OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Mr Kevin Joseph John McDonnell**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2012/2537
DELIVERED ON:	10 June 2015
DELIVERED AT:	Brisbane
HEARING DATE(s):	23 February 2015, 18-20 May 2015
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, Mental Health treatment, Involuntary Treatment Order, Observations, leaving the ward

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis, Office of State Coroner
Counsel for Metro North Mental Health Service and staff:	Mr J Allen QC I/B Metro North Legal Services
For the family:	Mr R McDonnell

Introduction

1. Mr Kevin Joseph John McDonnell was aged 80. His medical history included depression, delirium and possibly a mood disorder. He was prescribed venlafaxine and olanzapine.

2. Mr McDonnell had been admitted to The Prince Charles Hospital (TPCH) on a number of occasions during the 1990's with a last admission in 2000. All admissions were characterised by rapid onset severe depressive episodes with psychotic features and suicidal ideation. He had been treated with electroconvulsive therapy (ECT) with good effect. Between admissions it is apparent he had good functioning with minimal symptoms.

3. Mr McDonnell was admitted to TPCH on 29 June 2012 with increasing suicidal thoughts (a plan to electrocute himself at his home) and deterioration in his self-care. Mr McDonnell had requested the referral by his GP. He was placed on an Involuntary Treatment Order (ITO).

4. There had been one previous episode during this last admission where he absconded from the ward but was found in the hospital grounds and brought back. He told medical staff he was feeling distressed and wanted to commit suicide.

5. After receiving ECT on 13 July, the consultant psychiatrist considered he was suffering from post-ECT induced delirium, which meant he was at a high risk of wandering and a high risk of agitation and misadventure when delirious. The consultant ordered Mr McDonnell be managed in either a locked ward or on constant nursing observations if the ward was unlocked.

6. After a review on 17 July 2012, it was felt Mr McDonnell no longer required constant nursing observations or the need to be managed in a locked ward, and that he could be managed in an open ward with 15 minute visual observations. Sometime over the next day it is apparent his level of observations changed from 15 to 30 minute observations.

7. On the morning of 19 July he went missing from the ward. Searches were instituted by nursing staff and then security staff and finally the Queensland Police Service (QPS) was advised.

8. On 20 July Mr McDonnell's body was located within a waterway in a highly vegetated roundabout near TPCH. At autopsy the pathologist concluded that Mr McDonnell had likely drowned.

9. Mr McDonnell's family had reasonable concerns regarding the treatment he received at TPCH hospital and particularly how Mr McDonnell was able to leave the hospital precinct. There were concerns about the timeliness of the commencement of the police search. They requested an inquest be held.

10. An investigation was conducted and a number of witness statements were obtained including from medical and nursing staff and QPS. TPCH conducted a Root Cause Analysis (RCA). An independent review of the mental health treatment received by Mr McDonnell was conducted by Dr Jill Reddan, Consultant Psychiatrist.

Issues for inquest

11. After carrying out the investigation, a decision was made to conduct an inquest. At a pre-inquest hearing conducted on 23 February 2015 the following issues were determined.

    a. The findings required by s. 45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death;

    b. The circumstances leading up to the death; and

    c. The adequacy and appropriateness of the mental health care provided to the deceased by TPCH, in particular:

    - Whether it was appropriate to move the deceased from the secure ward to an open ward;
    - Whether it was appropriate to change the frequency of observations from 15mins to 30mins; and
    - Whether staff acted appropriately once it was identified he was missing, including the communication with the QPS.

12. A number of witnesses were heard at the inquest as follows:

- Dr Jill Reddan – Independent expert;
- Dr Peter Devadason, consultant psychiatrist;
- Dr Lana Fernandes, psychiatry registrar;
- RN S Nolan;
- RN J Cookson;
- RN C Bailey;
- RN A Doneley;
- RN D Housley;
- Michael Kilshaw, Nursing Director, MHS;
- Sgt Gibson, QPS:
- Ms Keryn Fenton, Mental Health Operations Director as the most appropriate person from TPCH to provide a statement regarding any improvements made in light of the RCA.

The inquest evidence

13. Mr McDonnell had been admitted to the inpatient unit on 29 June 2012, with increasing suicidal thoughts (a plan to electrocute himself at his home) and a deterioration in his self-care. A diagnosis was made of delirium of unknown cause, on a background of a probable relapse of

his bipolar disorder, and recurrent episodes of severe depression with melancholic features characterised by severe agitation. The delirium was possibly due to lithium toxicity and this was ceased to minimise any post-ECT delirium. He was placed on an ITO. A thorough organic screen including an MRI of the brain was ordered to consider if there was any organic brain issue contributing. The scans did not reveal any acute pathology but there were global atrophic changes and chronic small vessel ischaemia. A CT head scan noted a lytic bone lesion, suspicious for a cancerous process. The investigation and management of this lesion was left to other medical staff.

