OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Patricia Van Putten**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Cairns
FILE NO(s):	COR 678/06(6)
DELIVERED ON:	15 December 2008
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HEARING DATE(s):	25, 26, 27, 28, 29 June 2007; 2, 3, 5 July 2007
FINDINGS OF:	Ms K McGinness, Coroner

CATCHWORDS: **CORONERS: Inquest – Suicide, Mental Health Patient**

REPRESENTATION:

Counsel Assisting: Mr John Tate (counsel)
Dr Una Stephenson: Ms Josephine Willis (counsel instructed by Miller Bou-Samra)
Queensland Nurses Union: Mr Michael Fellows (counsel instructed by Robertson & Kane)
Department of Health: Ms Lisa Evans (counsel instructed by Crown Law)
Family: Ms Monique Van Putten

Introduction

[1] These are my findings in relation to the death of Patricia Van Putten ("Patricia"). These findings seek to explain how her death occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. The *Coroners Act 2003*[1] provides that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organizations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The Coroner's jurisdiction

The scope of a Coroner's inquiry and findings

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

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

[3] There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as that issue was not contentious in this case I need not seek to examine those authorities here. I will say something about the general nature of inquests however.

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

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.*[2]

[5] The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[3]

[6] A coroner must not include in the findings or any comments or recommendations or statements that a person is or may be guilty of an offence or civilly liable for something.[4] However, if, as a result of considering the information gathered during an inquest, a coroner reasonably suspects that a person may be guilty of a criminal

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[1] *Coroners Act 2003*, s45
[2] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[3] s46
[4] s45(5) and 46(3)

offence; the coroner must refer the information to the appropriate prosecuting authority.[5]

The admissibility of evidence and the standard of proof

[7] Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate.*" That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

[8] This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

[9] A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

[10] It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[9] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The evidence

[11] I turn now to the evidence which I will not attempt to summarise in full, however I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Social Background

[12] Patricia was born on 17 April 1956. She was 49 years of age at the time of her death. Both her parents had been deceased for approximately 20 years. Patricia had one sister Monique who was 4 years her junior.

[13] Patricia was a school teacher by profession. She had retired after a 30 year teaching career. The reasons behind her retirement are not entirely clear however her retirement resulted in her feeling useless and without a future career.

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[5] s48
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[10] (1991) 65 ALJR 167 at 168

[14] By all accounts she was a talented and committed teacher who loved and worked well with her students which led to reciprocal high regard from the children she taught.

[15] Patricia and her sister Monique had a troubled relationship after Monique returned to live in Mareeba in approximately 2002. After a falling out in 2005, Patricia and Monique were estranged and had no meaningful contact for a period of approximately 1 year until Patricia's final hospital admission on 2 February 2006.

[16] Dawn Rowan, a very close family friend of Monique and Patricia, remained a link between the two sisters and provided constant support to both Patricia and Monique up until the time of Patricia's death.

[17] In 2006 Patricia was also in a relationship with Mr Lowe-Brock. They were engaged to be married. Mr Lowe-Brock previously resided with Patricia but had moved into a caravan some months prior to her death. He intended to recommence co-habiting with Patricia in a cottage at Paddy's Green which he and Patricia had leased just prior to her death.

[18] Friends, family and the medical staff and professionals who knew Patricia described her as clever, charming, and entertaining, with an enormous capacity for warmth, love and caring, as demonstrated by her relationship with her students, close friends and her animals.[11]

[19] Patricia was also perceived to be very private and did not allow those close to her to know what she was thinking or feeling.

Mental Health History Preceding Years

[20] Patricia had a long standing patient relationship with Dr Murray Towne who worked at the Mareeba Medical Clinic during the relevant period. He had seen Patricia intermittently over a 10 to 12 year period during which he diagnosed mental health problems of anxiety and depression. Dr Towne confirmed a significant deterioration in Patricia's mental health between July 2005 and her death.

[21] Monique recalls Patricia having a history of anxiety, experiencing "highs and lows" [12] and taking medication to help her sleep since her early 20's. She recalls Patricia as always being unstable in terms of mood and personality. She observed Patricia fluctuate between being happy, energetic, extroverted and witty, to becoming depressed, vindictive and withdrawing from family and friends.

[22] Tablelands Mental Health documentation records contact with Patricia on five occasions to July 2005 for anxiety and depression.

Metal Health History July 2005 until February 2006

[23] Patricia's mental health deteriorated rapidly from about July 2005 when she presented to Tablelands Mental Health Department and to Dr Towne with longstanding sleep problems, suicidal thoughts and relationship difficulties.

[11] Transcript 28/06/07 page 26
[12] Transcript 25/06/07 page 56

[24] She attended Dr Towne or his colleague Dr Bestmann on 23 occasions during this period. Dr Towne treated Patricia with counselling and medication and referred her to Tablelands Mental Health on a number of occasions. He also referred her to psychiatrist Dr Woolridge for assessment. He diagnosed her as severely depressed with a history suggestive of Bipolar Disorder and personality difficulties.

[25] Since December 2005, Patricia attempted to take her life on a number of occasions by various methods including lacerating her neck and wrists, overdosing on medication, and placing a "live" hair dryer into her bath water. Patricia was admitted to Mareeba Base Hospital on two occasions in 2005, the first occasion with suicidal thoughts and the second occasion following an attempted suicide by overdose.

[26] On 8 January 2006 Patricia cut her arms and was admitted for surgical and Mental Health treatment to Cairns Base Hospital where she was diagnosed with major depression, borderline personality disorder and situational crisis. She remained an inpatient until 12 January 2006.

[27] On 23 January 2006 Patricia again cut her wrists and was admitted to Mareeba Base Hospital, then transported to Cairns Base Hospital Mental Health Unit where she was again assessed. An Involuntary Treatment Order was considered. She was discharged on 24 January with Community Mental Health follow-up.

[28] On 2 February 2006 Patricia cut her throat and left forearm in a further suicide attempt and was admitted to the Intensive Care Unit at Cairns Base Hospital where she remained until her discharge on 12 February 2006 with Community Mental Health follow-up. During this admission Patricia required urgent surgical intervention and suffered serious physical injury. Patricia was kept in the surgical ward for most of her stay because of her physical injuries. For Mental Health purposes she was under the care of Dr Una Stephenson Consultant Psychiatrist, Dr Gynther Psychiatrist, a number of Psychiatric Registrars and the Cairns Base Hospital Consultation Liaison Psychiatric team.

