OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Justin**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO:	2009/563
DELIVERED ON:	2 July 2013
DELIVERED AT:	Cairns
HEARING DATE(s):	27 June; 6 September; 18 & 19 September; 11 December 2012
FINDINGS OF:	Kevin Priestly, Coroner
CATCHWORDS:	Coroners: inquest, inpatient suicide, choking on bar of soap, clinical management of long term, acute and complex patients, environmental risk management.

REPRESENTATION:

Counsel Assisting:	Ms S Williams, i/b Office of the Northern Coroner
Family of Justin:	Ms K Williams, i/b Townsville Community Legal Service Inc
Townsville Health Service District:	Ms S Gallagher, i/b Cooper Grace Ward

Introduction

Throughout these findings the deceased will be identified as Justin. I granted an application on the part of Justin's family to prohibit the publication of Justin's family name or to identify any of his family. The primary reason was to protect family members, particularly a vulnerable younger member still attending school and involved in part time work from bullying or harassment that might flow from such publication. The absence of the family name does not adversely impact on my capacity to discharge my statutory responsibility to make findings about who, when, where, how and what caused Justin death.

Justin was 35 years of age and he was first diagnosed with a mental health condition in 2006. There was an acute deterioration in 2008 resulting in referral to the Townsville Mental Health Unit for Electroconvulsive Therapy. He had 13 treatments with minimal improvement. In December 2008 Justin had a 10 day admission to the Mental Health Unit. He was further admitted on 3 March 2009 after discharging a nail gun into his chest, penetrating the left ventricle. It was an attempted suicide. He was medically treated and then transferred to the Mental Health Unit to start what eventually became a two month admission. On 5 April he was released on leave and jumped out of a moving vehicle at 60kph. He was returned to Townsville Hospital, treated and returned to the Mental Health Unit. On 25 April 2009 Justin absconded from the Unit, returned home and retrieved his car. He then deliberately drove into a bridge, got out of the car, walked into the path of oncoming cars, sat on the bridge and threw himself off backwards. He fell only 2m into wet swamp grass. Again, he was returned to Townsville Hospital, treated and transferred to the Mental Health Unit.

On 3 May 2009 Justin was in the Psychiatric Intensive Care Unit (PICU). He was earlier seen resting on his bed. However, at about 10am, he was found unresponsive with a bar of soap in his mouth. Attempts to resuscitate Justin failed and he was pronounced deceased.

As noted earlier, I am required to make findings about who, when, where, what caused the death (medical cause of death) and how the person died. It is immediately apparent that most of the required findings can be made on the available information. However, Justin's mental health status was such that he required involuntary admission to the Mental Health Unit. Therefore, relevant to the issue of 'how' he died, is how the risk of suicide was managed during his admission. In pursuing this course, I am mindful that a Coroner is precluded from including in the findings any statement or comment that a person is or may be guilty of an offence or civilly liable for something (s.45(5) and s.46(3) of the Coroners Act 2003).

In addition to making the required findings, I am mindful that a Coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to public health or safety and ways to prevent deaths from happening in similar circumstances in the future.

I have approached these tasks by a more detailed consideration of:

- The immediate circumstances surrounding his death;
- The findings at autopsy;
- How the periodic observations of Justin were conducted;
- The results of an internal investigation into Justin's death;

- A review of his clinical management;
- The long term management of complex and challenging cases like Justin; and
- The management of physical hazards to patients at high risk within PICU.

Immediate Circumstance Surrounding Death

On 3 May 2009 Registered Nurse Cheryl Leigh started her shift in the PICU at 7am. The staff from the earlier shift briefed her on Justin, reporting he had a bad night and hadn't slept well. It was decided to let Justin rest until around 9.30am. He was on 15 minute periodic observations. Nurse Katherine White also commenced her shift at 7am in the PICU. She saw Justin briefly before 7am as she was arriving. She said hello. He did not acknowledge her and appeared to be returning to his room.

Nurse Tom Rogger was the final member on the shift in PICU starting at 7am. He did not recall seeing Justin on his arrival.

In her statement, RN Leigh stated she saw Justin lying on his bed from 7.15am onwards. He changed position several times. She conducted the observations looking through the window in his door. According to RN Leigh there was no need to go into his room or interact with him as he needed rest.

At 9.45am, RN Leigh said she saw Justin through the observation window. He was lying on top of his bed on his back, "Everything appeared to be OK". Nurses Rogger and White confirmed that RN Leigh attended to her observations of Justin.

