Introduction

This is the inquest into the death of IAN LESLIE WEST who died on 14 January 2003

Coroner's jurisdiction [1]

The Coroner's Act 1958 is the appropriate, relevant Act for our purposes as Mr West died before 1December 2003, the day on which the Coroners Act 2003 was proclaimed. I will refer to the Coroners Act 1958 as "the Act".

The Act provides that a coroner has jurisdiction to inquire into the cause and circumstances of a reportable death.

Section 24 of the Act provides that where an inquest is held it shall be for the purpose of establishing so far as practicable

(a) the fact that a person has died
(b) the identity of the deceased person
(c) when, where and how the death occurred and
(d) whether any person should be charged with, for our purposes, manslaughter

The Act does not permit a coroner to consider charges under any other Acts.

After considering all of the evidence, findings must be given in accordance with Section 43 of the Act. This section provides that the findings shall include

(i) who the deceased was
(ii) when, where and how the deceased came by his death and
(iii) the names of any persons committed for trial.

An inquest is not a trial between opposing parties but an inquiry into the death. .

In a leading English case it was said

> *"it is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor prosecutes 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."*[2]

The focus is on discovering what happened. We are not here to ascribe guilt, attribute blame or apportion liability.

---

[1] I am indebted for assistance with some formal parts of this decision to the State Coroner, Michael Barnes and a number of his decisions.

[2] R-v- South London coroner; Exparte Thompson (1982) 126 SJ 625

The purpose is to inform the family and the public of how the death occurred In order that we may reduce the likelihood of similar deaths.
Accordingly the Act at S43(5) says that a coroner shall not express any opinion on any matter outside the scope of the inquest except in a rider which, in the opinion of the coroner, is designed to prevent the recurrence of similar occurrences.
At S43(6), no finding is to be framed in such a way as to appear to determine any question of civil liability or as to suggest that any particular person is found guilty of any criminal offence.

S 34 of the Act allows the coroner to admit any evidence the coroner thinks fit – in other words the strict rules of evidence do not apply.
Coroners apply the civil standard of proof i.e. on the balance of probabilities rather than the criminal standard, i.e. beyond a reasonable doubt.

However, coroners are required to comply with the rules of natural justice and to act judicially. This includes the fact that no findings adverse to the interest of any party may be made without first giving that party the opportunity to be heard in opposition to that finding and it includes giving an opportunity to make submissions against findings that may be damaging to the reputation of any individual or organisation.
Evidence was given in this inquest by 17 witnesses and there were 55 exhibits. It is obvious that I cannot refer to every piece of evidence and that I have of necessity had to select what I consider to be most important.

Evidence was first given in Townsville on 6 September 2004 and then at Longreach on 20 January 2005 and then at Longreach over 5 days in November 2005 and finally at Brisbane over 4 days in March 2006. Final submissions were made in Brisbane on 15 August 2006.

The witnesses can roughly be divided into those who were actually present at the Longreach Hospital on 30 & 31 December 2002, such as Dr Dan Rainolds, Registered Nurse Jamie Spark, Registered Nurse Susan Archer, Enrolled Nurse Wendy Newport, Registered Nurse Lisa Harvey, Rosemary Jackson; those not present but who were called by telephone including Clinical Nurse Consultant Jason Thackery, Dr Mark Marshall, Director of Nursing Maree Rankin and certain experts and doctors including Professor Paul Mullen, Dr Marilyn Shrapnel, Dr Jill Reddan & Dr Susan Roberts and other witnesses including Sgt David Perry, Mrs Sharon Roberts, Mr Douglas Hawley and Ms June Lithgow.

The evidence

I intend at the beginning to deal with the evidence of Sgt Perry and Mr Hawley which really relates to matters of importance to the inquest but they were not involved at the time the injuries were suffered on 31 December 2002.

Sgt Perry

Sgt Perry said that he first became aware of the incident on 3 January 2003 through an article in the Longreach leader, Exhibit 24. The article states in part:

> "In an unrelated incidence, an ambulance officer was called to the Longreach Hospital at about 4:00am Tuesday" and goes on with a couple of paragraphs concerning Mr West's fall. Mr West was not identified.

I quote the article because it refers to an unrelated incident – the main "incident" being referred to occurred the same day when there was a "scare" at the Longreach post office concerning a white powder thought initially to be anthrax.

That day, i.e. 31 December 2002, Director of Nursing Maree Rankin said that she told Senior Sergeant Von Saane about Mr West's fall so in fact "the police" actually knew of it not that long after the event but for whatever reason no police action followed until some days later when Sgt Perry attended the hospital. He was basically told that as Mr West was alive it was not a coronial matter, any questions he had should be directed to the District Manager, Ms Lithgow and that he had no right to be seeking information and if any staff member provided information they would breach their terms of employment and S63 of the Health Services Act.

Statements from witnesses were taken by a solicitor for Qld Health, not a police officer. Suffice it to say that no crime scene was ever established at Longreach Hospital and therefore the possibility of obtaining physical evidence at the time was lost forever. Furthermore the statements were very scant in detail. I will return to the issue of S63 of the Health Services Act later.

Mr Hawley

Mr Douglas Hawley is the Principal Inspector (Investigations) for the Department of Industrial Relations. He is based in Emerald. He gave evidence of a lack of co-operation by Queensland Health despite his legislative obligation to enquire into the incident.

He also provided information concerning the balcony railing at the Longreach Hospital. It seems that when the hospital was built the 910mm railing complied with the then requirements but now the Building Code requires such railings to be no less than 1 metre high. Mr Hawley said that if railings were less than 1 metre there was an

unacceptable risk that a person may have a centre of gravity that allowed them to easily topple over the railing. Mr West was about 5ft 10 inches tall.

Other Evidence – before admission

Mr West had previously been diagnosed with bipolar disorder.

Exhibit 25 is the Rockhampton District Mental Health Service Network file. Much of this file is in the hand writing of Jason Thackery, Mental Health Co-ordinator at Longreach. The notes indicate that Mr West had been an in-patient from 30 October 2001 to 12 November 2001. He had had a "manic episode in patient with Bi-polar affective disorder". During this admission he received Electro Convulsive Therapy.

There is also within this file a copy of a letter from Dr Ian Wilson, Clinical Director, Rockhampton District Mental Health Service addressed to "To whom it may concern" The letter is dated 9 November 2001. The letter reads:

> *Ian has been an inpatient in the Rockhampton District Mental Health Service inpatient unit continuously since 30-10-2001 (inclusive) He has a moderately severe bipolar affective disorder, in its manic phase. He may well have been in milder stages of this condition for 18 months. His condition causes overactivity, rapid thinking with ideas racing from one to another, excitement, impulsivity, over confidence, high spirits, lack of sleep and at times irritability. His condition was not controllable by high doses of medication but was effectively treated in the last week with electroconvulsive therapy. His judgement during his illness would have been very poor, caused by the illness.*

In my opinion this letter is of critical importance in this case – and it did not get to the Longreach Hospital as opposed to his Mental Health Service Network file at Longreach.

I will refer to this letter again later.

Ian West had been a patient at Longreach Hospital since at least 1987, when he was only 10 years old. Exhibit 27 in his medical record from that hospital.