[29] Dr Una Stephenson was the consultant Psychiatrist at Cairns Base Hospital and also to the Atherton and Mareeba Community Mental Health Unit during this period. Patricia first came under her care as an inpatient on 9 January 2006. Dr Stephenson initially assessed Patricia on 9 January 2006 and reviewed her medication, changing it to Dothiepin and Olanzapine.

[30] Dr Stephenson continued overseeing Patricia's treatment during her subsequent hospital admissions as well as after Patricia's discharge on 12 February 2006.

[31] Patricia's sister Monique and close friend Dawn Rowan were deeply concerned that, if released, Patricia would continue to attempt suicide. After waiting a considerable time at the Cairns Base Hospital on 4 February 2006 they spoke to Dr Harper, a psychiatrist not part of Patricia's treatment team, to whom they voiced their concerns and provided collateral information about Patricia. They visited Patricia who, perceiving Monique wished to have her institutionalized, withdrew her consent for Mental Health staff to discuss her details and future plans further with Monique.

[32] Patricia's mental state improved and after continued assessment and consultations between the clinical staff and Dr Stephenson, a discharge plan was formulated based on a decision to maintain positive therapeutic alliance between Patricia and her carers. Patricia was assessed as not psychotic. She was extremely resistant to admission to the

Mental Health Unit. Dr Stephenson determined Patricia would best be treated as an outpatient and an Intensive Discharge Plan was put in place. Patricia's release was delayed until Sunday evening 12 February to allow time for intensive community follow-up to be put in place to commence on Monday 13 February.

[33] The discharge plan included daily visits and reviews by mental health nurses Ms Walker and Ms Fitzgerald ("carers"), consultations with Dr Overland Psychiatrist, sessions with private psychiatrist Dr Woolridge,[13] support from her fiancé Mr Lowe-Brock and reviews by Dr Stephenson.

[34] Over the following week Patricia's carers Ms Walker and Ms Fitzgerald visited her on a daily basis. She was visited on 13 February by Dr Overland during which she and Ms Walker comprehensively noted Patricia's mood and discussed future goals such as moving to new accommodation.

[35] Dr Overland and Ms Walker also met and spoke with Mr Lowe-Brock.

[36] On 16 February the carers became concerned for Patricia's mental health. They contacted Dr Stephenson who faxed through a prescription for sodium valproate. Patricia talked of suicidal thoughts. She mentioned to Ms Walker that a girlfriend knew of someone who had died taking "Roundup." Patricia also discussed the effects of "Roundup" with Mr Lowe-Brock. He told her not to take it as it "burns all the way down".[14]

[37] On 17 February, after further discussion with their team leader, the carers visited Patricia and Mr Lowe-Brock. They told Patricia that there were no beds available in the Mental Health Unit in Cairns but she could wait in the Emergency Department until a bed in the hospital became available. Patricia did not want to go to hospital or to the Mental Health Unit.

[38] Ms Walker contacted her team leader Ms Williamson at Atherton Mental Health. As a result a plan was put in place for the weekend which involved Mr Lowe-Brock staying at Patricia's residence over that weekend. He agreed he would not leave her by herself at any time. The plan was approved by Dr Bayley, the Director of Cairns Mental Health. The mental health carers spent a lengthy period of time talking to Patricia and Mr Lowe-Brock about the need for him to stay with Patricia constantly over the weekend. He and Patricia willingly agreed. Arrangements were also put in place for Ms Walker to work after hours to enable her to visit Patricia daily and as needed, over the weekend.

[39] At approximately 2pm that day Patricia rang Ms Walker and advised her she had purchased some "Roundup". Ms Walker went to the house and collected the "Roundup". When she arrived Patricia and Mr Lowe-Brock were present. Patricia was in a brighter mood and stated to Ms Walker "It was time I concentrated on living".[15] Further discussions occurred which confirmed that Mr Lowe-Brock would remain with Patricia over the weekend at all times. When Ms Walker left Patricia's home on the afternoon of 17 February she states she had no reason to doubt Mr Lowe-Brock would keep his promise to stay with Patricia. He portrayed himself to all staff who met with him as very aware of, sympathetic to and concerned about Patricia.

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[13] Exhibits 23&28
[14] Exhibit 10
[15] Exhibit 17

Circumstances of Death

[40] On 18 February 2006, despite his agreement to remain with Patricia, Mr Lowe-Brock left Patricia by herself at her home sometime before 9am to attend to some chores. He stated Patricia was "perky and quite happy" prior to him leaving and he was not at all concerned she would harm herself. He intended to return later in the day. At approximately 9am a bottle of "Roundup" was purchased from the local hardware store. Sometime after 9am on that day Laurel Leinster, Patricia's landlord, neighbour and friend, spoke briefly to Patricia at her flat. Patricia told Ms Leinster she felt nauseous and was going to lie down. Ms Leinster returned to her own flat next door.

[41] At about 10.15am Ms Walker arrived at Patricia's home but found the gate locked with a sign on it from Patricia saying she and Mr Lowe-Brock had gone for a drive. Ms Walker accepted this to be the case and left, planning to return later in the day. Around this time Ms Leinster heard a scuffling noise from Patricia's flat but when she went over and knocked on Patricia's door she received no answer. A short time later Ms Leinster heard bumping noises on the floor boards which she thought may have been a signal for help from Patricia. She went into Patricia's flat and found Patricia lying on a mattress in the spare room. Patricia told her she had swallowed a bottle of "Roundup".

[42] Ms Leinster contacted Queensland Ambulance Service and also Monique who was working across the road at a Veterinary Surgery. Queensland Ambulance Service arrived quickly and officers transported Patricia to the Mareeba District Hospital close by where she was declared life extinct at 11.25am due to respiratory failure.

[43] Mr Lowe-Brock had still not returned to Patricia's home by 2pm when Dawn Rowan informed him by phone of Patricia's death.

[44] Patricia's family and friends were, and no doubt continue to be, distraught by Patricia's death. What became apparent during the inquest was that all Mental Health staff who had come into contact with and treated Patricia were also deeply affected and saddened.

Issues for Consideration

[45] I now turn to the issues which have arisen for consideration concerning Patricia's treatment and care.

[46] Dr Kingswell, Psychiatrist assisting the coroner, provided a report to the Court which highlighted a number of issues that needed to be explored during the inquest including Patricia's clinical management, the medication prescribed, diagnoses, the treatment plan and clinical documentation.