RN Leigh had morning tea and returned to PICU at 10am. She got Justin's medication and a cup of water before going into his room. She knocked on the door before entering and walked towards his bed. She saw his eyes were closed and had a white object protruding from his mouth about 1cm from the front of his teeth. She yelled 'Justin' and got no response. RN Leigh ran out of the PICU and got help. Nurses Rogger and Viddler (the latter from the Open section) rushed to Justin's room. Justin was put into the recovery position and the Medical Emergency Team was called. Viddler and Leigh attempted to remove the protruding object but Justin's teeth had bitten onto it. The personal duress alarm was activated. Others arrived and assisted. The resuscitation trolley was retrieved. On call doctors on the ward arrived. CPR was started. Nurse Vidler managed to remove the obstructing soap with scissors. The Medical Emergency Team arrived within minutes and took over resuscitation efforts.

Dr Ponti was a member of the attending Medical Emergency Team and provided a statement to the court as well as attending the hearing to give evidence. He was a Principal House Officer from Intensive Care. He found Justin was blue, cold, pulseless and not breathing. He felt for a carotid pulse and auscultated his chest for breath sounds. A Gudel airway was in place providing access to his airway for ventilation. Oxygen was delivered by mean of a bag and mask. A 20 gauge needle was inserted for intravenous access. Chest compressions were continuing and managed alternately with adrenaline administration. Resuscitation efforts continued for 30 minutes with good ventilation, good chest compressions and administration of adrenalin; without any success.

In evidence, Dr Ponti described Justin's colour as dusky blue and his body temperature as cool from peripheral shutdown. He said the skin cools quickly following peripheral shutdown. Dr Ponti explained that the blueness from lack of oxygen may become apparent within 4-7 minutes of lack of oxygen. He also reported the possibility of a 2 degree drop in body temperature within 5 minutes.

The description of vital signs from Dr Ponti was consistent with a recent loss of circulation.

Dr Abdul Rahim had arrived shortly after Dr Ponti and supervised resuscitation efforts. Dr Rahim had a background in anaesthetics and was working in ICU. He reported Justin was blue when he arrived and confirmed the view that patients generally turn blue within 7 minutes of cessation of breathing, in some conditions – within 4 minutes. Further, temperature drops, say from 36 degrees to 34 degrees, when infused with anaesthesia can occur within five minutes or so. Again, a range of variables were discussed in evidence with Dr Rahim but no foundation was established for a differing view about how recent the loss of circulation and thus the choking event was.

Autopsy

On 7 May 2009 Professor Williams conducted an autopsy on Justin and confirmed that death was due to choking on soap in his airway. Professor Williams found small amounts of soap about the epiglottis and vocal cords. He was provided with the soap reportedly found in Justin's mouth and noted it formed a tight fit at the back of the throat in the area between the pharynx and epiglottis. It showed marks consistent with exposure to teeth. There were no other abnormalities found. Toxicology revealed varying levels of different hypnotics, anti-psychotics and pain medication consistent with his treatment regime and within normal therapeutic levels.

During his evidence, Professor Williams was asked questions about the process of choking to death. He reported that it can occur very quickly, a matter of seconds, or over a prolonged period, a matter of minutes. Sometimes the person's face will turn blue because they can't breath. However, he reported that sometimes you may not see any signs of choking. He gave the example of a 'café coronary' where a person dies as if they had a heart attack but in fact the person choked and collapsed. He said that although an accidental choking may be accompanied by reflex coughing, if it were deliberate, there may be no sign[1]. Professor Williams was informed that when Justin was found he was cold and blue. Numerous questions were asked with a view to ascertaining how long Justin might have been dead based on his appearance and temperature. To my mind, the answers to those questions raised more variables not in evidence. Further, Professor Williams, as a Pathologist, was probably not best qualified to respond to those questions. His experience with patients whom moments earlier suffer a loss of circulation or have suffered a loss of circulation and died, is very limited.

There were also attempts to explore the observations of hypostasis as the basis for estimating a time of death. Again, the questions raised more variables that were either not in evidence or unable to be ascertained reliably through evidence.

Manner of Conducting Periodic Observations

During the course of the evidence of nursing staff, the manner in which the observations were conducted of Justin and the usual method of conducting observations were explored.

RN Leigh told the court that she checked Justin by looking through the window in the door. Justin was 'under the blankets' whenever she checked that morning. Although she didn't have a view of his mouth, she recalled changes in the position of his body,

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[1] 4-16, 17

arms and legs between checks. She also recalled seeing his chest move. At the 9.45am check, he was laying on his bed with the blanket pulled over his body and up to his neck. Although RN Leigh was normally vigilant, she conceded in evidence that since this experience, she is more vigilant. She now always opens the door to the bedroom and listens until she can hear breathing. The rooms are relatively bare and it is relatively easy to hear someone breathing.