On 2 December 2001 the file first mentions "bipolar disorder", when he was admitted to hospital as a voluntary patient. He was seen by Dr Marilyn Shrapnel on 4 December 2001 and allowed to go home that day. It is apparent that some months later, in April or May 2002, Mr West stopped taking his prescribed medication and he also failed to attend a number of appointments with Dr Shrapnel in 2002. Ultimately his mental health file was closed.

The next notes on this file are dated 26 December 2002 when Mr West went to the Out Patient Department. There is no time to this entry which was made by a person called SCHIMKE.

At 1210 the same day Registered Nurse Walsh made a further entry which included *"patient spat out pill from last night*" so it would seem that the first entry dated 26 December must have been in the early hours. At 1215 he saw Dr Bentley who made a long and detailed note.

Towards the end of the notes Dr Bentley wrote:

> *"advised patient that if he becomes danger to self/others then (he has to go to) Rockhampton advised patient he needs to re-start medication.*

He then noted a conversation with Dr Choudrey, Psychiatric Register at Rockhampton Base Hospital. And then:

> *Patient agrees to the above -> home for now. Review Dr Rainolds tomorrow.*

The next day, 27 December, Dr Rainolds noted:

"*Patient looks fairly composed, sitting, normal conversation. Does not look agitated. Does not appear to be danger to himself or others. Family say he has been drinking last night and was sleeping only 3 hours. Looks sleepy now. Continue medication. If further problems return to hospital for further assessment and ???????(Olanzapine 10mg BD and Epilum 5BD)*

On 28 December Mr West and Ms Jackson attended the hospital at 21:30 and a nurse made the following entry:

> *"patient presented with partner. Partner states nil improvement in manic state following medication changes and said "he was rubbing knife against neck at kitchen bench" spoke to patient and asked if wanting to harm self and he stated NO"*

He then saw Dr Rainolds again – this entry is not timed but it apparently was made soon after the previous entry. Dr Rainolds noted:

> '*extremely agitated according to partner. Running around the town since 6:30 and advises not feel like settling or going home. Still does not appear to be danger to himself or others. Still insight in his state and understands need to be treated. Refuses to stay at the hospital. 50mg of Acuphase stat. Appointment with Dr Shrapnel. Revision tomorrow and Monday'*

Then on 29 December Dr Rainolds wrote the following untimed entry:

'after consultation with Dr Claire Ballingal, Rockhampton Psychiatric Registrar. Increase Olanzapine to 15 mg BD add Clonazepen 2 mg TDS PRN. No driving cars while on medication. Still manic. No danger to himself or others, taking medication regularly. Understand need to have medication. Refuses to stay at the hospital. If Clonazepam does not help he will agree to stay.'

In his statement at paragraph 9 Dr Rainolds said:

"Based upon my clinical assessment of Mr West, Dr Ballingal did not believe he would fulfil the criteria for involuntary treatment."

Then on 30 December, sometime before 13:00, Dr Rainolds wrote:

'patient looks groggy but his partner claims that he "didn't slow a bit" ? partner unreliable source? He still refuses to stay at the hospital but agrees to take any medication and to come back for check-ups. Also he agreed to stay at the hospital if no improvement by tomorrow. Continue Olanzepam 15mg BD Epilum 500mg twice BD Clonazepam 1-2mg(?) 2 – 3 x day. Contact Dr Shrapnel discuss the case, if not possible Rockhampton. Revision tomorrow.'

At either 13:00 or 13:30 that day, director of nursing Maree Rankin made this note:

Phone call from mother Sharon Roberts concerned since phone call from partner (Rosie) to her this a.m. Mother concerned re: treatment. Sharon has phoned MHU Rockhampton and discussed Rosie's conversation re: treatment with them. I reassured mother that medical officer (?) was unavailable due to emergency but Ian was being followed up and attending appointments and MO has been in contact with appropriate people (i.e. MHU Rockhampton & Dr Shrapnel) addit. Sharon requested to speak with MO.

At 14:30 that day Dr Rainolds wrote:

contacted Dr Shrapnel after reporting to her on patients state she advised that he should be transferred to Rockhampton for further assessment and therapy as very likely psychotic.

The relevant outpatients notes end there.

The file also contains copies of the Request for Assessment completed at least in part by Ms Jackson and dated 30 December 2002 and the Recommendation for Assessment completed by Dr Rainolds and dated 30 December 2002.

The Request for Assessment states the "reason for request" as:

gentlemen has bi-polar mood disorder please assess behaviour and medication.

The Recommendation for Assessment states in the "reasons must be given" section which is sub-titled "facts known because of personal observation"

person appears to be in manic state. Severity of his state is such that he is unmanageable at home. Compliance with medication questionable too. Immediate assessment required. Has refused to be assessed in hospital environment.

Then in "facts communicated by other" Dr Rainolds wrote:

does not sleep more than 1-3 hours per day, can not stay in one place, breaks the things around the house, yells and believes that he is centre of vicious game, writes angry notes to other people in the house. ?danger to kids?

The patient admission form has the "time admitted" as 16:00.

Dr Jill Reddan, Consultant Psychiatrist was asked to prepare a report which became Exhibit 49. She also gave evidence. She was asked by Sgt Swan whether she thought that Mr West should have been placed under an involuntary assessment order earlier than 30 December 2002. This question was in fact the first question she was asked to respond to by Tress Cox.

Her written response was:

No, it is not good practice or within the spirit of the Mental Health Act to seek to manage a patient with a mental illness in the first instance in the most restrictive way. It was not only reasonable but necessary for staff to attempt to engage Mr West in having voluntary treatment. Mr West was attending for review and he was willing to take medication. The medication prescribed, both type and doses was orthodox in the management of mania and advice was sought from the Mental Health Unit in Rockhampton. And later*: there was no adequate reason before 30 December to regulate Mr West.* ***Further more, no matter when Mr West was regulated, the same problem would have arisen about containing Mr West until he could he moved to the Mental Health Unit in Rockhampton.***

Professor Paul Mullen, Forensic Psychiatrist, was asked to comment on Dr Reddans response to this question. He replied:

I don't think I would have any substantial disagreement with Dr Redden. I think the only thing I would say is that you know obviously with the benefit of hindsight you would have admitted this man much earlier and on order. ***But they didn't have the benefit of hindsight*** *and what actually occurred was entirely a different story.*

Both expert witnesses agree that admission on 30 December 2002 was appropriate and it would not have been appropriate before that time.

The conversation between Dr Dan Rainolds and Clinical Nurse Consultant Jason Thackeray

Jason Thackery was separately represented at the inquest by Ms Coman. He was the Clinical Nurse Consultant, Rockhampton District Mental Health Services based in Longreach.

When Mr West was admitted at 16:00 on 30 December 2002 Registered Nurse Jamie Spark was on duty at Longreach Hospital.

It is apparent that a conversation took place between Dr Rainolds and Nurse Spark concerning the necessary forms for Mr West's' admission. Neither knew where the forms were so Nurse Spark rang Mr Thackery who was at home and off duty.

Nurse Spark said in evidence "I just thought I would ring Jason and ask him"

He said "and then I put him (Mr Thackery) onto Dan (Rainolds) because Dan wanted to talk with him also"

Dr Rainolds did not tell Nurse Spark why he wanted to talk to Mr Thackery and Nurse Spark does not know what was discussed.