Documentation and Clinical Note Taking

[47] Dr Kingswell, on a review of the Medical files, found there was insufficient documentation by clinical staff of Patricia's admissions and treatment including:

- medical history
- presentation
- risk assessment mental state examination

- reasoning behind diagnosis and treatment choice

[48] He had concerns regarding the documentation made by Dr Stephenson, including her clarity of writing and her documented reasoning for clinical decision making. He recommended an audit of a random number of Dr Stephenson's cases.

[49] In relation to the criticism of the adequacy of her note taking, Dr Stephenson's evidence was that she accepted that her notes were brief, but that the brevity of her notes matched the nature of her position, and that her own notes would always be supplementary to other's notes on the file. Dr. Stephenson said that the majority of the record keeping was done by the junior staff and nursing staff as they made their day-to-day reports within the hospital files.

> "My notes were generally brief summaries of impressions of what was going on."[16]

[50] Dr Bayley the Clinical Director, who has worked with Dr Stephenson over a lengthy period, stated that she has seen Dr Stephenson's records on many occasions. Dr Bayley was adequately able to see and understand what Dr Stephenson wrote in the medical charts.

> "If I have to do a patient of hers on the week-end, I can see what she's doing. It's just sometimes her writing's not very good, but I'm fortunate enough that one of her registrars writes in there, that's – well, we know what she's doing. And I think chart communication in the end is about being able to communicate what is happening with the patient and where to go from. You know, what the consultant wants. And I can generally get that from Dr Stephenson's charts.[17]"

Dr Bayley continued

> "But the point is I can actually if I pick up a chart and Dr Stephenson's written in it, I know what she wants and we can follow what she wants. That is the whole point of documentation – is being able to communicate what diagnosis, assessment, treatment that this patient has. And I really don't have a problem with a lot of Dr Stephenson's charts that I see."[18]

[51] Dr Bayley stated that she did not believe that Dr Stephenson's case load and recent discharges should be examined. Significantly, Dr Bayley stated that clinically she has heard Dr Stephenson discussing difficult patients, such as Patricia with other staff at the service, and she had discussed them at appropriate supervision forums and consultants meetings, where

> "we've all been putting our heads together in how best to manage them, So I have no concerns about her clinical competency."[19]

[52] Dr Bayley's response to the proposed review of Dr Stephenson's file entries was:

> "I think it would be a waste of resources"[20].

Dr Bayley acknowledged that she had nonetheless spoken to Dr Stephenson about the need to make more thorough notes on patient's files, specifically to

[16] Transcript 04/07/07 page 28, lines 30-50
[17] Transcript04/07/07 page 64, line 20
[18] Transcript 04/07/07 page 64
[19] Transcript 04/07/07 page 65, line 20
[20] Transcript 04/07/07 page 65, line 22

record the reasons supporting her clinical decision making as well as the need to write more legibly. Dr Bayley has also had similar discussions with other registrars and consultants under her supervision.[21]

[53] There is no evidence of any kind, or any suggestion that there has been any negative medical consequence of the brevity of the notes in the charts by Dr Stephenson in Patricia's case.

[54] Dr Kingswell's report also suggested consideration be given to whether it is appropriate for Dr Stephenson to be supervising trainees. The Clinical Director Dr Bayley stated in her evidence:

> "I don't have a problem with her supervising trainees. Una is probably better to supervise more advanced trainees, because that's when you can get the benefit of her vast experience. She's probably not the best person to give a first year trainee, straight out of you know whatever, to talk about documentation things on, And that's not her forte. Her forte is her experience, her clinical acumen and what she's seen in the world of psychiatry…which is invaluable.[22]"

Dr Bayley stated that Dr Stephenson generally supervised the out reach registrars who were usually more experienced doctors.[23]

[55] I am satisfied that the Clinical Director has already identified the most effective way of enabling Dr Stephenson to participate in training other staff and utilizing her skills and experience to the maximum.

[56] I accept Dr Kingswell's evidence that hospital forms pertaining to risk assessment, history taking, diagnosis and treatment need to be accompanied by:

- Appropriate monitoring of performance
- Clear rules around which staff members are responsible for each task
- The need to ensure tasks are completed adequately and in a timely manner
- Adequate supervision of the above by the consultant psychiatrist responsible for the patient's care

A common feature that exists is the failure of clinicians to seek information from, family, police, ambulance officers and other important witnesses as to a mentally ill person's history and presentation resulting in unnecessarily limited risk assessment and diagnosis.

Diagnosis and Treatment

[57] Issues arose in this inquest as to the appropriate diagnosis and treatment of Patricia's illness, including use of medication, and whether she should have been released into the community or made the subject of an Involuntary Treatment Order ("ITO").

[58] Dr Kingswell's review of the medical files prior to the inquest led him to form a diagnosis of Major Depressive Disorder. He did not find any documented evidence of an additional diagnosis of Borderline Personality Disorder. He was concerned therefore about the diagnosis and treatment management of Patricia by Dr Stephenson.

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[21] Transcript 04/07/07 page 65, line 8 onwards
[22] Transcript 04/07/07 page 66, line 28 onwards
[23] Transcript 04/07/07 page 55, line 53

[59] It emerged during oral evidence from Dr Towne, Dr Stephenson, other medical clinicians, Monique Van Putten and Dawn Rowan that Patricia's history and presentation certainly supported the additional diagnosis of Borderline Personality Disorder through their face to face dealings with Patricia.

[60] Dr Stephenson initially diagnosed Patricia as suffering Borderline Personality Disorder in Crisis. She thought a diagnosis of Major Depressive Disorder was incongruous with Patricia's presentation during consultations where she appeared non psychotic, emotionally appropriate in speech and behaviour, and willing to discuss positive plans for the future.

[61] Dr Stephenson also considered that, by the time of the conclusion of the 2 February admission, her provisional diagnosis was really firming up into a final diagnosis of personality disorder coupled with depression. Dr Stephenson stated in her oral evidence:

> "we're not talking about mutually exclusive diagnoses, there is a borderline personality disorder pretty entrenched with quite a lot of chaotic conduct with a superimposed depression....with at least or – better say fluctuating. This is the most notable thing with how the fluctuations, you know we present as, you know, severely depressed on Tuesday evening and by Thursday morning was all say – now, 'what was that about? When can I go home?" [24]

[62] Dr Stephenson considered Patricia's personality disorder caused the most problems in treating her erratic behaviour and moods. Dr. Stephenson noted that some of the precipitants of her depression were situational. This diagnosis was in part supported by Dr Gynther who diagnosed Patricia as suffering Major Depression, or Personality Disorder or both. He considered Patricia had symptoms and a presentation which suggested significant personality vulnerabilities, a personality disorder, perhaps amplified by depression.[25]

[63] After hearing the evidence of Dr Stephenson, it was apparent that these difficulties and complexities matched those encountered by Dr Towne and other specialists in the Cairns and Tablelands Mental Health services.