RN Brierley told the court her usual practice was to open the door as quietly as possible and enter the room but not to go so far as the bed. Using the hallway light at night, she looks to see if the patient is lying comfortably and breathing normally. If the patient was facing towards the door, she would also look to see if the eyes were closed. RN Brierley said one of the changes since this incident was to include additional information on the observation sheet, presumably as a check that a greater range of features were observed.

RN Brierley did the check at 6.30am and noted that Justin was asleep. She placed great emphasis on the need to hear breathing. RN Katherine White told the court she conducted observations by looking through the window in the door unless she had concerns, in which event she would enter and listen for breathing. RN Rogger said he made the checks from outside the door, watching for the rise and fall of the chest. If that was not detected, he would enter and listen for the sound of breathing.

Root Cause Analysis Report

A RCA Report was commissioned pursuant to s.38M of the Health Services Act 1991. The report followed an internal investigation by a multi-disciplinary team to establish what happened, why it happened and what can be done to prevent it happening again. The approach is comprehensive and systematic, focusing on processes and systems rather than individual performance. A copy of the resulting RCA report is in evidence.

The report identified the size of the soap as a contributing factor and recommended that the purchase of smaller bars of soap 10-15gm rather than 100-125gm. By this means, the prospect of an airway obstruction is reduced. Further, the report identified an opportunity to improve the manner of conducting observations by requiring the documentation of clinical wellbeing rather than merely the status of awake or asleep.

The RCA report also identified an issue with the Medical Emergency Team's access to the building that contains the Mental Health Unit. Although there was a slight delay in gaining access, it did not affect the outcome. However, for future purposes, steps were taken to ensure swipe card access to MET members.

The report identified as a contributor: "Medications were regularly changed and the diagnosis of psychosis was not confirmed within the clinical review team". This was thought important as 'complex cases within the Mental Health Unit require a team approach identifying critical components of a patients care with well defined pathways of management'. The report recommended that clinical review documentation be written in a framework reflective of hospital's Clinical Review Workplace Instruction, "Reviews encompass: assessment, treatment, discharge planning, acute developments, referral or intervention required, medication review, MHA status and requirements, special observations, community team contact". Essentially, the report mapped a process by which the Unit's compliance with this guideline is to be checked in the future.

The recommendations of the report were accepted and implemented at Townsville Hospital. I particularly note that more extensive information now required on the observation sheet as a prompt for a more comprehensive set of observations. It is evident from the evidence of some of the nursing staff, that implementation of those changes has translated to changed practices at the ward level.

Review of Clinical Management

Although a clinical narrative is attached, I will summarise the clinical management including diagnosis and treatment of Justin prior to his death before considering the evidence of the expert reviewers.

The focus of the review relates to the management of Justin during his last admission. He was initially admitted under the care of Dr Finlay, Consultant Psychiatrist, for one month before Dr Argyle, Consultant Psychiatrist, took over. However, it is important to note that most of the mental health practitioners before Dr Finlay diagnosed and treated Justin for a major depressive disorder.

Although Dr Finlay first had contact with Justin on 20 December 2008 as the on-call psychiatrist, he became involved in his continuing treatment on 11 March 2009. Dr Finlay assessed Justin and concluded his presentation was consistent with a psychotic illness. No management plan was decided at that point, planning to continue his assessment in following days.

After interviewing Justin and gathering collateral information, Dr Finlay concluded Justin was psychotic. Diazepam was increased and Justin was started on anti-psychotic medication (Risperidone). Dr Finlay interviewed Justin again on 16 March and was convinced of his psychosis.

On 19 March, Dr Finlay attended the Multidisciplinary Team Meeting and reported on his intended management of Justin including the diagnosis of psychosis. About this time, Venlafaxine was introduced and increased in dosage over the following days. Dr Finlay reviewed Justin again on 26 March and planned to change him over from oral to depot Risperidone under the First Episode Psychosis Protocol. He expected Justin would continue on anti-psychotic for at least 12 months, if not life long. Dr Finlay reported that he administered the first injection of Risperidone on 17 March, the second was due on 31 March with a third due two weeks afterwards. He reported the injectable preparation has no effect for 2-3 weeks, therefore patients are supplemented with oral Risperidone which is gradually phased out.

Dr Finlay's term at Townsville Mental Health Unit concluded at the end of March and Dr Argyle took over management of Justin on 30 March. Dr Finlay does not recall a verbal handover and assumes Dr Argyle took the usual course of reviewing the patient's notes and documents. However, Dr Argyle recalls discussing Justin with Dr Finlay before he left.