Jason Thackery said that during that conversation he advised Dr Rainolds as follows:

> *"You're going to need to look at having him specialled or look at getting the police".*

Specialling is the expression used for 1 on 1 contact with a patient at risk. Specialling is not restricted to Mental Health patients – it can be used for "seriously unwell patients with perhaps a cardiac condition as any serious clinical illness":

The use of police in these situations is referred to as "escort" and occurs if a patient is unmanageable or unsafe to themselves or others in rural and remote locations where there is no hospital security.

Specialling and police escorts are initiated by a senior clinician (such as Mr Thackery) or a medical officer not by nurses.

Dr Rainolds denied that this part of the conversation took place. He said he wanted to speak to Mr Thackery because it was part of a protocol to inform Mental Health

and because of the separate charts, i.e. Longreach Hospital and Longreach Mental Health. He said that was the reason he wanted to speak to Mr Thackery NOT because he needed his advice.

Mr Thackery said that Dr Rainolds did not actually seek advice but

> *"I offered that advice" because "at the time when I was speaking to him there were certain lengthy pauses and …. I…. felt as though he was kind of looking for some kind of direction in terms of how to proceed."*

I prefer the version given by Mr Thackery to that of Dr Rainolds' and believe that in fact Mr Thackery did draw specialling and a police escort to Dr Rainolds attention.

The evidence clearly shows that neither of these two alternatives were followed up by Dr Rainolds – nor any other staff that night. DON Rankin said that she gave the necessary forms to Dr Rainolds. She may have – but I still accept that Dr Rainolds spoke to Mr Thackeray.

Exhibit 29 is a Memorandum of Understanding between Queensland Health and the Queensland Police Service.

Part 3 is headed "Guiding Principles" and at 3.5 it says:

> "*Police have the responsibility to protect the safety of all parties.*
>
> *The management of any crisis situation should be achieved with primacy given to the safety of all persons concerned and, where not able to be avoided, the imposition of minimum restriction upon the individual."*

The police were not called. Both Dr Marshall and DON Rankin said that they knew police could be called and in fact had been called previously.

Exhibit 30 is a Review of Queensland Forensic Mental Health Services carried out by Professor Paul Mullen and Ms Karlyn Chettleburgh in 2002.

At paragraph 8 of the Executive Summary they say:

> *"Police play a minor, but all important, role in the functioning of effective mental health services to the community. All too often in Queensland and other jurisdictions, co-operation is impaired by misunderstandings fostered in a clash of attitudes and priorities."*

The police were not called.

Post admission

Between 16:00 and 18:00

Sometime around 16:00 on 30 December 2002 Mr West was admitted to the Longreach Hospital. The patient admission form is timed at 16:00 as are notes made by Nurse Spark. Before Nurse Spark's notes Dr Rainolds wrote an untimed note as follows: *admission for involuntary assessment (Rockhampton).*

Diagnosed with bipolar disorder by Dr Shrapnel. '

5-6 months non compliance.

Relapse since 26-12-2002. please see outpatient notes for (?).

Rockhampton and RFDS contacted. Transport in the morning.

Nurse Spark made the following entry at 16:00

Patient admitted to ward via A&E – for transport to Rockhampton Mental Health Unit Tuesday a.m.

Patient very restless, pacing corridor

IVC inserted into R. Arm

Given Acuphase 50mg 1M and

Midazolam 4 mg IV – little effect noted.

The inpatient medication chart shows that Mr West was given the following drugs:

16:20	Acuphase	50mg	IM
16:20	Midazolam	4 mg	IV
17:00	Olanzapine	15mg	O
17:00	Valproate	1 g	O
17:00	Clonazepam	2mg	O

It is obvious that the noted times of 16:00 and 16:20 cannot be correct as Nurse Spark noted at 16:00 "*Given Acuphase and Midazolam – little effect noted*" but these drugs were not given until 16:20.

Acuphase is an anti-psychotic drug
Midazolan is a major tranquilizer used in short surgical procedures for anaesthetic purposes and rapid sedation of agitated patients.
Olanzapine is an anti-convulsant used to treat mania
Valproate is an anti-convulsant used to treat mania
Clonzepan is a sedative.
Mr West was given four (4) major tranquilizers which each have a significant impact on the central nervous system and in combination may each affect the metabolism of the others. For example, according to Mr Thackery Midazolam can lead to respiratory depression and decline in blood pressure so if a patient on Midazolam gets up too quickly "their blood pressure can go through their boots and that can lead to being unsteady on their feet, dizziness, light headedness" so when this drug is used blood pressure, oxygen saturation pulse and etc must be taken at regular intervals and compared with the baseline observations made at admission.

It is noted that there were no observations made at admission and indeed none until after Mr West was found to have fallen.

Dr Susan Roberts of the Royal Flying Doctor Service said:

> *"We would normally keep patients who are receiving intravenous Midazolam under very close scrutiny."*

In her statement she said that she told Dr Rainolds that"

> *"patient would need to be kept heavily sedated overnight with administration of Midazolam as necessary"* and *"he would need a significant amount of sedation to keep him at the hospital".*

This advice was apparently not heeded.

Professor Mullen in his report, Exhibit 44, refers to the use of all of the drugs administered to Mr West and <u>at best</u> says that this was poor practice and <u>at worst</u> "is reprehensible and only defensible in extreme circumstances".

Dr Marilyn Shrapnel described the medication as "fairly heavy".

Nurse Spark was asked a series of questions about the lack of observations by Sgt Swan.

Sgt Swan: D*o you recall making any clinical observation?*

Nurse Spark: *I don't personally, no*

Sgt Swan: A*nd is it the norm to make those?*

Nurse Spark: Y*es*

Sgt Swan: C*an you give any reason why they may not have been done?*

Nurse Spark: Y*es. If I didn't do them, to me, there was no physical condition that was presenting, no blood pressure, respiration, pulse, really meant nothing to me.*

Sgt Swan: A*re you aware of the adverse effects of some of the medication administered?*

Nurse Spark: *Midazolan, not so much on the Acuphase, no*

Sgt Swan: S*o the Midozolam can have some side effects?*

Nurse Spark: He *was yep. To me, they were presenting none of those side effects because he was very mobile, no changes in speech or movement. And the valium – well – take a truckload of valium.*

Later in response to questions by Ms Coman Nurse Spark said that his understanding of Midazolan was

> "*that it's a sedative that at the right quantities can put you into an unconscious state but at the dose he was getting it was more of a light sedative to have a good nights sleep"*

Ms Coman: D*id you have any concerns that it might depress his respiratory system?*

Nurse Spark: N*o I wasn't, not at that dose.*

Ms Coman: Y*ou said in your earlier evidence that you followed orders that were given. Were you not told to take observations of the patient piror to the giving of this drug?*

Nurse Spark: I *don't believe I was told to take observations. But again* ***<u>its just like a standing order anyway.</u>***

Ms Coman: *so you didn't see a need to take ---?*

Nurse Spark: N*obody told me to take observations was the story* **–** ***<u>it was my decision not to.</u>***

No observations were taken at admission.

No observations were taken during Nurse Spark's shift.

No observations were taken during Nurse Harvey's shift until after the fall.

No observations were taken despite Mr West receiving at least <u>6</u> different medications, some of which were sedatives or even anaesthetics.

Rosemary Jackson said in her statement that:

> *"At about 4:30 p.m. Dr Rainolds and a male nurse called Jamie came up and administered Westy with more drugs and said that this would give him about fourteen (14) hours sleep".*

The fourteen hours sleep never eventuated but it seems that it was Dr Rainolds expectation at the time and may explain the lack of a care plan.