[64] Much of the evidence of Dr Towne corresponded with the observations provided in the evidence and hospital notes of Drs Stephenson, Overland and Gynther, all of whom had the advantage of having direct consultations with Patricia. Given that Dr Kingswell, who was appointed to review the documentation surrounding the death of Patricia, formed his own opinions about diagnosis and medications, Dr Gynther was asked if there is an advantage in actually meeting a patient face-to-face. Dr Gynther replied:

> "There are huge advantages, because – especially with a diagnosis of personality disorder because very much the diagnosis is made, often through not what is said but the nature of the interaction, and the nature of your own emotional response to the patient and as well as the history and everything, You need – you need the history, the past history, the current stresses and all the things that have been happening, but then very much you monitor the nature of the

[24] Transcript 04/07/07 page 40, line 20 to 30
[25] Transcript 02/07/08 pages 42-43

> interaction, and – and without that, you certainly miss a large component of the diagnosis."[26]

[65] It is worth noting, therefore, the primary observations and experiences of Dr Towne as given in his evidence. Dr Towne stated that Patricia was a very guarded person and that she did not let people in very easily.

> "Even with me, and even 10 years ago when I saw her for other problems, it was always a battle to break through into the real Patricia."[27]

These comments were echoed by Dawn Rowan, Patricia's close friend of 31 years, who said in her evidence.

> "The true Patricia never revealed herself to anyone, only those that were the very closest knew the true Patricia".[28]

Dawn Rowan also said in relation to Patricia's stay in the Mental Health Unit

> "She's playing people. She tells people one thing and does another".[29]

Patricia's sister Monique held the same view.[30]

[66] Dr Towne also described Patricia as being a patient who was particularly difficult and resistant to change. Dr Towne made reference to:

(a) Patricia stopped and started anti-depressant medication unexpectedly; also Patricia's use of alcohol compounded her problems.[31] (Patricia's self medication with alcohol was also alluded to by Dr Stephenson).[32]

(b) The exhaustive list of medications prescribed by him for Patricia which reflected the frustration he (and other Doctors in his clinic) experienced treating Patricia.[33] Also, Patricia was loathe to take medications and did not see them as her answer.[34]

(c) Patricia experienced a history of bi-polar highs and lows and at times said things for effect.[35] When she was on a high, she was engaging and charming.

(d) Patricia reported memories of unhappiness with her father (which coincides with the family history taken at the initial interview on 4 July 2005 in the Mareeba Hospital File).

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[26] Transcript 02/07/07 page 56, line 10
[27] Transcript 28/06/07 page 39, line 10
[28] Transcript 26/06/07 page 60, line 20
[29] Transcript 26/06/07 page 65, line 30
[30] Transcript 04/07/07 page 46, line 40
[31] Transcript 28/06/07 page 33, line 10
[32] Transcript 04/07/07 page 41, line 1-10
[33] Transcript 28/06/07 page 44
[34] Transcript 28/06/07 page 32
[35] Transcript 28/06/07 page 45

(e) Patricia was resistant to seeking out a fix for her problem; she wanted to feel better but did not want to go down the path that needed to be made to help her; she did not want to explore, by use of therapy, where all her problems were coming from.[36]

(f) Patricia could herself, having good insight into her own condition, see no answer to her problems. This was the basis of her suicide attempts.[37] Dr Towne and Patricia spent a lot of time discussing this. Many of these consultations were lengthy.

[67] Dr Towne observed that at times Patricia would improve and appear to be getting on top of her condition. He said that there wasn't a straight decline in Patricia's condition. There were significant periods when he thought "*OK we're winning here*".[38] This is very much in line with the observations of the treating psychiatric nurses (McNamara, Walker, and Fitzgerald) and the psychiatrists Dr Stephenson, Overland and Gynther, all of whom disagreed with Dr Kingswell's reference to Dr Turner's review on 9 January 2006 which included a reference to melancholia. Each of the treating psychiatrists noted that Miss Van Putten's mood would change significantly, fluctuating between highs and lows.

[68] Dr Towne considered that Patricia had significant insight into what was going on and was not psychotic. He thought she was in her own way like a patient with terminal cancer who decides to end their life because they see nothing in the future. Dr Towne pondered, after Patricia's several attempts on her life, as to whether any interventions could have been put in place.[39] It was with deep sorrow that Dr Towne recounted his own anguish when hearing Patricia had passed away. He spoke to Dr Woolridge, his other colleagues, and Ms Walker, asking:

> "what could we have done differently?...we couldn't come up with anything".[40]

[69] This is in accord with the view expressed by Dr Gynther who stated towards the end of his narrative of efforts in providing care for Patricia that she

> "was treated intensively in the community with all the resources we had and all the intent and it still happened. There are some –I mean if people die after having a cardiac even where they get an ischaemic chest pain and then they have an angioplasty, I guess we're used to people dying after that. In patients (mental health) because they're so – everyone's so different and there's people who are so dynamic and varied. There are a certain number of people who we can't save with any ideal system. And I mean, it may well be that she was one of those ladies".[41]

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[36] Transcript 28/06/07 page 37
[37] Transcript 28/06/07 page 32
[38] Transcript 28/06/07 page 32
[39] Transcript 28/06/07 page 34, line 30-40
[40] Transcript 28/06/07 page 33, line 40
[41] Transcript 02/07/07 page 50, line 10 to 20

[70] Dr Towne gave evidence that he had attempted to have Patricia attend upon Dr Woolridge, a psychiatrist who had prepared a report in 2005, however, Patricia did not go despite special arrangements being put in place at the request of Dr Towne, which would see her being bulk billed. It is noted also that Patricia spoke to Mr McNamara on 7 February, prior to her discharge and in contemplation of her discharge she told Mr McNamara of her intention to make arrangements to have a consultation with Dr Woolridge and that she had already arranged to do so on a bulk billing basis.[42] Patricia did not attend upon Dr Woolridge despite these assertions and special arrangements.