14. On 4 July Mr McDonnell absconded from the ward but was found in the hospital grounds and brought back. There was no documentation in the medical record describing this event, or as to what time he absconded, how long he was missing and where he was found. He told Dr Fernandes the next day he was feeling distressed and was going home to commit suicide.

15. In the week prior to him absconding it appears he was suffering from post-ECT delirium for which he was being managed.

16. Mr McDonnell commenced receiving twice weekly ECT from 6 July 2012. It was reported he consented to and in fact requested ECT.

17. Dr Fernandes appropriately considered he was at risk of absconding and committing suicide and ordered that he should be treated in a locked ward or on constant observations if unlocked. The consultant Dr Devadason agreed with this assessment. It seems Mr McDonnell was then transferred to the secure Psychiatric Intensive Care Unit (PICU). He was discharged from that unit on 10 July 2012. During his stay in PICU his care was provided by a different medical and nursing team.

18. On 12 July the psychiatry registrar, Dr Fernandes gave verbal instructions for Mr McDonnell to be managed in an open ward with 15 minute visual observations. Dr Devadason considered that in light of the improvement in his mood and lack of suicidal ideation for the last few days, this was appropriate.

19. After ECT on 13 July the consultant considered he was suffering from post-ECT induced delirium, which meant he was at a high risk of wandering and a high risk of agitation and misadventure when delirious. He was provided with oxazepam to decrease agitation. In the meantime further tests including an MRI were being organised to further investigate a possible neoplastic (cancer) process that was occurring within his brain, which had been noted on a CT head scan.

20. The consultant Dr Devadason ordered that he be managed in either a locked ward, or on constant nursing observations if the ward was unlocked or within the locked intensive care unit.

21. The consultant gave further instructions that if over the weekend his delirium resolved and he was not agitated or suicidal he could probably be managed in an open ward on 15 min observations.

22. On 17 July it was considered Mr McDonnell was still depressed with some suicidal ideation, but while he had features of post-ECT delirium the depression was significantly improved from the day before. Nevertheless, the consultant felt it appropriate to reduce the level of observations on the basis he considered Mr McDonnell no longer required constant nursing observations and he could be managed in an open ward with 15 minute visual observations. He was no longer considered to be a restricted patient and this meant he was free to leave the ward.

23. The inpatient psychiatric East Wing ward was normally an open unlocked ward at the time of Mr McDonnell's admission in July 2012. [1]However, because there were a number of patients who required nursing within a locked ward, nursing management had taken the step to lock the East Wing most days by allocating a staff member to guard the exit. Patients on the East Wing ward who were not required to be restricted to a locked ward, such as Mr McDonnell, were still able to leave the ward.

24. On 18 July 2012, the records show that Mr McDonnell was changed from 15 minute visual observations to 30 minute visual observations. There was no documentation in the medical record from any medical officer ordering this change in the patient observations. It was noted that hospital policy required that only a medical officer can change the level of visual observations for a patient.

25. The consultant Dr Devadason stated in his report to the coroner that he believed the decision to place Mr McDonnell on 15 minute observations was reasonable. In trying to allow patients the maximum amount of freedom from scrutiny and restrictions, which are consistent with safety, clinical decisions have to be made and these may, with the benefit of hindsight, turn out to be incorrect. Neither Dr Devadason nor Dr Fernandes appear to have made any decision to reduce the level of observations from 15 minutes to 30 minute observations.

Events of 19 July 2012

26. RN Ann Marie Doneley was Mr McDonnell's allocated nurse during the morning shift of 19 July 2012 and had seen Mr McDonnell at about 8:30am.

27. A witness told police that at about 8:45am he was driving along Webster Road approaching the roundabout at the intersection of Webster Road.

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[1] All mental health inpatient units in Queensland are now required to be locked pursuant to a decision made by the Queensland Government, which came into effect from 15 December 2013.

He noted an elderly gentleman with what appeared to be a white hospital tag on his wrist coming from the direction of the hospital. He appeared a little bit disoriented and unaware of his surroundings. The witness described his clothing to include dark pants and a maroon jumper (clothing noted in the police form 1 as being the clothing Mr McDonnell was wearing when found). This evidence leads to a conclusion that the person was Mr McDonnell. He was seen to walk onto the roadway and traffic had to stop to avoid hitting him. He then walked into the vegetation area situated in the middle of the roundabout. The witness later heard on the news the next day about a missing person from the hospital and contacted Crime Stoppers and passed on his information.

28. Student Nurse Farrugia was completing visual observations of patients at 9:00am and was unable to find Mr McDonnell. The staff then largely but not precisely followed the *Absent without Permission Management Procedure.* There is some uncertainty as to the subsequent timing of events because hospital staff did not document in the records, as required by the procedure, at what time paperwork was faxed through to QPS, what time telephone calls were made to confirm these faxes and the name of the individual police officers spoken to.

29. RN Bailey was the shift coordinator and was first informed of Mr McDonnell's absence by Student Nurse Farrugia after 9:00am. Given it is likely that the time taken to complete the 9:00am observations would have been close to and perhaps in excess of 15 minutes, it is probable this information was provided some time around or shortly after 9:15am.