Doctor Rainolds said he left the hospital at about 18:00. He left no notes on the file concerning future treatment of Mr West. He had a telephone handover to Dr Marshall who was on call and who never attended the hospital and never saw Mr West until after the fall, at about 4:00 on 31 December 2002. Dr Rainolds said in evidence that:

> *"At the point where I left the hospital medication was working and I had no reason to suspect it would stop working".*

He also said:

> *"I didn't think it was my place to suggest to my superintendent what to do if the treatment that I prescribed did not work".*

<u>Between 18:00 – 22:00</u>

There are only 2 nursing entries as follows:

> 19:00 *patient very adamant that he was not staying in hospital overnight. Asked patient to hang around and discuss options. Contacted M. Marshall – if any further problems or patient leaves (let him leave) and contact police. Meanwhile give 10mg Valium orally stat and in 1/24 give 10 mg Valium orally if nil effects contact M. Marshall.*

22:00 patient given above medication. Patient has been verbally aggressive. Restless – nil signs of physical aggression noted – patient has finally decided to sleep. Dr Marshall notified – can give further 10 mg Diazepen if required overnight. Photocopies of relevant documentation to accompany patient to Rockhampton with medications.

Both entries were made by Nurse Spark.

Mr West was given 10mg Valium orally at 19:00, 20:00 and 22:00.

During this period Nurse Spark spent a lot of time with Mr West including time on the balcony. Mr West wanted to smoke and he was happy up there. Ms Jackson was also present until about 21:30 and Nurse Spark said that Mr West was calmer when she was with him. Mr West was placed in the closest room to the nurse's station. The only other patients, 3 women, were in a room 2 doors away.

Some time before Nurse Spark ceased duty at about 23:00 Mr West went through the ward where the women were, went outside and urinated against the wall. During the process he wet his pants. Nurse Spark then physically helped Mr West shower. Nurse Spark did not note this in the file as he "didn't see (it) really relevant" neither did he tell Dr Marshall although he thinks he told Nurse Harvey.

Before this, Mr West had been asleep in his allocated room, not on the balcony. Mr West told Nurse Spark that he urinated there because "he wasn't sure of where he was going" but he thought he was somewhere that was appropriate.

Despite the fact that Nurse Spark had no concerns for his own safety due to Mr West, he nevertheless had concerns for the female nurses coming on shift after he ceased duty, for the other patients and for Mr West himself.

In relation to the phone call by Nurse Spark to Dr Marshall at 19:00, Nurse Spark said

> *I imagine I would've filled him in on the course of events to get him up to speed, to ensure he's got the best knowledge of what's going on in case he wanted to give more medication or redevelop his treatment.*

It seems odd that in the later, 22:00, call Nurse Spark did not "Get Dr Marshall up to speed" on the fact that Mr West had gone through the women's ward and urinated on the outside wall – surely an unusual thing for a patient to do.

In response to Mrs Roberts, Nurse Spark said

> "*In the latter parts of the shift he was a bit unsteady but he was never groggy. His eyes were just – he was so tired. He just wanted to go to sleep."*

Mrs Roberts*: "if you didn't feel he was groggy or anything, why did you feel the need to have to shower him?*

Nurse Spark: I*n the earlier stages of the shift he wasn't. …but the latter stages he was unsteady, and that was when that occurred.*

Nurse Spark said that when he ceased duty Mr West "*was in the bed"* as distinct from being on the balcony. Nurse Spark commenced duty at 14:30 but we do not know when he left the hospital although it was certainly after a face to face handover to Registered Nurse Lisa Harvey at about 23:00.

<u>22:00 – 04:00</u>

The relevant inpatient progress notes for this period are as follows:

> 23:50 patient becoming increasing agitated. Attempted to leave building x 1, convinced to stay. Incontinent of urine. Showered self. Dr Marshall contacted, phone prescription. Diazepen 10mg PRN PO, same given. Patient unable to settle, verbally aggressive, refuses to go to room. <u>Wants to sleep on chair on balcony</u>.
>
> 02:00 patient sleeping
>
> 03:00 patient sleeping
>
> 03:55 heard a noise outside, found patient lying supine below on cement driveway. Patient groaning, responding to pain. PEARL, pulse regular. Dr Marshall contacted. Hard collar applied. Log rolled onto spinal board and transferred to A & E.

All of these entries were made by Registered Nurse Lisa Harvey. The only medication given was at 00:10 on 31 December – 10mg Diazepam, i.e. the phone order referred to at 23:50.

Registered Nurse Lisa Harvey arrived at the hospital at about 22:45 to commence her shift at 23:00 with Registered Nurse Susan Archer and Enrolled Nurse Wendy Newport. There were 4 patients. Nurse Harvey had a handover from Nurse Spark and she details this in her statement at paragraph 8.

Enrolled Nurse Wendy Newport recalls the handover a bit differently. She recalled that they were told that Mr West had "threatened his family with knives" (the reason for his "sectioning") and not to stand in his way if he wished to leave.

Nurse Spark and his shift apparently went off duty around 23:00 and the staff then on duty were RN Harvey and EN Newport upstairs with 4 patients – Ian West and 3 women – and RN Archer downstairs looking after emergency but she had no patients.

Nurse Archer said that as she had no patients she came upstairs and although she never saw Ian West when she first came upstairs, she did hear him talking with Nurses Spark and Harvey. During the next few hours Nurse Archer alternated between upstairs and down – she was back upstairs at 00:10 when Nurse Harvey was getting the Valium prescribed by Dr Marshall over the phone, and given to Mr West at 00:10.

Nurse Archer said that Nurse Harvey had told her she had rung Director of Nursing Rankin but Nurse Archer does not know what was said.

In evidence, she said that by the time she came back upstairs Nurse Harvey had rung both DON Rankin and Dr Marshall.

She understood that Nurse Harvey had told both the DON and Dr Marshall that Mr West was out on the balcony.

She was asked by Sgt Swan if she had any conversation with Nurse Harvey about the "sort of response that she received from Maree Rankin and Dr Marshall".

Nurse Archer was not present for the conversations but she said:

> *"Thinking back it was probably that they were happy if he settled out there, that was fine"* and
>
> *"Just to keep close to it, I guess, and keep in close contact with what was happening".*

Nurse Archer said you had to leave the nurse's station in order to look out and see Mr West on the balcony. She said she stayed upstairs while Nurse Harvey had her meal break, that she and EN Newport took turns answering any calls and that

> "*Wendy (Newport) spent most of her time in the hallway actually looking, watching the patient".*

Nurse Archer estimated that between them Nurse Harvey and Nurse Newport checked on Mr West 5-6 times before she went on her meal break at 02:30.

She did not go upstairs again after her meal break and her next involvement was after Mr West fell.

Nurse Newport had a good recollection of events, both in her statement (made on 10 February 2003) and in her evidence. In her statement she recalls Mr West being very demanding between 23:00 and 23:50 and that during this period Mr West wet his pants and had a shower. She had been told at handover about the earlier urinating incident outside the women's ward.

She recalled the incident concerning Mr West saying he wanted to leave and Nurse Harvey's response that she would call the police and she recalled that Nurse Harvey

rang the DON and Dr Marshall and the prescribing of 10mg of Valium. She also heard Nurse Harvey ring the DON again after speaking with Dr Marshall.