[71] After hearing the oral evidence of the above named, Dr Kingswell acknowledged in his evidence that from time to time professional minds differ about treatment and diagnosis. Dr Kingswell stated that it was usually a matter of degree, rather than complete opposition:

> "And perhaps that is true here as well. I mean, we're talking about whether she was severely depressed or moderately depressed. I think there was general agreement that she was depressed."

[72] Dr Kingswell added:

> "I mean, they know what they saw and they know what assessments they did and they know what conclusions they reached. But, I don't know that because they didn't write it down very clearly and what is written down quite clearly are these repeated references to a very severe depressive illness characterized by sleep disturbance, weight loss, persistent suicidal ideation, anhedonia and on it goes."[43]

[73] I accept Dr Kingswell's evidence that some of the clinical documentation in Patricia's medical files was inadequate. Once Patricia's history, diagnosis and treatment were more fully revealed during oral evidence he moved away from his original position and was inclined to accept Dr Stephenson's general approach to Patricia's treatment.

[74] After considering all the evidence, both oral and documentary, I accept Patricia's mental health status was extremely complex and difficult to diagnose. The evidence tends to support a diagnosis of Major Depression coupled with a significant personality disorder. I find the evidence, as a whole, supports the working diagnosis of Dr Stephenson and the approach taken by her and the other clinicians as to how to treat Patricia.

Medication

[75] Dr Kingswell queried Dr Stephenson's prescription of Dothiepin, normally used for the management of schizophrenia or bipolar disorder, and Olanzapine. He was concerned that neither Dr Stephenson nor Dr Gynther obtained approval from the medical Superintendent as required.

[76] Doctor Gynther, (who holds a PHD in a mixture of neurophysiology and neuropharmacology from the John Clinton School of Medical Research at the Australian National University and who undertook three years subsequent postdoctoral research in the same field), gave evidence that he concurred with the anti-depressant

[42] Exhibits 23&28
[43] Transcript 04/07/07 page 15, line 20 to 30

medication prescribed by the treating team. Dr Gynther stated that he had worked with Dr Stephenson for some six years:

> "I highly value her clinical decision (making) and especially her use of medication. She uses that with great acumen".[44]

Dr Gynther spoke of the use of Olanzapine commenting on its effectiveness in immediately calming down the patient, decreasing arousal and increasing calming emotional responses.

[77] Dr Kingswell questioned the prescribing by Dr Stephenson, on 16 February 2006, of Sodium Valproate which is an anticonvulsant, efficacious in the management of acute mania. He stated there was no objective evidence supporting its use as an effective anti-depressant.

[78] Dr Gynther, during evidence, said sodium valproate was classically used for the treatment of bipolar disorder to help treat manic episodes and to help treat depressive episodes. Dr Gynther stated that it is also used prophylactically. In the field of personality disorder, it is one of the medications that is trialled in order to decrease impulsivity, and to decrease the propensity of people to have rapid mood swings.

[79] Dr Gynther noted that, in his experience, Dr Stephenson generally wasn't a great fan of Sodium Valproate. He said that Dr Stephenson preferred other medications so if she was using it, it would have been because other medications were ineffective and she was using something that would decrease risk. The records show that this medication was prescribed by Dr Stephenson in the week that Patricia had been discharged. Dr Stephenson said in evidence that the prescription was about:

> "erraticness and anger, the other of which seemed to precipitate the self harm.[45] I picked a sort of impulsive, erratic, angry aspect to her self-harm and to her reactions to as a treatment team and it was this impulsiveness and erraticness."[46]

[80] I accept the medications prescribed for Patricia's treatment were appropriate based on the evidence from Dr Gynther. There is no evidence that the prescribed medication contributed in any way to Patricia's death.

Discharge into the community versus Involuntary Treatment Order

[81] The decision to discharge Miss Van Putten on 12 February and the decision not to force a return to hospital by way of an Involuntary Treatment Order on 17 February must now be examined.

[82] S14 *Mental Health Act* sets out the treatment criteria for a person when considering the making of an Involuntary Treatment Order:

(1) the "treatment criteria" for a person, are all of the following-
  (a) the person has a mental illness;
  (b) the person's illness requires immediate treatment;
  (c) the proposed treatment is available at an authorised mental health service;
  (d) because of the person's illness-

[44] Transcript 04/07/07 page 41, line 50
[45] Transcript 04/07/07 page 41, line 50
[46] Transcript 04/07/08 page 42, line 1

(i) there is an imminent risk that the person may cause harm to himself or herself or someone else; or
(ii) the person is likely to suffer serious mental or physical deterioration;

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

(f) the person-
(i) lacks the capacity to consent to be treated for the illness; or
(ii) has unreasonably refused proposed treatment for illness

[83] Both Dr Gynther and Dr Stephenson explained to the Court the difficulty of such a decision and the balancing factors that are considered in each case. Dr Gynther noted that patients with personality disorders who are admitted involuntarily become angry at the treatment and demonstrate this by making further suicide attempts in hospital or when out on day leave. That is balanced against the fact that if the patient is in hospital and there is a longer time to observe, the staff can ensure that a patient is taking medication whilst hoping that whilst the patient is admitted, they improve. The alternative is to try and treat the patient intensively in the community. This is the option that was ultimately considered the most appropriate for Patricia. Dr Gynther said there was no clear right or wrong decision. The long term plan of having Patricia treated in the community permitted long term care which may have had a much better outcome in the long run. Dr Gynther said:

"I think there are risks of a tragic outcome with either procedure."[47]

[84] Dr Stephenson spoke of turning her mind to an involuntary admission for Patricia on the final admission to hospital, saying that the issue definitely came up for discussion. Dr Stephenson stated that she is a cautious user of the Mental Health Act noting that she thought:

> "first of all the spirit of the laws and the letter is that first of all you try and treat patients in the least restrictive way, and in fact, if your patient says I agree with your treatment plan and is willing to co-operate, you're on very thin ground for – very shaky ground for using it at all."[48]

