hospital, should have been followed through more promptly. He was triaged in the emergency department around 7.30pm and assessed medically as fit to go to the psychiatric ward but was not assessed from a psychiatric perspective. By 10.00am the next morning when the psychiatric registrar went to assess him, he had absconded.***

81. Nurse Boodmowtee Ward gave evidence at the inquest. She was working on the ward on the morning of 10 July 2005. Nurse Ward is an enrolled nurse with ten years experience at the Princess Alexandra Hospital. On that day she worked a shift from 7.00am until 3.30pm. She had not met or nursed Robert prior to the 10 July. She made the entries in the record which read:

"Patient has not been sighted since 10.00am. Hospital grounds searched, AWOL papers completed and faxed to various authorities. Tried to phone patient's relatives. Father was unavailable."

82. The next entry is:

"Patient's father contacted the ward said the possibility where Robert could be at the following address - 131 Gladstone Road between Gladstone/Beacon Street. Signed B Ward"

83. Her final entry at 14.25 (2.25pm.) reads:

"Robert's parents brought clothes and tobacco for him, his mother said that Robert was at his place this morning. When Robert returns please notify his father. Phone 0416407626. Signed, B Ward"

84. Nurse Ward's evidence was that a colleague named Natalie had the responsibility for making the visual observations for the patients and recording this in the medical chart. Nurse Ward had been allocated the responsibility for care of Robert. She said she was on a tea break from 9.15am until between 9.30 to 9.35am. She said when she returned Robert was still present on the ward. It was after the next check at 9.45am that her colleague told her he was absent. A search was conducted of the ward and then the hospital. Hospital security was informed but Robert could not be located. The nurse in charge was informed and also the psychiatric registrar, Dr Martin who happened to be on the ward. Nurse Ward was told to complete the required paperwork for the attention and signature of the Registrar. This was a three page document titled "Requirement to return to authorised health service".

85. Nurse Ward obtained the information to complete that document by looking through the file and copying other information. The only information that was based on her knowledge was the note on the third page which read *"Wanted to leave hospital to buy tobacco"*. She said Robert had told her this earlier during the morning.

86. She identified the other documents upon which she relied to complete the new form as the "AWOL papers done in Accident and Emergency". There were admission and assessment documents completed on 9 July when Robert was brought to the hospital the previous day. Nurse Ward completed the necessary documents as quickly as possible and then faxed them to the relevant authorities to commence the process of finding and returning Robert to the hospital.

87. After observing and listening to both Nurse Ward and Mr Henderson, I do not find it surprising that their communication was perhaps less than optimal. There are examples in the transcript. I am not being critical of either of them, simply stating that their communication was not effective. For example, I find that Nurse Ward has misunderstood the situation about Robert's whereabouts after he left the hospital on 10 July. She believed that Mrs Henderson told her on the phone that Robert had been to her home that morning. I find that this is not the case and that Mrs Henderson was talking about a phone call she had with her son that morning.

88. Criticism has been implied (on the part of the family) that health professionals accepted Robert's word about resuming medication, abstaining from alcohol and keeping contact. Hindsight and perhaps the parents' foreboding based on long disappointment give a very clear impression that their son was unreliable. The case manager did bring his concerns to the attention of the consultant psychiatrist and a decision was made to bring Robert into the hospital. My understanding of the evidence is that when Robert was admitted onto the ward on 9 July, there were no beds available in the acute observation area which is a closed ward. He was placed on fifteen minute observations in the open ward.

Summary and comments pursuant to section 46.

89. A coroner's inquest of course only occurs after a death and has the benefit of an investigation and time to review all the information.

90. Robert had a long history of substance abuse coupled with mental illness. The nature of his illness was variable. It could sometimes present as psychosis yet at other times it manifested in a more manageable form. When able to be managed, treating professionals considered it appropriate for Robert to live in the community under close monitoring. There was always an element of risk, both to Robert and for the people around him (such as his parents) due to his unpredictable episodes of aggression and violence.

91. On the basis of the evidence, I find that the case worker, Mr Williams rightly identified and brought to the attention of the treating psychiatrist that Robert needed to be brought back to hospital for review. On the basis of his own documentation reviewing Robert's recent history and assessing the risk of both self harm and absconding, Mr Williams did not properly summarise the level of risk. A review of training and/or supervision of team members by the team leader is warranted**.**

92. As I have already noted, it appears that on Robert's final admission to hospital he came to emergency in the early evening and was transferred to the psychiatric ward overnight without psychiatric review. Given Robert's history this delay in assessment overnight was unsatisfactory.

93. However, it must be borne in mind that Dr Leong's evidence, as the consultant treating psychiatrist who reviewed Robert's placement in the adult psychiatric open ward, was that he would not have considered it necessary to place him under acute observation, meaning a locked ward. It must also be noted that although Robert was brought in by police he was alert and cooperative with no apparent sign of psychosis recorded at the time. Against this was the weight evidence which I find persuasive, that in fact there were problems with Robert reliably remaining in the emergency department. There are multiple references to absconding or being absent noted in the reports of Dr Leong, Mr

Williams, Nurse Ward, the emergency type written note, Dr Martin and finally in the hospital's own summary review document. It is simply not explicable without accepting that there *were* two occasions when Robert was away from the emergency ward without authority. Either the records presented to the inquest are missing references to these events or they were never recorded. As the hospital's own review noted, the record keeping is of critical importance particularly in a multi disciplinary treatment team scenario with a highly volatile patient requiring constant review. The hospital notes for this final admission are incomplete and poor. The record is vital to inform all members of a treating team who may never have encountered the patient previously, of his history and current status.