After this Valium Mr West said something like:

> *"I want to sleep on the balcony. I want to sleep outside."*

She said that both she and Nurse Harvey attempted to dissuade Mr West but to no avail. Nurse Harvey refers to Mr West wanting to sleep on the balcony in her 23:50 file note.

She said he took his pillow and blanket from his bed, removed the mattress from the lounge chair on the balcony, placed them on the floor and made himself a bed.

She said she and Nurse Harvey checked Mr West every 15 minutes or so and on 2 occasions she went out onto the balcony and physically checked him.

She went downstairs at about 03:00 and when she came back 10 minutes later she checked him again and then sat at the nurse's station with Nurse Harvey.

At 03:30 she checked him again and went for her meal break. Just before 03:48, while she was in the Children's Ward, she heard a strange noise, looked out but could see nothing. She went to and walked past the Nurse's station and told Nurse Harvey of the noise. She looked out onto the balcony and said to Nurse Harvey "*Ian is not there. Can you come with me."*

They both walked onto the balcony and looked over at different places. She saw Mr West on the driveway below and told Nurse Harvey and they both went down the stairs and out to him.

During her evidence Nurse Newport said that she and Nurse Harvey discussed the fact they could not look after both Mr West and the other patients.

She felt he needed specialling and explained that she had worked in a psychiatric hospital and had specialled many patients. She felt that she herself could have specialled Mr West but that they would need another nurse to assist with the other patients. She said:

> *"I thought she (Nurse Harvey when speaking to the DON) was wanting someone to come up and help us to special him."*

She also said that she and Nurse Harvey discussed the situation concerning Mr West "and felt as though he should be specialled and that's why Lisa rang."

Mr McDougall asked Nurse Newport:

> *"Is it fair to say that Mr West was the centre of your whole attention for the whole evening?"*

To which she replied "*Yes".*

Nurse Newport felt that the nurses never needed to call police to come and assist with Mr West. She agreed that Nurse Harvey was in charge. She also agreed that you could not see Mr West whilst seated at the nurse's station but she said "*We were visually – like looking at him all the time – a lot of the time.*" This evidence agrees with that of Nurse Archer. Nurse Newport did not hear Nurse Harvey tell Dr Marshall that Mr West was asleep on the balcony.

She said that while she personally went out onto the balcony and checked Mr West twice, she checked through the glass door "*several times – many times.*"

She agreed that Mr West was <u>not</u> under "*constant observation 'cause that would be called specialling.*" The nurses had <u>not</u> been told to special Mr West.

She agreed that no physical observations such as pulse, temperatures and blood pressure were done.

The checks on Mr West were "*to make sure that he hadn't moved or turned over or just to be aware of what he was doing and where he was.*"

Nurse Newport agreed that she had absolutely no concerns that Mr West might fall off the balcony:

> *"It didn't even enter my head that he might fall off the balcony. I was just concerned because of the situation and the area where he was."*

Mr Fleming asked her if Nurse Archer had have been upstairs all of the time then:

> *"_ _ _ between the three of you there was sufficient resources that Mr West could have been kept under constant supervision, could be specialled?"*

She replied:

> *"There would have been if she'd been up there, yes."*

She also agreed that to her knowledge there was no plan for dealing with Mr West, his physical or mental condition or his medication overnight.

She felt it would probably have helped if either Dr Marshall or DON Rankin had come in that night and helped manage Mr West. Neither did come to the hospital before Mr West fell.

Nurse Newport said she saw Mr West's medication chart, was aware of the effects of the sedatives given to Mr West, was aware of "the basics" of bi-polar disorder and agreed that:

> *"…if a patient is asleep as a result of those medications and wakes that they could be groggy and disorientated."*

She said: *"I suppose, in the back of my mind, I knew the risk was there but I really didn't think it would happen."*

Registered Nurse Lisa Harvey was "in charge" of the patients from about 23:00 30 December 2002 to perhaps 07:00 31 December 2002 i.e. she was the Senior Nurse on duty.
When she came on shift she had a handover from RN Jamie Spark. I have referred to this handover earlier.

She said she read Mr West's history at about that time and noted he had no history of self-harming behaviour, suicidal ideation or physical violence.
She was introduced to Mr West who she described as about 5ft 10 in with a shaven head and tattoos. Nurse Newport described him as "somewhat an intimidating fellow, a big man."
Nurse Harvey thought that Mr West became more agitated when he was told that a different staff member would look after him that night.
For the period from 23:00 – 00:00 he spent much of the time at the nurse's station talking, asking for things and on one occasion reported that he had wet himself. During this time his speech, which had been slightly slurred at the beginning

> *"Became progressively less slurred as he became more agitated."*

On one occasion he told her he was leaving but she said she would ring the police so he stayed - but not happily. During that same hour "*he became increasingly agitated and aggressive, eg swore, and punched the wall."*

Nurse Harvey said that if she thought he would self harm she would have "specialled" him, i.e. kept him under constant supervision and would have rung and asked Dr Marshall to come, but Mr West did not indicate self harm.
Nurse Harvey rang DON Rankin at 23:50

> *"to express my concern with Mr West's increasingly agitated and aggressive behaviour."*

She explained the situation to the DON who suggested she ring Dr Marshall, the on-call doctor and if she wanted to, ring Rockhampton Mental Health Team for advice.
Nurse Harvey rang Dr Marshall and "*explained to him what she had observed of Mr West and his level of agitation."* Dr Marshall gave a telephone order for 10mg Valium PRN which was administered at 00:10.

> *"Dr Marshall advised me that if Mr West was most settled outside smoking to let him continue to smoke <u>out on the balcony</u> and if he attempted to leave, to let him go, telephone the police and request their assistance in returning him to the hospital."*

Apart from her statement dated 4 April 2003, Exhibit 15, Nurse Harvey made hand written notes of the incident before she ceased duty on 31 December 2002, Exhibit 47 and typed out a note on 1 January 2003, i.e. the next day, Exhibit 48.

In her hand-written notes Nurse Harvey, when referring to the phone call with Dr Marshall, wrote:

> *"Rang Dr Marshall – he gave order for 10mg Valium and advised not to confront Mr West if he tried to leave or go out on the balcony."*

In her type-written notes she does not mention the balcony.

In evidence Nurse Harvey was questioned by Sgt Swan concerning who made the decision to allow Mr West to sleep on the balcony and who knew about the decision. She said at p703

> *"I was concerned and once I'd spoken with Maree and Dr Marshall, and the patient seemed to be a lot happier, and we'd made the decision to allow him to sleep on the balcony, which all happened by about 00:10, I believe……so then I felt a lot happier."*

Sgt Swan: *"OK – so whose decision – you just said "we'd made the decision to allow him to sleep on the balcony" obviously you were part of that process. Was that with Maree Rankin or with Mark Marshall?"*

Nurse Harvey: *"No, that was my decision. I had told Maree Rankin about it and she'd left it in my – it was ultimately my decision."*

Sgt Swan: *"What about Mark Marshall? Had you not discussed that with Dr Marshall?"*

Nurse Harvey: *"Yes, I did."*

Sgt Swan: *"And he was aware that the patient … was wanting to sleep on the balcony?"*

Nurse Harvey: *"Yeah"*

Sgt Swan: *Was he aware of your decision to allow him to sleep on the balcony?"*

Nurse Harvey: *"Well I told him, yeah"*

Sgt Swan: *"OK and did he have any argument with you on that point?"*

Nurse Harvey: *"No"*

Sgt Swan: *"OK – there was no other suggestion given to you to do something different?"*

Nurse Harvey: *"Not that I can recall…. I'd told them that I'd try to sleep him in his room, but every time I attempted to, he'd get more and more agitated and aggressive… that was the only place he was settled."*

In relation to the phone call to Doctor Marshall, Nurse Newport said at Para 16:

"*After the Valium had been given to him, Harvey tried to encourage him to do back to bed and rest several times. I also suggested several times to him to do that. He would not go and lie down he simply refused. He said something like "I want to sleep on the balcony. I want to sleep outside" and "he took his pillow and his blanket and walked past the nurse's station and said he was going to sleep on the balcony."*

In oral evidence she said a similar thing.