30. RN Bailey contacted Nursing Director Kilshaw. Nursing Director Kilshaw directed RN Bailey and Student Nurse Farrugia to conduct a search of the area until security were alerted. The records held by Security indicate they were informed at 10:15am and Security commenced their search at around 10:20am. The search consisted of checking the main acute hospital, the designated smoking area, the Breeze Café and a drive around the hospital site. Security records indicate the search concluded at 10:44am. As Mr McDonnell could not be found it was determined he was now likely off campus and QPS assistance was required.

31. RN Bailey then in part prepared *Authority to Return* (ATR) paperwork. It appears RN Nolan may have signed the ATR at around 10:30am and Dr Hebble authorised it at 10:50am. The ATR noted Mr McDonnell was a current inpatient on an ITO, had a current risk to himself and signs of mental illness. The ATR also noted that there had been no history of a previous absconding. That omission is likely due to the fact the first absconding was not set out formally in the medical records as an incident other than reference to it by Dr Fernandes in the progress notes.

32. RN Bailey then sent the ATR through to QPS warrant bureau, Boondall Station and Police Communications but it appears this was as late as around 11:29am. The ATR was loaded onto the QPS QPrime system at

11:57am and QPS officer Senior Constable Thomas was tasked to attend at Mr McDonnell's home address. This occurred at 12:30am.

33. Senior Constable Thomas was unable to locate Mr McDonnell. He continued to conduct searches and to make enquiries. He told Police Communications the enquiry should remain open and asked for a Police *Be on the Lookout (BOLO)* to be produced. QPS then commenced a missing person investigation. Fliers and photographs were circulated amongst local police who commenced patrols of local shopping centres in an attempt to locate Mr McDonnell. QPS alerted the media and published a media release.

34. At approximately 10:45am on 20 July 2012 Mr McDonnell's body was located in a bushy roundabout at Chermside. A Brisbane City Council bus driver, who was proceeding around the roundabout at the intersection of Webster and Hamilton Roads, observed a human body lying inside the vegetation inside the roundabout.

35. QPS were alerted and attended and found the body in a creek to the east of the overpass bridge approximately 20 metres from a concrete culvert. Police observed the body to be face down with the top of his head and shoulders exposed.

36. Checks of the body did not reveal any external injuries.

Autopsy results

37. An autopsy examination found severe coronary atherosclerosis. There was fluid in the sinuses and hyper inflated lungs. There were minor abrasions and bruises which were not contributory.

38. Given the location of the body, the pathologist considered the most likely cause of death was drowning. The presence of severe coronary atherosclerosis may also have been a significant contributing factor in Mr McDonnell's death, as this would have further compromised the oxygen supply to his heart and can lead to a more rapid death.

39. The pathologist was not able to entirely exclude the possibility of a proceeding natural event, such as an acute cardiac event, causing Mr McDonnell to fall into the water.

40. Toxicology analysis found an elevated level of olanzapine (an antipsychotic) within a toxic range and elevated but non-toxic level of venlafaxine (an antidepressant). Olanzapine can be unstable in stored specimens and therefore the pathologist stated the level may not accurately reflect the ante-mortem level, which may have been even higher.

41. The pathologist stated it is possible that olanzapine was at a toxic level at the time of Mr McDonnell's death, however, it was unlikely to have

been a direct causative factor in death given the post-mortem findings and the circumstances in which he was found.

Root Cause Analysis findings

42. The RCA review team could not find any direct factors that caused Mr McDonnell to abscond from the inpatient mental health unit.

43. Mr McDonnell had been admitted for 20 days prior to him absconding. The only other time during the admission Mr McDonnell had attempted to abscond was 15 days prior. The RCA could find no evidence to indicate further attempts had been made by Mr McDonnell to abscond until the final attempt. Throughout the admission he was constantly risk assessed for suicidal intent and risk of absconding and these were rated low at the time.

44. The RCA considered the decision to provide ECT treatment twice a week was appropriate and Mr McDonnell was being appropriately managed for post-ECT delirium.

45. The RCA was not able to ascertain why Mr McDonnell was changed from 15 min visual observations to 30 min visual observations which he was on at the time of absconding. Even though the inpatient unit was 'locked' the day he absconded, Mr McDonnell was still free to leave the ward at any time.

46. The review team considered the clinicians' treatment was performed at a high level. The mental health unit was under a great deal of pressure the day Mr McDonnell absconded, however the clinicians were still undertaking all duties diligently.

47. The TPCH MHS Model of Care involves balancing risk management against the treatment plan for the patient. The review team could find no gap in processes or assessments that could have been undertaken to prevent Mr McDonnell's unfortunate death.

48. The RCA team could not identify any system processes that may have improved the quality of treatment received.

49. The RCA did identify some system issues that could be improved to ensure the service provided to inpatients was more transparent. These were developed as Lessons Learnt.