94. Reference was made to the one file system. There were times when the physical document may not have been available to the relevant part of the treating team. Team members may be in the community at Annerley or at the emergency department or on the ward. Dr Nelligan referred to a period of long delay when a patient's file might be unavailable for treating team members. The situation is not ideal but preferable to multiple sites for various sections of the one file.

95. **Ideally with today's technology, an electronic medical file should be accessible by all staff both hospital and community. This would maximise access to timely, complete and correct information. No doubt, a question of resources available to the mental health sector dictates the possibility of this option being realised however there would be immeasurable benefits for all stakeholders in implementing such a system.**

96. With hindsight, if Mr Williams' summary had correctly tallied the points counted to assess risk of absconding, staff may have been alerted to be more watchful after his admission. The detailed layout of these forms are intended to guide the user to consider various risk factors but they are less valuable if care is not taken in proper completion of the document.

97. Despite these deficiencies, the reality is that Robert was admitted to the psychiatric ward and stayed overnight without problem. There was no bed available in the acute observation section overnight. The tragedy was that Robert left the ward shortly before review by a psychiatrist.

98. The evidence from toxicology indicates Robert accessed drugs other than those prescribed to him via his treating team. The drugs in his body were mainly prescription drugs. There was also a toxic level of morphine which was not prescribed and may have been via an illicit form such as heroin. Robert had a known long history of drug abuse. It cannot be determined how he obtained some of the prescription drugs detected in his system. There was nothing in the facts surrounding his death to suggest he deliberately overdosed – there

was no note. It was equally consistent with his past history of drug usage that he accidentally overdosed. Mr Hancock told police he thought Robert was simply intoxicated when he came home that night prior to his death. Autopsy revealed there was no alcohol present and the impression that Mr Hancock formed must therefore have been due to the effects of drugs not alcohol. Robert was a long term substance abuser but this does not make him immune to the risk of accidental overdose.

99. The other issue of some concern was the minimal documentation for prescribing and in some cases physically supplying prescription mediation to patients. I have no doubts whatsoever that only appropriate prescription and supply of medication was made in Robert's case by the treating team. While medication was only given for short periods, the prescription and dispensation of drugs (including supply of sample medication) must still be properly documented. The evidence was that samples were sometimes provided as a practical means of medicating a patient who did not have the financial means to buy medicine. However, where there is a history of drug abuse, it is vital that all medication is properly documented in the record so that the information can be accessed by all members of the treating team and avoid the possibility of inappropriate stock piling of drugs or other possible problems.

100. The other comment I make relates to the information gathered by police when they first attended and discovered Robert to be deceased. It can be inferred that the police had access to enough information about Robert to have suspected that this was a drug related death. The scene itself suggested this possibility. I would have expected that attending police would record information and direct photographs be taken detailing all medication or other drug paraphernalia located at the scene.

101. In this case there was minimal investigation conducted at the scene where Robert was found, especially considering the amount of relevant evidence present. For example, while it was a noted that a packet of Zyprexa Olanzapine medication was found on the fridge it was not recorded by the police who the medication was prescribed to, how many tablets remained and in what quantity the medication was packaged. There was reference to other medication in the house but again, no detail. That sort of relevant information needs to be noted at the first occasion, before it is lost or removed or otherwise changed. It should not require a coroner's direction to commence appropriate investigation.

102. Copies of findings will be forwarded to Queensland Health and the Queensland Police Service, including the relevant minsters and Directors General as well as the Attorney General.

Section 45 findings

103. Robert Joseph Henderson died on 11 July 2005 at Gladstone Road, Highgate Hill ("Gladstone Road premises"). The cause of death was mixed drug toxicity. The inference I draw from all of the information available is that the death was due to accidental overdose. Robert had a long history of both mental illness and drug abuse. At the time of his death he was subject to an Involuntary Treatment Order pursuant to the *Mental Health Act 2000*. He had been compelled to return to hospital but had absconded. An order had been issued to require his detention and return to the hospital. His death was therefore a "death in care" pursuant to section 9 of the *Coroners Act 2003*.

104. On the day before his death, police attended at the Gladstone Road premises in order to locate Robert. At the time of their visit they were informed that Robert had been there, but was not presently there. When Robert returned, the resident at the address, Mr Hancock thought that Robert was intoxicated by alcohol. Mr Hancock was himself old and in ill health; he did not recognise Robert to be at any risk and left him to "sleep it off". It was the next morning that a visiting nurse identified that Robert was not breathing and called for the ambulance.

In conclusion

I acknowledge the efforts of his parents, Mr and Mrs Henderson who have tried their very best to help and safeguard their son over many years of illness and struggle. I extend condolences to them on the death of their much loved son.

Thank you to counsel assisting and all counsel for their input and submissions to this inquest, which is now closed.

Chris Clements
Deputy State Coroner
3 September 2007