This seems to indicate that the sleeping on the balcony followed the conversation with Dr Marshall.

Nurse Archer recalled in her statement that she spoke to Nurse Harvey as she was getting the medication for Mr West, i.e. the 10mg Valium ordered over the phone by Dr Marshall, and Nurse Harvey said:

"He's out on the balcony cause he wanted to go out on the balcony to sleep."

In her statement at Para 19 Nurse Harvey refers to the conversation with Dr Marshall, at Para 20 she says she gave the Valium to Mr West at 00:10, at Para 22 she said she then did a medication round for the other patients and at Para 23 she says:

"*At that time (i.e. after she returned to the nurse's station) Mr West walked up to the nurse's station with his pillow and blanket…and said to me he was going out on the balcony to sleep."*

At Para 26 she said she again rang the DON and told her that:

"(a) Dr Marshall had given me an order for PRN Valium I had administered 10mg

(b) the patient had said he was going to sleep on the balcony

(c) I had been unable to persuade him to return to bed

(d) he had made himself a bed on the balcony and appeared to be settled."

At Para 27:

"The DON said to me "Are you concerned about him being out on the balcony?" I said that I had reviewed his chart earlier and could find no entry that indicated to me he was likely to self-harm or had suicidal ideation."

At p240, Dr Marshall was asked by Sgt Swan:

"When did you become aware that he was sleeping on the balcony?"

Dr Marshall: "*At, I believe, but I'm not – I believe when I found him – when I got called to say he was on the concrete down below, after that…I'm not absolutely certain of that."*

Doctor Marshall could not recall if Nurse Harvey had told him that Mr West would not return to his room or that he seemed most settled when he was outside on the balcony smoking cigarettes.

In all of the circumstances I am not satisfied that Dr Marshall ever knew that Mr West was sleeping on the balcony until he was called to the hospital about 04:00 on 31

December 2002 but I do believe he knew that Mr West had been out on the balcony smoking.

In her statement at Para 6 DON Rankin said:

> *"I asked Harvey where Mr West was within the ward. She said that he was out on the balcony. Harvey indicated to me that he had said he was going to sleep on the balcony, that she and Newport had tried to dissuade him and that he had sworn at them and gone out onto the balcony. He had not physically pushed her aside but had been determined to get outside. She said "he seems quite happy out there, he has made himself a nest." I said "What do you mean. Is he on one of the lounge beds?" She said he had pulled the mattresses off the lounges and had laid down on them to go to sleep. I said "keep a careful eye on him "and something along the lines of* ***"I don't want him going over the balcony****."*

I therefore accept that DON Rankin knew that Mr West was on the balcony asleep or for the purposes of sleeping by about 00:15 on 31 December 2002.

I believe that 4 nurses knew that Ian West was asleep on the balcony on the morning of 31 December 2002, i.e. DON Rankin, RN Lisa Harvey, RN Susan Archer & EN Wendy Newport. No doctor knew of this.

The Committal Question

In his submissions, Mr McDougall drew my attention to a recent inquest by the State Coroner Mr Barnes into the death of John Walter Hedges.

Mr Barnes looked carefully at the question of criminal negligence in a medical setting and while I will not go into the same detail as Mr Barnes did, I will spend some time on this very important issue.

I will also use some of Mr Barnes's wording.

S43(2)(b) of the Act requires a finding setting forth "*the person (if any) committed for trial," i.e. whether any person should be charged, in this case, with manslaughter."*

As I said earlier, S43(b) does not permit a coroner to suggest that any particular person is found guilty of any criminal offence – but I am required to consider whether a jury, properly instructed, could convict a person.

The Criminal Code

Section 291 of the Criminal Code provides that it is unlawful to kill another person unless that killing is authorised, justified or excused by law.

Section 293 provides that any person who causes the death of another is deemed to have killed that person.

Section 296 says that a person who does an act which hastens the death of another is deemed to have killed that person, even if the deceased person was labouring under some other disease or disorder.

Section 300 states that "*any person who unlawfully kills another person is guilty of a crime, which is called murder, or manslaughter, according to the circumstances of the case.*"

Section 302 defines murder as an unlawful killing where the offender intends to kill or do grievous bodily harm.

Section 303 provides that any person who unlawfully kills another in circumstances which do not constitute murder is guilty of manslaughter.

Therefore the only offence that needs to be considered by me is manslaughter by way of criminal negligence.

Section 288 of the Criminal Code also needs to be considered. In so far as is relevant to this case it provides: *"it is the duty of every person who….undertakes to administer surgical or medical treatment to any other person….to have reasonable skill and to use reasonable care in doing such act, and the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty."*

In my opinion, before anyone could be found guilty of any criminal offence relating to allowing Mr West to remain on the balcony to sleep, the prosecution would need to prove beyond a reasonable doubt the following:

(1) by allowing Mr West to remain on the balcony they failed to use reasonable care and

(2) that failure caused the death of Mr West in a direct sense

Courts have held that to be criminally liable the prosecution needs to prove a more blameworthy departure from the expected standards than is required by a plaintiff seeking civil redress.

The classic judicial articulation of this difference is found in R –v- Bateman [3] where Hewart LCJ said:-

In explaining to juries the test which they should apply to determine whether the negligence in the particular case amounted or did not amount to a crime, judges have used many epithets, such as "culpable", "criminal", "gross", "wicked", "clear", "complete". But, whatever epithet be used, and whether an epithet be used or not, in order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subject and ***showed such disregard for the life and safety of others as to amount to a crime against the State*** *and conduct deserving punishment….it is desirable that, as far as possible, the explanation of criminal negligence to a jury should not be a mere question of epithets. It is in a sense a question of degree and it is for the jury to draw the line, but there is a difference in kind between the negligence which gives a right to compensation and the negligence which is a crime. (emphasis added)*

In the case of Taktak (1988) 34 A Crim R 334 Yeldham J, when considering whether negligence is sufficiently serious to amount to criminal negligence, said that "a very high degree of negligence" was necessary and also "indifference to an obvious risk", that the jury had to be convinced that the defendant had a reckless disregard to the danger and that mere inadvertence was not enough. *(emphasis added)*

In the case of Nydam –v- The Queen [1997] VR 430, the Court said that to amount to criminal negligence the act causing death must have involved such a great falling short of the standard of care which a reasonable person would have exercised in the circumstances and which involved such a high risk of serious harm that the act merited punishment. *(emphasis added)*

In an article in (1999) 6 Journal of Law and Medicine, 253, Professor Yeo and Ms Callahan suggest that while in civil cases any falling below the standard reasonably expected will lead to liability, in criminal cases the amount and degree of negligence determine whether a crime has been committed.