Lesson Learnt 1

50. When undertaking the RCA a review of the medical record considered it to be generally of good standard. There were three areas where the record was not clear:
    a. On 4 July Mr McDonnell absconded. There was no documentation by nursing staff describing the event. The reviewers were unable to ascertain when Mr McDonnell absconded and for how long or what his mental state was prior to and post absconding.

b. On 18 July the records show Mr McDonnell was changed from 15 min to 30 min visual observations. There was no documentation in the medical record from any medical officer ordering this change.
c. The records did not indicate which clinicians were present at the Friday PICU weekend planning meeting and which ward PICU was discussing.

Recommendation

a. The PICU weekend planning stamp to be redesigned to include the information.
b. Implementation of an education program to address issues relating to poor documentation.

Lessons Learnt 2

51. Mr McDonnell was initially assessed in the Emergency Department by a psychiatry registrar during the evening of Friday, 29 June 2012. Mr McDonnell was not seen by a psychiatry medical officer until Monday 2 July 2012. It was considered that if a patient is sick enough to be admitted to an inpatient unit on a Friday, then they should be assessed over the weekend, rather than wait up to three days for a further mental health assessment by a psychiatry medical officer.

Recommendation

a. A process needs to be developed to ensure all new Friday admissions to mental health service inpatient units who are not seen by the treating team on the Friday are reviewed by a psychiatry registrar over the weekend. The admitting psychiatry medical officer needs to develop a plan for the weekend psychiatry registrar on all new patients who will require a weekend review.

Lesson Learnt 3

52. Mr McDonnell was not assessed by any psychiatry medical officer for the two days prior to him absconding from the ward. This was due to the psychiatry registrar being away from work on sick leave and the consultant psychiatrist undertaking duties at the Community Mental Health Clinic.

53. If a patient is in an inpatient unit on visual observations they are required to be reviewed by a medical officer every 24 hours. In this case Mr McDonnell was not reviewed for over 48 hours.

Recommendation

a. A system needs to be developed to ensure inpatients (as required) are seen by a substitute psychiatry medical officer when the patient's treating team is unexpectedly away from work (e.g. sick leave).

Lesson Learnt 4

54. When reviewing the type of 'visual observations' Mr McDonnell was on it was noted that:
a. There is no identified area on the Visual Observations Form where a clinician can document the times when the inpatient unit is locked.

b. There is no operating guideline/procedure that provides direction on what action should be taken when the number of patients on visual observations becomes ‘unmanageable’.
c. It was considered important to be able to retrospectively review records to determine when a ward is locked.

Recommendation

55. The process of visual observations should be reviewed. Consideration should be made as to when the number of patients on visual observations becomes unmanageable/unsafe and requires escalation. During this review the current Visual Observation form should be reviewed. A section for recording the times the ward is locked would be valuable to have on the form.

Implementation of recommendations from RCA

56. Ms Keryn Fenton is the Operations Director of Metro North Mental Health (the service). She was asked to provide a statement in respect to actions taken by the service to implement the RCA ‘Lessons Learnt’ and associated service improvements. She noted the ‘Lessons Learnt’ relate to documentation and communication of care, weekend clinical review of patients admitted on a Friday, medical staff absenteeism notification and visual observations.

57. In respect to clinical documentation the service has conducted audits in respect to the use of and importance of clinical documentation and communication. The service has now implemented electronic exchange of clinical information through the Electronic Patient Journey Board. This allows the electronic exchange of clinical information to enable multidisciplinary teams to access information throughout the various inpatient and mental health community services.

58. The service now has a morning teleconference clinical handover between the inpatient and community services to ensure timely clinical communication.

59. In relation to weekend clinical review there are now bi-weekly meetings to review bed occupancy and acuity as well as to highlight patients who may be assessed as high medical or mental health risk. This information is documented and distributed to all relevant clinicians such as the Nurse Unit Managers and the After Hours Nurse Manager.

60. Processes are now being updated to include that newly admitted patients who have not been seen by their treating team must be reviewed by the psychiatry registrar over the weekend.

61. In regards to the notification of medical staff on emergent leave or absenteeism, the Executive Support Officer is to be contacted by the relevant medical staff member and arrangements are made from existing staffing resources to provide appropriate medical coverage.

62. The Visual Observations Board has been revised to ensure it clearly states whether the ward was locked at the time. With respect to the number and frequency of visual observations, this should be included in the morning handover, or as changes in clinical presentation occur. The medical staff inform nursing staff who change the visual observations form to reflect these changes. This document is also documented in the patient's clinical file as well as the Electronic Patient Journey Board.

63. Ms Fenton stated in evidence the service is now trialling a new visual observation sheet applicable to a single patient. Dr Reddan suggested a change to the visual observation chart to make it clear what are the specific visual observation orders then current. It is apparent this recommendation is non-contentious and the service agrees.

64. The service did trial the use of alarm bracelets by way of a wandering monitoring system but it appears this was not altogether successful. Ms Fenton also noted that more CCTV cameras have been placed at the hospital campus, although it is noted these are not monitored in real time. She emphasised that the hospital and mental health wards should not be considered prisons.