[85] Dr Stephenson stated that she has appeared at the Mental Health Tribunal. She stated that if a patient cared to take it to the Mental Health Tribunal review process, *they'd very likely say look this patient would be better treated voluntarily.*[49] Dr Stephenson noted the effect of an Involuntary Treatment Order on a patient like Patricia and stated that the best control to have over such a patient was control within the mental health team's relationship with their patient, which one tries to make as positive as possible.[50] Dr Stephenson noted that the intensive treatment in the community included Mr Lowe-Brock who met with the staff both at the hospital prior to discharge and at home. All staff including Nurses McNamara, Walker, Fitzgerald and Dr Overland came away with a positive sense of Mr Lowe-Brock and felt that he had Patricia's best interests at heart and that he could be trusted to do the right thing.[51]

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[47] Transcript 02/07/07 page 45, line 55
[48] Transcript 04/07/07 page 36, line 30
[49] Transcript 04/07/08 page 36,line 30
[50] Transcript 04/07/07 page 36, line 45
[51] Transcript 04/07/07 page 38, line 10-15

[86] Patricia felt that the Cairns Mental Health Unit was a place of shame.[52] She detested the thought of being institutionalized.[53] This accords entirely with the records of Nurse McNamara who recalled that Patricia used the word "institutionalized" when explaining her fear of what her sister, Monique, had allegedly told her she would request.

[87] Patricia believed that her sister Monique was seeking to have her "institutionalized" and consequently withdrew her consent for the hospital staff to discuss her condition with Monique. Dr Stephenson considered that Patricia took Monique's concerns completely the wrong way in concluding that Monique wanted her locked up forever. Dr Stephenson considered that Patricia's perception of Monique's motives was entirely consistent with her histrionic nature.[54] Patricia's loathing of the mental health unit was referred to by her long time friend Dawn Rowan who said:

> "she didn't want to go back over to Mental Health. That was her biggest fear, to go across into the unit at Mental Health."[55]

[88] When Dr Overland visited Patricia on 13 February 2006 she determined Patricia did not meet the criteria for an Involuntary Treatment Order.

[89] As already acknowledged, the management of Patricia did indeed raise complex issues. I am satisfied on the evidence that the predominant reason behind Patricia's release into the community was the result of careful consideration by Dr Stephenson and the treatment team. They assessed the best outcome for Patricia to be treatment by way of a consensual therapeutic alliance with her. I accept they made an appropriate decision when balancing the many difficult factors in how best to achieve a positive outcome in Patricia's treatment.

Bed Block

[90] Dr Kingswell was concerned that a reason for Patricia remaining in the community rather than being admitted to the Mental Health Unit was that no beds were available within the unit as at 17 February 2006. Other inquests concerning mental health patients have also noted the worrying unavailability of bed space for urgent cases. Subsequent to earlier recommendations arising out of these inquests, Dr Janet Bayley has since implemented a workplace protocol to staff outlining the processes to follow when there are no Cairns Base Hospital Mental Health Unit Beds available for new admissions[56].

[91] Patricia refused to return to hospital on 17 February 2006. The evidence before the court in her case suggests that 'bed block' played little if any part in the decision not to admit her.

Further Issues raised by Dr Kingswell

[92] I accept Dr Kingswell's opinion that the Cairns District Mental Health Service should introduce a training package with competency assessment for all clinicians working in acute mental health services where they might have responsibility for initial

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[52] Transcript 28/06/07 page 34, line 10-20
[53] Transcript 28/06/07 page 27, line 1
[54] Transcript 04/07/07 page 37, line 20
[55] Transcript 26/6/07 page 64, line 40
[56] Exhibit 34

assessment. The package would need to cover history taking, mental state examination, provisional diagnosis, risk assessment and initial management planning. Dr Bayley agreed that more training should be available and should be mandatory.

[93] Dr Kingswell recommended that the Clinical Director of the Cairns Mental Health Service should introduce a system to monitor the prescribing of antipsychotic medications and ensure that there is compliance with the Queensland Health Standard Hospital Drug List. Dr Bayley has issued a guideline requiring psychiatrists to notify her and receive approval before using medications which are not listed in the Standard Drug List.[57] I am satisfied with the steps Dr Bayley has taken and do not intend to make any further recommendations on this issue.

[94] I accept Dr Kingswell's recommendation that the Clinical Director of the Cairns Mental Health Service should introduce a system to monitor the performance of psychiatrists working in the service, particularly their adherence to evidence based treatments.

Communication with Families

[95] Monique Van Putten and Dawn Rowan expressed their frustration, confusion, fear and anger at the obstacles met whilst communicating with the mental health staff concerning Patricia's history and treatment.[58] Dawn Rowan expressed the hope that families and close friends are able to pass on important collateral information about their loved ones which would be documented and taken into account by the treatment team.

[96] As outlined earlier, Dawn and Monique made a number of phone calls in an attempt to speak to a doctor about Patricia. They waited at the Cairns Base Hospital for a number of hours to speak to a doctor involved in Patricia's treatment. When they eventually spoke to the psychiatrist Dr Harper, she spent some considerable time with them, listening to and documenting their information and concerns which were recorded on Patricia's file and taken into account by the treatment team. Telephone conversations between staff and Monique were also adequately noted by Mr McNamara as to content and date in the hospital files.

[97] During evidence Dr Bayley also explained to Monique and Dawn that staff were bound by issues of confidentiality. (On 10 February Patricia withdrew her consent for the treatment team to discuss her progress or plans with Monique[59]).

[98] Monique and Dawn were relieved to hear that their concerns were, in fact, taken into account, however this is a reminder to medical staff of their duty to communicate with family members who may be invaluable sources of information.

[99] Dr Bayley accepted that mental health staff need to provide more psycho-social education and aid to families of patients. Steps were underway at the time of the inquest to run carer information courses for families. Dr Bayley agreed there was a need to educate staff state wide as to the importance of documenting comprehensive

[57] 24/7/07 transcript 60
[58] Transcript 26/06/07 pages 12;70
[59] Ex23

information from family. The documentation already in use has a section titled "Collateral History from Family"[60].

[100] Dr Bayley also accepts that staff should be educated and reminded about what patient confidentially really means. Dr Bayley noted confidentiality still allows staff to listen to families as opposed to disclosing information even if no consent exists.

Lack of communication between the Public and Private clinicians

[101] Although there was appropriate phone communication on occasions between Dr Towne and the mental health clinicians there was no written information passed onto him by the Mental Health Unit, for example, Patricia's discharge plan. Dr Towne in fact had received no written communications concerning Patricia's treatment at any time, yet Dr Towne, as Patricia's longstanding GP, was to be heavily involved in her community treatment.