But what is that degree of negligence that is needed for criminal liability?

---

[3] R –v- Bateman (1925) 94 LJKB 791; (1925) All ER Rep 45; (1925) Cr App R 8

The Nurses on Duty

Nurse Harvey agreed that while Mr West had been heavily sedated "it hadn't touched him" She said that by allowing him to go onto the balcony and smoke she could see that he was markedly more composed and calm and she felt that if she allowed him to continue to do that she would be able to control the situation. Surely there is a difference in degree between allowing Mr West to go onto the balcony to smoke as opposed to Mr West telling her that he was going to sleep on the balcony.

Nurse Harvey said at p698 transcript that "*I didn't ever consider that a patient could fall over the railing (on the balcony).*"

She said that if he had shown signs of being heavily sedated and she was worried about him she would have moved him to a room where she could observe his respiration and check that he was not going into respiratory arrest or choke on his tongue. Similarly if he had been suicidal he would have been under constant watch. She was asked: "*..surely there is a risk of having a patient who is groggy, may not know where they are, maybe disorientated on the balcony?*"

To which she replied (p699)

"In hindsight, yes – of course but I had 2 choices – force him to stay in his room or allow him to stay on the balcony where he was safe and observe him regularly and at that point in time it wasn't in my mind that he would fall over the edge."

At page 700 she said:

> "*Now looking at it, there's a potential that with all those medications on board that it would suddenly hit him at some stage – it certainly hadn't, unfortunately, when I came on.*"
>
> *"After I gave him 10mg Valium you could see he was exhausted mentally as well as physically, he went to sleep almost straight away – I guess that was when the medication was catching up with him, but this is all hindsight."*

There seems to me to be significant evidence that Nurse Harvey's conduct in allowing Mr West to sleep on the balcony falls short of the care that a reasonable person in her position could be expected to exercise. But – is this based on hindsight or is it something that a reasonable nurse in her position or even a reasonable person would have foreseen?

Nurse Harvey said "*it wasn't in my mind that he would fall over the edge.*" – But would it have been in the mind of a reasonable observer?

I believe that it would.

We have expert evidence from Professor Mullen who said when commenting on Dr Reddan's *"with the information available to the medical and nursing staff at the time, it was reasonable for the nursing staff to allow Mr West some choice and to spend time on the balcony"* The difference between spending time on the balcony or sleeping there overnight:

> "*my reading of the evidence from the nursing staff and their statements suggest that it wasn't, as it were a favoured option, it was a no alternative choice, or at least the only alternative would have been to manhandle him off the balcony and into his room. That appears to be, to me, the burden of what the nursing staff said about the situation. So it's a choice really between physically removing him or accepting the fact that he was on the balcony……and I think I can understand in those circumstances why they accepted his remaining on the balcony"*

With the greatest respect, I believe that common sense would then say if he is to remain on the balcony and sleep, what should or could the nurses have done to ensure he was safe?

Nurse Harvey said that if he had shown signs of being heavily sedated and if she was worried about him she would have moved him to a room where she could observe his respiration and check that he was not going into respiratory arrest or choke on his tongue.
Or if he had been suicidal he would have been under constant watch.

She did not suggest extra staff, nor that she would need authorisation to do these things but she seemed to indicate that she would have ensured constant supervision and/or observation in the above circumstances BUT she felt he was safer on the balcony.

Nurse Harvey did not foresee the risk and therefore in all the circumstances I do not believe that a properly instructed jury could convict her.

Nurse Harvey was the Senior Nurse that shift. She was in a direct sense responsible for the welfare of the patients – but I do not believe she was the only person responsible for the patients.
Most witnesses agreed that Dr Marshall was ultimately responsible for the patients and their treatment – but he did not know that Mr West was sleeping on the balcony.

As I said previously, Dr Marshall could not be held responsible for Mr West's fall in a direct sense.
I will return to Dr Marshall again later.
I believe that DON Rankin had a certain responsibility for the patients – and that this increased when she was told by Nurse Harvey that Mr West was asleep on the balcony. When Nurse Harvey told DON Rankin that Mr West was sleeping on the balcony, the DON asked *"are you happy about him sleeping on the balcony?"* (Transcript page 698).

In her statement DON Rankin said at paragraph 6:

"*What do you mean? Is he on one of the lounge beds?"* She (Nurse Harvey) said he had pulled the mattress off the lounge and had laid down on them to go to sleep. I said *"keep a careful eye on him"* and something along the lines of *"I don't want him going over the balcony."*
Nurse Harvey denied in her evidence that the last words about going over the balcony were said. She did not mention these words in her written statement nor her notes, Exhibit 47 and Exhibit 48.

Even if the words were uttered (and I have some doubt that they were) they indicate that DON Rankin actually turned her mind to the possibility that Mr West may in fact fall from the balcony. This must certainly raise her level of responsibility and commensurately reduce that of Nurse Harvey.

It seems to me that even though Mr West was actually at Longreach Hospital awaiting transfer he did in fact receive medical treatment in terms of S288 and allowing him to sleep on the balcony was a part of this "medical treatment."

Registered Nurse Susan Archer

Nurse Archer was rostered downstairs and although she came upstairs to lend a hand she was downstairs when Mr West fell. I believe that she, in all the circumstances, was to all intents and purposes subordinate to RN Harvey. Accordingly therefore, on all the evidence before me I do not believe she could be held criminally liable for Mr West's death.

Registered Nurse Wendy Newport

Nurse Newport was on the ward. At the time she was employed through an agency, Mediserve, and it was only her second night shift at Longreach Hospital and only her

second week at the Hospital. She was rostered upstairs to work with, but certainly subordinate to, RN Harvey. She gave evidence of her own views in relation to "specialling" Mr West and I believe that she herself was ready, willing and able to do that – but she was neither asked to nor told to and so she did not. On the evidence available to me I am also unable to find that she could be held criminally liable for Mr West's death.

DON Rankin

But what of DON Rankin? IN her statement at Para 6 she told Nurse Harvey "*to keep a careful eye on him"* and something along the lines of "*I don't want him going over the balcony".*

In her evidence at p404 she said *"I asked them to do sight observations on him and keep a close eye on him."*

She said in evidence that she was not happy for Mr West to be on the balcony, but she did not take steps to ensure he was moved "*because it was indicated that he was settled at that stage".*

Exhibit 38 contains various file notes, etc. from Longreach Hospital. In a document dated 20 July 2004 and headed

> "Statement of opinion as to the diligence and conscientiousness of the actions taken by Lisa Harvey in the matter of Rosemary Faye Jackson – Ian West (deceased)".

DON Rankin stated:

> *"Staff members continually observed the patient (Mr West) between midnight and the time of the incident."*

Of course this statement is incorrect. There is no evidence that Mr West was "continually observed" – in fact quite the contrary. The evidence is clearly that he was observed from time to time, not continually.

DON Rankin did foresee the possibility of Mr West *"going over the balcony"* but the best advice she could give Nurse Harvey was to "keep a careful eye on him" She agreed with Mr Diehm that looking back, Mr West should have been specialled if he was to remain on the balcony and she would have used Nurse Archer to do this.