65. To some extent the issue of patients leaving wards has been overcome since 15 December 2013 when it was directed by the State Government that all mental health inpatient units were required to be locked subject to any structural modifications required. The East Wing where Mr McDonnell was an inpatient has been locked from this date.

Report of Dr Reddan

66. Consultant psychiatrist Dr Jill Reddan was provided with all of the investigation material and prepared a report. She was asked to address a series of issues.

Whether Mr McDonnell's diagnosis and treatment was appropriate

67. Dr Reddan considered the evaluations undertaken by Dr Devadason and Dr Fernandes were appropriate, comprehensive and well documented. It was clear that the diagnosis of a recurrent Major Depressive Disorder with melancholic features and at times psychotic features was appropriate. It was understandable that Dr Fernandes considered on 2 July 2012 that Mr McDonnell had a delirium but this implies a more acute condition. With the benefit of hindsight, Dr Reddan considered it was more likely that he in fact had an emerging dementia, probably of the vascular subtype, although the subtype is not entirely relevant. This did not mean that he did not require active treatment for his depressive disorder but it was certainly going to make it more difficult to treat and would have implications for both his acute and chronic management.

68. Dr Reddan considered that the presence of an underlying brain abnormality, over and above normal ageing, made it more likely that Mr McDonnell would have developed a post ECT confusional state or a post ECT delirium and it was appropriate that the doctors tried to reduce this

by administering ECT only twice a week and by the prescription of galantamine.

69. Dr Reddan opined that Mr McDonnell clearly required some sedative drug but it was important to be careful in their use in the elderly for a number of reasons. She noted it can be a very difficult balancing act to provide a patient with some relief of their stress whilst not exposing them to unacceptable side effects and increased risk.

70. Dr Reddan stated that although the use of promethazine in the elderly is reasonable, it could be stated that Mr McDonnell might have been better off prescribed a smaller dose of 12.5 mg instead of 25 mg. Drs Devadason and Fernandes in evidence conceded this was not an unreasonable opinion but were able to give a number of arguably valid reasons for the higher dose. Dr Reddan agreed Drs Devadason and Fernandes had the benefit of observing Mr McDonnell and were in the best position to assess the level of dosages. It can be a difficult balancing act.

71. Dr Reddan noted that Mr McDonnell must have been given 25 mg of promethazine during the early morning hours of 19 July but there is no documentation in his notes about why this was given. In this respect it does appear there is an error in the records and the dose may have been given earlier at just before midnight on 18 July. Mr McDonnell was then given his usual morning medications at 08:00 hours.

72. Whatever is the case, Dr Reddan stated it is impossible now to know, when Mr McDonnell left the ward sometime after 8:30am on 19 July, as to where he was trying to go, but it is possible that the promethazine contributed along with the olanzapine to some degree of confusion in a man who almost certainly had a vascular dementia. She noted that at autopsy the levels of olanzapine were high and even a few days after ECT, Mr McDonnell still had metabolites of the anaesthetic drugs on board.

Whether it was appropriate to move Mr McDonnell from the secure ward to an open ward

73. Dr Reddan noted Mr McDonnell was clearly developing some physical frailty and he was not a very large man. Very often secure wards, for an individual with very severe melancholic depression who was elderly and frail, are not necessarily a safe place. She considered it was appropriate for him to be moved to an open ward.

74. She commented that in addition, locked wards should never be a substitute for proper staffing and interaction with, and observation of patients. Dr Reddan stated there is insufficient attention in many mental health services to the development of a therapeutic alliance with the patient.

Whether it was appropriate to have been changed from 15 min to 13 min observations

75. Dr Reddan noted that Dr Fernandes had intended for Mr McDonnell to be managed in an open ward on 15 minute observations after she reviewed him on 17 July. The RCA had identified it was unclear how the observations had changed but this appears to have occurred from sometime during the night or early hours of 18 July 2012.

76. Dr Reddan observed that it has to be acknowledged that if a patient is going to either deliberately walk out of a ward or wanders from a ward, 15 minute observations would not necessarily prevent that. It would just ensure the patient would be noticed missing a little earlier.

77. She noted however that there seems to have been some problem in communication or failure of communication about the observations some time from 18 July 2012. The fact Dr Fernandes was off work unwell may be relevant, however it was really the responsibility of the nurse in charge of the ward to make sure the observations were carried out as ordered.

78. Dr Reddan noted there was no evidence to suggest the decision was made by medical staff and it may well have been a mistake that occurred in the middle of the night during the night shift.

79. The evidence now appears to indicate it was a nursing transcribing error.

Whether staff acted appropriately once it was identified Mr McDonnell was missing, including the communication with the QPS

80. Dr Reddan noted that nursing staff clearly informed the police. It was appropriate for the staff to look around the grounds and to ask Mr McDonnell's family to check on whether he had somehow made it home. Generally speaking hospital staff do not conduct searches off hospital grounds.