[102] Dr Bayley advised the court that the Coroner's Action Plan[61] had introduced plans to better integrate private and public practice information sharing. She stated the present practice was to remind mental health staff they should contact a patient's general practitioner to obtain collateral information (subject to obtaining consent from the patient). Dr Bayley conceded there was a constant need to remind staff to do so. As a result of the Previtera Report a request has already been made for resources to strengthen communication with private agencies, for example "GP liaison positions" have been flagged as necessary to help with admissions, discharges and improving primary care.[62]

Access to public and private psychiatrists

[103] The general consensus of all mental health clinicians and Dr Towne during evidence was that the only long term solution to Patricia's health (apart from other treatment already in place) was long term intensive psychotherapy which is not readily available in the Cairns region. There is a serious lack of these professionals working in the Far North Area let alone those whose services are affordable to the average person.

Mr Lowe-Brock

[104] Mr Lowe-Brock and Patricia were in a relationship for approximately 18 months prior to her death. He was aware of her previous suicide attempts. He had spoken with Dr Towne, Mr McNamara, Ms Fitzgerald, Ms Walker and Dr Overland about Patricia's mental health problems. He described Patricia in the weeks leading up to her death as "on a mission"[63]

[105] Mr Lowe-Brock was with Patricia on both occasions when the carers visited Patricia on 17 February. He was aware of her threats to use "Roundup". Ms Walker and Ms Fitzgerald together with Mr Lowe-Brock and Patricia formulated the treatment plan for the weekend commencing 17 February 2006. The plan involved Mr Lowe-Brock staying at Patricia's home Friday night, all Saturday and Sunday and not leaving her by herself during that time. Ms Walker left contact numbers for the emergency department

[60] Transcript 02/07/07 page 80
[61] Exhibit 36
[62] Transcript 02/07/07 page 27
[63] Exhibit 10

with Patricia and Mr Lowe-Brock and told them to contact the hospital at any time because the hospital would then contact Ms Walker. Mr Lowe- Brock and Patricia both agreed to abide by the plan.[64] The plan was approved by Dr Bayley. Ms Walker also advised them she would visit at 10am on 18 February. On 17 February Ms Walker delivered a copy of the plan to the Emergency Department at the Mareeba Hospital for their information.

[106] Mr Lowe-Brock's evidence at the inquest was vague and contradictory. He gave no satisfactory explanation for leaving Patricia at home alone or for failing to contact the hospital to say he was going out. Where his evidence conflicts with Ms Walker and Ms Fitzgerald, I accept their evidence. I accept the carer's evidence that a different plan would have been formulated if they thought Mr Lowe-Brock was not to be present with Patricia at all times. I note that Mr Lowe-Brock had previous mental health problems which only came to light during the inquest. The concern is that Mr Lowe-Brock was not an appropriate person to supervise Patricia that weekend.

The Nursing Staff

[107] I accept the submissions of Counsel acting on behalf of the Nursing staff that none of them should be the subject of any criticism. All nurses acted in accordance with the directions of the doctors and the various management plans. Mr McNamara thoroughly documented all necessary occurrences in Patricia's medical file, participated in the formulation of the management plan and appropriately consulted with and acted in accordance with directions from Dr Stephenson and Dr Bayley.

[108] Ms Walker and Ms Fitzgerald also acted in accordance with all directions. They attended upon Patricia regularly, made every effort to establish a sound therapeutic relationship with Patricia, counselled her appropriately, assisted Patricia to cope with her situational stressors such as the need to move into alternative accommodation and communicated in a timely manner to superiors their concerns when crises arose throughout the week of 12-17 February.

[109] One concern as raised by Dr Kingswell was the practice (as seen in prior inquests) used to elicit from Patricia a promise she would 'guarantee her own safety'. This practice seems to permeate the whole mental health system. It is used by Doctors as well as nursing staff. I accept Dr Kingswell's opinion that it is of little or no benefit and needs to be reviewed.

[110] Concern is whether the carers and doctors caring for Patricia had sufficient information to determine that Mr Lowe-Brock was a reliable person to supervise Patricia on the weekend of her death. I accept that he certainly presented to all clinicians who spoke with him as reliable and genuinely concerned for Patricia's wellbeing.

Findings required by s45

[111] I am required to find, as far as possible, who the deceased was, when and where she died, what caused the death and how she came by her death. As a result of considering all of the material contained in the documentary exhibits and the evidence given by the witnesses I am able to make the following findings in relation to this matter.

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[64] Exhibit 3A

1. The identity of the deceased was Patricia Van Putten
2. Her date of birth was 17 April 1956
3. Her last known address was 9A Middlemiss Street, Mareeba, North Queensland
4. At the time of her death her occupation was retired school teacher, unemployed
5. The date of her death was 18 February 2006
6. The place of her death was Mareeba District Hospital
7. The formal cause of her death was respiratory failure sequential to ingestion of Glyphosate due to depression and personality disorder
8. The cause of death was not suspicious.

Concerns, Comments and Recommendations

[112] Section 46, in so far as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in the future. What follows is a summary of some of the progress that has thus far occurred and a number of recommendations.

Coroner's Action Plan and Other Improvements

[113] In March 2006 a Root Cause Analysis Team investigated the systems issues surrounding Patricia's death. They delivered recommendations to the Cairns Integrated Mental Health Service ("CIMHS"). An action plan was put in place to address each recommendation.[65]

[114] On 15 December 2006 Coroner Previtera delivered her findings into the cause and circumstances of the deaths of Baggott, Lusk, and Barlow. Coroner Previtera conducted a thorough review of the delivery of Mental Health services in Queensland and made over 50 recommendations for the implementation of mental health policy and service reform. I note Coroner Previtera's recommendations were released ten (10) months after Patricia's death and six (6) months prior to the current inquest.