Is this omission to use reasonable skill and reasonable care in relation to Mr West sufficient to hold her responsible for the consequences which resulted, i.e. to bring

her within S288 of the Criminal Code? Was it such a reckless disregard to the danger as to amount to such gross negligence that it deserves condemnation and criminal punishment or was it mere inadvertence?

Dr Marshall

Dr Marshall was, I believe, ultimately responsible for the welfare of the patients at the Longreach Hospital on the night of 30/31 December 2002.

He did not attend a handover at the hospital but rather had a telephone handover from Dr Rainolds. He never came to the hospital until after Mr West fell. He never checked Mr West's chart even though Mr West had been prescribed and given 6 different drugs earlier in the afternoon and evening.

He merely prescribed Valium.

He was rung by Nurse Spark at 19:00 and 22:00 and by Nurse Harvey at 23:50 but even then he did not attend the hospital. He was asked "*Did you believe it was necessary for you to come in and review Mr West?"* to which he replied *'I didn't come in because I believed I had sufficient information to make a decision about what should be done then."*

I have said earlier that Dr Marshall did not know that Mr West was on the balcony but the question remains – does Dr Marshall come within S288?

There is not doubt that he was administering medical treatment to Mr West.

He had a duty to use reasonable skill (and I will accept that he did or should have had reasonable skill).

He then had a duty to use reasonable care in administering that medical treatment and in this regard I believe that he failed to do this by his failure to attend the hospital in all the circumstances but merely prescribed more Valium over the phone. In relation to his perceived duties that night Dr Marshall said:

> *"the duties that I had to undertake which was to try and keep him safe, try and keep him in hospital and waiting for the RFDs to come and take him to a facility where there are staff who are trained and medical staff who are specialists in that area."*
>
> *"My plan was to keep him calm enough so that he could be reasoned with so that he would stay in hospital by himself."*

The question is – does his failure to attend the Hospital amount to such gross negligence that it deserves condemnation and criminal punishment or was it mere inadvertence? Did it show such disregard for the life of Ian West that it amounts to a

crime against the State? Was it a reckless disregard to an obvious danger? Did it involve such a high risk of serious harm that it merits punishment?

Dr Dan Rainolds

In all the circumstances I believe that Dr Rainolds failed in many respects, eg to have a care plan, to have knowledge of the required procedures to admit an involuntary patient, to basically understand the way things work in remote parts of Queensland – but I do not believe that he could be convicted of manslaughter.

FINDINGS

(I) The identity of the deceased was IAN LESLIE WEST

(II) His date of birth was 4 June 1976

(III) His last known address was 25 Quail Street, Longreach

(IV) His occupation was labourer

(V) His date of death was 14 January 2003

(VI) The place of death was Townsville

(VII) The formal cause of death was bronchopneumonia following a severe head injury.

At this point I draw the attention of all parties to an amazing but terribly sad coincidence. Exhibit 26 is the Townsville Hospital file which includes Mr West's entire record there.

On 10 January 1980, when he was 3½ years old, Ian West was admitted to the Townsville General Hospital. He had fallen 12 feet from a balcony onto an escalator. He suffered a broken left femur and broken jaw.

As a Coroner I am not bound by decisions in other inquests nor by previous cases but previous inquests and cases are very persuasive so I have taken the opportunity to consider a good number of these, both recent and older.

I have carefully considered what other Coroners and Courts have considered to be medical negligence deserving of <u>at least</u> committal to the Supreme Court if not actual findings of guilt.

I am also aware that the decision I make will bring happiness to some people and sadness, anger and unhappiness to others – but above all I am required to act justly and without fear or favour.

I am to consider all of the evidence including expert evidence.

I am to consider whether a jury <u>could</u> convict a person of manslaughter, not whether they <u>would</u>.

I have spent many months considering this question and in the end result I am of the opinion that no jury, properly instructed, could convict either Director of Nursing Maree Rankin, Dr Mark Marshall or any other person of the offence of manslaughter.

I now make a number of riders which will be forwarded to Queensland Health – hopefully for implementation to ensure that the standard of care given to all Queenslanders will improve.

1. I recommend that Queensland Health review the current contractual arrangements concerning the position of "Medical Superintendent" at the Longreach Hospital. I believe that if a Medical Superintendent was present and involved in this case there may have been a different result. This would also include employing hospital doctors, not employees of the contractor.
2. I recommend that Queensland Health review the practice of telephone handovers between doctors in regional, remote and small hospitals except where the patients have very uncomplicated illnesses and particularly where patients have been prescribed and given a range of medications including a number of mood-changing and anti-psychotic or sedatives as in this case.
3. I recommend that Queensland Health give very clear directions that all patients are to have physical observations performed on admission and at specified intervals and particularly where anaesthic-type drugs such as Midazolam are prescribed. Nurse Harvey said that she believed that all the drugs finally caught up with Mr West and there is little doubt that the result would have been different if regular physical observations had been performed.
4. I recommend that Queensland Health direct all staff to carefully and clearly date and time all file notes and ensure that the notes are accurate as to important events, e.g. time of call to on-call doctors, details of all important conversations, etc. In this case such detail would have avoided obvious anomalies between evidence of various witnesses.
5. I recommend that Queensland Health carefully review all protocols and arrangements with external bodies and invite agencies such as police to attend to investigate serious events rather than to positively discourage such investigations. I believe that in this matter Queensland Health hid behind the then section 63 of the Health Services Act and instead of seeking the truth they attempted to conceal it and to "limit the damage". In this regard I say that I accept all of the evidence of Nurse Thackeray and consider that the behaviour of Queensland Health (not only at Longreach) and their legal

advisers is such that it should never be repeated. I specifically refer to the evidence of Ms Lithgow, the extremely poor statements obtained from Queensland Health staff which were obviously obtained with the thought to protect rather than seek the truth and certain communications, particularly an email forwarded by Ms Lithgow to Dr Buckland on 1 July 2003 which read in part *"Although I do not see this as an official misconduct issue, I believe that serous issues in relation to the delay in retrieval and that the patient was allowed to sleep on the balcony will impact against Queensland Health"* and an email from solicitor Stephanie Gallagher of the then Tress Cocks and Maddox to June Lithgow at 14:30 on 14 January 2003 concerning the use of Section 63 to prevent release of information *"Next of kin could consent under Sec 63(2)(b)"* but no steps were taken to advise anyone of this, even after Mr West had died.

6. I recommend that Queensland Health review the need for "care plans" or similar documents for use by nurses when doctors are on-call and not available on site. In this case such a document would have provided the nurses with a guide with parameters outside of which the doctor would have come to the hospital.
7. I recommend that Queensland Health prohibit all patients going onto outside balconies, etc., at night time and specifically prohibit patients sleeping in all places except their assigned beds.
8. I recommend that Queensland Health prepare a training course for all overseas trained doctor concerning the use of external agencies such as police and Royal Flying Doctor Service and other Queensland Health institutions such as Mental Health Services.
9. I recommend that Queensland Health review the information and documents which should be sent to other medical services on discharge from one institution to another. In this case if the letter written by Dr Ian Wilson, Clinical Director, Rockhampton Mental Health Services addressed to "To whom it may concern" had been on Mr West's file, had been read and given due consideration the result would have been very different.

A G Kennedy
Coroner
10 January 2007