Whether adequate steps were taken to locate Mr McDonnell when it was determined he was missing

81. Dr Reddan considered this was difficult to answer but it is clear the staff did look for Mr McDonnell around the ward, and contacted the police and his family. Staff cannot be required to conduct large-scale searches outside of the building and grounds.

Any other issues

82. Dr Reddan considered it was quite clear from the documentation that Mr McDonnell was appropriately and comprehensively evaluated. The care of the elderly with brain abnormalities and serious psychiatric conditions is quite difficult. Given the ageing population in Australia she considered the resources available to treat them are sparse and it is difficult to see how much forward planning is going on.

83. Dr Reddan considered it was difficult to know what the precise interaction was between the drugs Mr McDonnell was administered, his

probable dementia, his coronary artery disease and the final drowning. She thought it was entirely possible that he had some sort of coronary event which led him to falling into the water and drowning. Alternatively, he may have well been quite confused and wandered off from the ward and this confusion again would have been related to his underlying brain abnormalities/dementia and sedative effects of prescribed drugs. Once gone, he perhaps stumbled and fell into the water and he could not then get himself out. Thus the precise interaction of a number of predisposing factors to his final demise is almost impossible now to be clear about. Dr Reddan opined that overall, the material does not suggest that Mr McDonnell suicided.

84. Dr Reddan also commented that there may be arguments for a change in treating staff when patients are placed in a PICU, but there are also compelling arguments against there being a change of treating staff. She commented that continuity of care is very important and it is also repeatedly found that changes in staff result in discontinuities, which then result in cracks in care through which patients can easily fall.

85. In this particular case Dr Reddan felt there was no evidence that changing of staff between the open ward, secure ward or the PICU played a major role, however such changes are sometimes the discontinuities which result in there being confusion about observation levels, for example.

Conclusions in relation to the facts and issues

86. In reaching my conclusions it should be kept in mind that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[2] 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.

87. If, from information obtained at an inquest or during the investigation, a coroner reasonably believes that the information may cause a disciplinary body for a person's profession or trade to inquire into or take steps in relation to the person's conduct, then the coroner may give that information to that body. In this case there is no evidence to suggest any such referral should be made.

88. Mr McDonnell had been an inpatient at TPCH mental health unit for three weeks. He was on an Involuntary Treatment Order and was receiving intensive treatment for his increasing suicidal thoughts. He had a long standing Major Depressive Disorder and recent delirium. Investigations as to the source of the delirium and possible organic brain condition, as well as probable vascular dementia, were being carried out.

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[2] s 45(5) *Coroners Act 2003*

89. As well he received ECT and it is likely he also developed post ECT delirium. He had been appropriately prescribed promethazine and olanzapine.

90. It was recognised by clinical staff that Mr McDonnell was therefore at risk of both self-harm and harm due to misadventure if he absconded. In fact he had left the ward on one occasion on 4 July and was found on the hospital grounds. He said he wanted to go home and kill himself. A number of strategies were put in place to manage the risks of absconding and self-harm. These included at various times close observations, admission to a secure ward, changes to medication, and as improvements in his condition objectively occurred, reducing the level of observations.

91. An independent review by Dr Reddan considered that overall his treatment program was appropriate, other than she gave a qualified opinion that a smaller dose of promethazine might have been better. I accept Mr McDonnell's treating team had arguably valid reasons and it was not outside of accepted medical practice in providing the higher dose.

92. Mr McDonnell was then placed on 15 minute observations and was not restricted to a locked ward. Dr Reddan considers this was a reasonable decision to make at the time it was made. It was stated, and I accept, that balancing the needs to ensure on the one hand, physical safety, to on the other providing appropriate freedom of movement, privacy and autonomy, are important therapeutic considerations.

93. I accept the opinion of Dr Reddan in all these respects. My own impression of the clinical staff, particularly of Drs Devadason and Fernandes, concurs with that of Counsel Assisting, Ms Jarvis, when she submitted they demonstrated a high level of understanding of Mr McDonnell's condition and needs and applied a considered approach to his management and treatment.

94. At some time on 18 July 2012 the hospital records indicate the timing of observations for Mr McDonnell was changed from 15 to 30 minutes. This was not due to any order or decision of a doctor. Reviews by TPCH have failed to offer any explanation for this change other than it appears to be a nursing staff transcribing error. I accept this is the most logical explanation and there was not a deliberate decision by nursing staff to change the level of observations bypassing medical staff. It was however a basic error, and no-one seems to have referred back to the records to check. This was also at a time when no psychiatric staff reviewed Mr McDonnell for two days due to no relief staff being available when Dr Fernandes was absent on sick leave.

95. Accordingly Mr McDonnell was at the time the subject of observation monitoring each 30 minutes when his medical team had ordered 15

minute observations. He was seen by nursing staff at around 8:30am on 19 July 2012 and marked off on the observation sheet.

96. RN Doneley spoke to Mr McDonnell at 8:30am as he left the dining room and he stated he felt poorly, although this was not an unusual comment. A witness recalls seeing an elderly man about 15 minutes later looking as if he was confused and disorientated and trying to cross a very busy and large roundabout.