[115] In early 2007 the Northern Area Health Service, the Clinical Support Unit Mental Health, the Alcohol, Tobacco and Other Drug Team and the CIMHS commenced analysing Coroner Previtera's report in order to evaluate existing Statewide and Local Practices and to develop an action plan to implement her recommendations. At the time of the present inquest Queensland Health had reviewed the findings and developed a response titled "Coroner's Action Plan." Some of Coroner Previtera's recommendations were in the process of being addressed.[66]

[65] 2/7/07 Transcript 86-96
[66] Exhibit 36

[116] Relevant improvements and/or changes that were occurring at the time of this inquest include the following (this list is, by no means exhaustive):

- The amalgamation of the Cairns, Innisfail and Tablelands Health Service Districts. This move has enhanced communication between clinicians and staff and promoted uniformity of decision making regarding care for mental health patients in the area;[67]
- uniform suite of documentation introduced as a pilot program to be used by all mental health services statewide; [68]
- introduction of the Northern Area Strategic Services Plan 2007-2012.[69]
- the appointment of a nurse educator and the introduction of training programs currently being developed in the local district in relation to mental state examinations, completing mental health documentation and risk assessments.[70]
- Identifying the need for increased resources to fund after hours work by Community Mental Health Services. [71]
- Introduction of the Workplace Protocol – "No Beds Available" (already referred to above).[72]
- Update of the Cairns Mental Health Service Staff Orientation package which includes guidelines for correct documentation procedures and information for all staff working within the Mental Health Service. [73]
- Introduction of the Queensland Health Clinical Governance Implementation Standard which sets out the mandatory auditable requirements regarding the roles and responsibilities for clinical governance; issued in April 2007 and reviewable annually. [74]

[117] I acknowledge that, since February 2006, many positive changes have been implemented within the Mental Health Service in Cairns and the surrounding areas. Dr Kingswell agrees progress has been made. Whilst acknowledging the current and continuing efforts to improve mental health services, there is still much to be achieved.

Recommendations

[118] In addition to the recommendations below, I also endorse those recommendations in Coroner Previtera's Report to which I have not specifically referred. Some of the following recommendations mirror a number of earlier recommendations by Coroner Previtera and other Coroners made prior to the current inquest and still requiring attention by Queensland Health. This reflects the need for proper dissemination and action by Queensland Health and the Government to address all recommendations.

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[67] Transcript 02/07/07 page 87
[68] Exhibit 35
[69] Exhibit 39
[70] Exhibit 37 CIMHS Training calendar
[71] Transcript 02/07/07 page 95
[72] Exhibit 34
[73] Exhibit 33
[74] Exhibit 38

Clinical Governance, Education and Improvement of Mental Health Services

1. Urgent funding for the Cairns Acute Care Team to expand of their clinical cover to 24 hours a day, 7 days a week.

2. An increase in the capacity of the rural mental health teams to facilitate best practice case management and follow-up care. This would be achieved by adding clinical positions to each of the Innisfail and Tablelands community Mental Health Teams. Such enhancement will enable after hours and weekend follow-up support when required.

3. Queensland Health continues to develop and implement a competency based training module on Clinical Documentation Standards to provide for competency based education modules to mental health and primary health staff in the CIMHS. The evidence of Mr Freele in the Harris Inquest was that this has already commenced with the appointment of two clinicians to educate staff. Clearly, these positions need to be extended. Further funding is required.

4. The CIMHS introduce a training package with competency based assessment for all clinicians working in acute mental health services where they might have responsibility for initial assessment. The package should cover history taking, mental state examination, provisional diagnosis, risk assessment and initial management planning.

5. Enhancement of CIMHS internal audit system to allow clinical audits to be regularly conducted in all CIMHS services including rural teams.

6. Queensland Health immediately cease the practice of requesting patients with mental health issues to guarantee their own safety.

Information Sharing

1. That the Director of Mental Health accelerate the implementation of a state-wide electronic network of patient information that allows treating health professionals, including both inpatient and community professionals, such as general practitioners, to rapidly access patient data throughout the State. Queensland Health must provide the necessary funding as a matter of priority.

2. Consideration is given to establishing a regular formal minuted meeting between the public and private sector medical staff that facilitates frank discussion of problems experienced from both perspectives and generates workable action plans to resolve identified difficulties.

3. The CIMHS receive funding to implement the “Partners in Mind” primary mental health care framework. This will improve referral pathways and collaborative management of mental health patients between the public and private system.

Families

1. State-wide development and implementation State-wide of a family focussed model of care that recognises the importance of the views and needs of families and carers of patients in the development of care plans. This should be underpinned by policy statements, clinical care guidelines and competency based training around the topic**.** This should include the provision of information to families concerning mental health illness.

2. Medium to high Risk Mental health patients should only be under the supervision of family members or friends when the Mental Health clinicians are satisfied that the family/lay carers have the capacity to provide appropriate supervision, are properly informed of the risks that they are assuming and have enough information to do their job such as when to call for assistance including when and who to call for assistance.

Confidentiality

1. Queensland Health continues to review the provisions of the *Health Services Act 1991 Qld* as they relate to the disclosure of confidential information and implement such changes to remove any doubt that the confidentiality of information relating to a person receiving a health service is balanced with the duty of care to that person, the rights of the public to protection against the risk of harm and the rights of carers and support networks to meet their responsibilities to the person and other members of the household.
2. Queensland Health to develop, implement and provide training in state-wide guidelines to all mental health workers defining the issues of confidentiality of mental health and the circumstances in which it is appropriate for mental health staff to share information regarding the person.
3. Removal of the requirement in s62I *Health Services Act* to have the authority of the chief executive in writing for a disclosure to be made of confidential information that is necessary to assist in averting a serious risk to the life, health or safety of a person, including a person to whom the confidential information relates; or public safety. (S62I the Act has been reviewed since 2006 and the powers of the Chief Executive are now delegable. In Cairns there are apparently delegations in place. It remains to be seen how effective this amendment will be.).

Community Mental Health Support

1. The Queensland Government to increase funding to a range of community-based services to assist both adults and children with mental health problems in the Cairns and the Integrated Mental Health Service Clinical Network. The Queensland Government ensure this includes both clinical and non-clinical services and support, both generic and mental health-specific services, in addition to nurses, allied health workers, psychiatrists, psychiatry registrars, indigenous mental health workers and life promotion officers.
2. Queensland Health invest in programs of intensive post-discharge support for patients in the Cairns District Health Service Area who have presented with suicide ideation or who have been assessed at risk of suicide or self harm.

Conclusion

[119] Before closing the Inquest I wish to extend my condolences on behalf of the Coroners Court to Patricia's family and friends. The court accepts that the period of time that has elapsed since Patricia's death has been particularly difficult for those close to her. I thank them for their patience and contributions during the inquest process.

[120] I also thank Sergeant Michelle Dodds, the investigating officer, counsel assisting, Dr Kingswell and the legal representatives appearing at the inquest for their assistance and cooperation.

[121] I close this inquest.

K McGinness
Coroner