97. The combination of all this evidence is such that it can be readily concluded that Mr McDonnell was in a confused state when he left the East Wing ward on 19 July 2012.

98. Sometime after the scheduled 9:00am observation regime Mr McDonnell was found to be absent. It is likely the communication of this fact was around 9:15am or slightly later, given the expected time it would take for a nurse to complete a full observation round of all patients on observations is about 15 minutes. The unit was said to be very busy that day, although it seems this was the usual state of affairs. Mr McDonnell's allocated nurse, RN Doneley, was engaged in taking another one of her allocated patients for an X-ray, which took a little longer than usual such that she did not come back to the ward until around 10:00am.

99. It has to be said that being on more restricted observations may have made a difference in this case. It is accepted, as Dr Reddan also says, if a patient is going to walk out or wander, 15 minute observations would not necessarily prevent that occurring. It would only ensure his missing status could be noticed earlier. That 15 minute interval in this case was likely a critical one, as given his age and known frailty, Mr McDonnell could well and truly have been on the hospital campus approaching the timing of the next 15 minute observation. It may have been a matter of minutes later that he crossed into the roundabout and it could be the alarm would not have been raised before then. It is difficult to be absolute as to what difference in the outcome there would have been with an earlier reporting, but it cannot be simply dismissed as an insignificant consideration.

100. The hospital staff then largely followed policy and procedure in commencing searches, notifying family and security and ultimately the police and sending the appropriate paperwork to enable police to return Mr McDonnell to the ward. There was a time delay to about 11:30am before QPS were officially informed. The policy for return of patients does not specify a time in which QPS should be informed but the policy provided for attempts to locate the patient immediately and other processes to be commenced and escalated. In this respect the policy appears to have been adhered to, other than the incomplete recording of some details concerning timing of events, especially in relation to communication with QPS.

101. The policy set out a range of search attempts starting with clinical staff, then security and finally escalated to QPS. I accept there are good reasons for this, and simply involving QPS at the first instance is unnecessary and a burden on their resources. Most patients who leave the ward or fail to return from leave and remain missing for a time are located. Hospital staff stated they could contact QPS earlier if needed. I would anticipate if staff had knowledge of emergent concerns for a patient that could be addressed by immediate attendance of QPS, QPS would not hesitate to do so. QPS would not need *'Authority to Return'* paperwork to proceed to a place where an emergency was taking place or to perform a welfare check. This is a routine experience for QPS.

102. The feeling I get from considering the totality of the evidence is that hospital staff did take the missing status of Mr McDonnell seriously, and escalated through the missing patient procedure appropriately, albeit rather slowly after the security had completed their search. The acuity of the ward may have had some part to play in this as I suspect competing responsibilities impacted with staff who were at a stretch. If the staff had known Mr McDonnell had made his way to the roundabout, in all probability QPS would have been informed.

103. In this regard I note TPCH has since placed more CCTV cameras around the hospital campus, although as this is not monitored in real time this would not have been of much advantage in this case. In any event, any delay in escalating to QPS would have had no impact on the outcome given it is likely Mr McDonnell was deceased by this time.

104. I have no concerns with the QPS efforts and attempts to find Mr McDonnell. The ATR made it clear he was on an ITO and he was a high risk patient. The error in including a statement he had no history of absconding would have made no difference. QPS acted appropriately.

105. Mr McDonnell made his way to the bushy roundabout near the hospital. This would have been prior to 9:00am. In this respect I have to consider, if possible, if the subsequent drowning was intentional.

106. There is no doubt one of the significant reasons why Mr McDonnell was being treated was due to increasing suicide ideations. He had left the ward on one occasion with an expressed intent to go home and electrocute himself. He had not previously suggested death by drowning. The creek where he was found was quite shallow and as noted by Dr Reddan, intentional death by drowning is almost always associated with larger expanses of water, often approached from a height. Mr McDonnell was found with his face in the water but the back of his head and shoulders were uncovered. This is not a situation where death would be inevitable.

107. Although a deliberate act of drowning is not able to be absolutely excluded, the evidence strongly and likely leans to a conclusion that Mr

McDonnell collapsed or fell in his confused state and in uneven territory and drowned. A possible cardiac event cannot be excluded.

108. Whether the death was due to suicide or misadventure, both were risks known to the treating team and which at the time were being managed by use of medication and what should have been a 15 minute observation regime.

109. It is possible, but not inevitable, that if the 15 minute observation schedule had been maintained Mr McDonnell would have been noted to be missing 15 minutes earlier and hence there was a greater chance of him being found in the hospital precinct. It is likely the timing of events are such that even in the case of an earlier alarm being raised, this would not have happened until after 8:45am and more likely closer to around 9:00am. By that time, if the motorist witness's estimate of time is accurate, Mr McDonnell had almost certainly crossed into the vegetation in the roundabout. Unfortunately precise timings cannot be defined with any accuracy, and the degree of contribution to causation of subsequent events due to the error in the observation schedule is inconclusive, but the error should not have occurred.

110. Mr McDonnell was entitled to leave the ward. It is unclear if there was anyone supervising the door at the time and certainly no nurse has been identified as being rostered for that purpose that day. These events could only have been totally prevented if the ward had been physically locked. It should be noted the issue of locked wards for all patients is a contentious one within the psychiatric community and is not one welcomed by many mental health clinicians. I heard evidence on this issue from Dr Reddan who has a strong view against the principle of locked wards for all mental health inpatients, whatever might be the risk to themselves or others. It is apparent Mr McDonnell's treating team may have similar views.

111. During the *Inquest into the deaths of SH and AW*[3] I also heard evidence from senior psychiatrists that for many patients, locking them in a ward is completely inappropriate from a therapeutic perspective and is likely to cause exacerbation of behavioural problems. In that decision I made comment that it was still incumbent on mental health services, in relation to patients who were on ITOs or Forensic orders, to find ways to manage the risks of absconding and self-harm. I heard evidence in that case that Metro South Mental Health Service was undertaking a number of activities focused on observations and supervision of such patients. Some of those activities, including use of an Electronic Patient Journey Board system, improvements to observation sheets and practical ways to identify which patients are able to leave the ward and when, have in part been considered and adopted or are being trialled by Metro North MHS. Permanently locking the ward for all patients was not one of the

[3] Inquest in the Deaths of SH and AW, delivered 25/1/2013

methods adopted, and was not one that I considered for recommendation.

112. However, the position at the time of this inquest and since 15 December 2013 is that all mental health inpatient units, whether secure or not, are required to be locked. It is therefore unnecessary to consider what other recommendations should be considered to prevent patients leaving the ward or ensuring they return to the ward.

113. Dr Reddan did suggest there could be changes to the visual observation chart used at the time of these events to indicate the level of visual observations each patient was meant to be receiving in the form of a further box providing for this input. Although there was a rudimentary indication of this on the form utilised, as this case indicates it was prone to easy error. It seems TPCH is currently trialling an individual observation sheet which notes this level of detail. TPCH has conceded any recommendation on this issue would be accepted and it is non-contentious.

Findings required by s. 45

Identity of the deceased – Kevin Joseph John McDonnell

How he died – Mr McDonnell was an inpatient at the Prince Charles Hospital mental health service. He was the subject of an Involuntary Treatment Order. He had a long term history of mental illness and when unwell this was characterised by severe depression, psychotic features and suicidal ideation. As well, it is likely he had an organic component to his condition consistent with probable vascular dementia. He received appropriate treatment and management of this condition including ECT, medication and varying observation and restricted to the ward regimes. His relatively advanced age, and the above conditions combined with his medication regime also are likely to have involved an increased level of confusion, agitation and drowsiness. On 19 July 2012 Mr McDonnell left the ward in a likely confused state. He was at the time meant to be the subject of 15 minute observations but he was not restricted to the ward. An error by nursing staff had increased his observation schedule to 30 minutes. He left the ward soon after he was last sighted by a nurse on the ward at 8:30am. He was seen by a motorist to enter a highly vegetated roundabout near the hospital at about 8:45am. Mr McDonnell's body was found

the next day in a shallow creek running through the roundabout with his head in the water. An autopsy found he had drowned. It could not be excluded that he had a cardiac event and fell and drowned, but it is also possible he stumbled and fell and in conjunction with his medical and mental health conditions and level of medications he was unable to recover himself. It is unlikely that Mr McDonnell intentionally tried to take his own life.

Place of death – Herrmann Place (Roundabout) Webster and Hamilton Roads Chermside Qld

Date of death– 19 July 2012

Cause of death – 1(a) Drowning
2 Coronary atherosclerosis

Comments and recommendations

I recommend, that any future version of the patient physical observations forms utilised by nursing staff at Metro North MHS include information as to the patient's observation regime as clinically recommended by their treating team. No doubt if there are changes to the policy of locked wards the observation sheets should also indicate whether patients are restricted to the ward or able to leave and for what periods.

I also wish to comment on the manner in which TPCH staff and Mr McDonnell's family approached this inquest. A number of staff expressed their condolences to the family during the course of the inquest. An apology was expressed by Ms Fenton. Mr Russell McDonnell, Mr McDonnell's son, stated that he appreciated those comments and they were very significant for him.

I also noted that Russell McDonnell personally approached witnesses as they were leaving the witness box and thanked them. In his written submission he stated he is grateful to the treating doctors for the care provided. Russell McDonnell's approach to staff was a very generous concession. He also submitted there were some time lapses, errors and omissions that should not be overlooked. It is hoped these have been explored during the inquest. I also thank him for his very considered and courteous approach during the course of the investigation to staff of the Office of the State Coroner and during the hearing.

My condolences to him and others of Mr McDonnell's family and friends are also expressed. I close the inquest.

John Lock
Deputy State Coroner
Brisbane
June 2015