Dr Argyle assessed Justin and came to a different diagnosis, namely a Depressive Disorder with Anxiety against a background of drug dependency and personality traits of antisocial avoidance. The medication regime was changed with cessation of Risperidone injections, reduction in oral Risperidone, cessation of venlafaxine, and introduction of the anti-depressant Dothiepin with gradually increasing dosages.

Dr Lawrence was engaged to provide an independent report to the court, reviewing the clinical management of Justin. Prior to expressing any opinions, Dr Lawrence noted the following important qualifications:

- She has had the benefit of hindsight and an opportunity to review the longitudinal history over a considerable period;
- Her review lacked the benefit of personal involvement, the opportunity of direct observation and communication with the person involved and the relatives, and the benefit of a period of ongoing observation to observe change and other variations in presentation, behaviour and events, all of which inform clinical opinion, particularly diagnosis and management.

Dr Lawrence then reported the following opinions and comments:

- Justin was suffering a serious Psychotic Disorder rather than a Personality Disorder with Anxiety and Depression;
- His history supported a diagnosis of Psychosis with Affective elements;
- Differentiation between Schizophrenic spectrum and Bipolar spectrum (within Psychotic Disorder) was not of concern in terms of treatment and management, both require adequate doses of anti-psychotic and anti-depressant for an adequate period of time;
- However, differentiation between a Personality Disorder and Psychotic Disorder was important due to differing modes of treatment and management.

Dr Lawrence thought the change of medication that Dr Argyle initiated on taking over management of Justin was premature:

> However, on my reading, there was insufficient time taken to consider the issue of benefits versus side effects versus need for duration and adequate dosage of drug use to take effect in his management.
>
> In particular, the cessation of effective doses of Risperidone and antidepressant and the attempts to decrease his utilisation of drugs of dependence and incorporate psychological strategies as management interrupted the possibility of beneficial effects to a potentially effective regime for treatment of his Psychosis.

She concluded:

> What is, in my view, regrettable, is that more active and energetic attempts to treat his Psychotic condition with high or, at least, adequate doses of an antipsychotic agent combined with an antidepressant and, in the longer term, a mood stabiliser such as Lithium or an alternative, was not, at the same time, instituted as the confinement, close observations and restrictions on his movements were instituted.

Dr Argyle and Dr Reilly, Director of Townsville Acute Mental Health Unit at Townsville Hospital, responded in detail to the analysis of Dr Lawrence. They challenged the opinions of Dr Lawrence in their subsequent reports. Dr Reilly was familiar with Justin both as a clinician and reviewer. He also detailed the experience and diagnoses of what appeared to be every psychiatrist and clinician that had contact with Justin in recent years with a view to demonstrating that most diagnosed Justin as suffering a depression like disorder.

According to Dr Reilly, a very important consideration when taking over a patient like Justin who appeared not to respond to multiple trials of anti-depressant, anti-

psychotic medication and ECT; was to take stock and reconsider other factors which may be contributing to the disorder or its maintenance. Dr Reilly considered Dr Argyle " … did this very appropriately and liaised with the family about this".

On considering the detailed reports of all the clinicians and reviewers, it became apparent to me the task of resolving the conflicting opinions would be difficult and complex, if it could be done at all. There is a mix of expert reviewers and clinicians, some who had personal experience with Justin while others had to rely on patient records of assessments of others with varying degrees of completeness and accuracy.

I also questioned the need to resolve the conflict. There was no evidence to suggest that the diagnoses and treatment plans of Drs Finlay and Argyle were not open to a reasonably experienced and competent psychiatrist.

Indeed, Dr Lawrence concluded her Executive Summary:

> It should be clearly understood that Justin … presented a complex and difficult picture which, unfortunately, is not unknown in Public Mental Health Services. Differentiation between longstanding Personality Disorders with Substance Abuse problems and self harm propensity, at times, can be difficult to differentiate from presentations of Psychosis, particularly when they are combined with some evidence of Substance Abuse or Dependence. Clinicians from different orientations and experience may well differ legitimately in understanding of these cases and management plans may alter.

Having said that, she concluded:

> It is however, I believe unwise to take over a case of some complexity and duration and make rapid, far-reaching decisions about management without due consideration, explanation and regard for all the circumstances of history and progress of the illness.

Dr Lawrence later reported, addressing the same issue:

> My primary concern relates to the significant change in management approach, based on a significantly different diagnosis made following the change of Consultant, and the speed with which that decision appears to have been made and pursued.
>
> I cannot say with certainty that, had the original antipsychotic and antidepressant regime been pursued, it would undoubtedly have been effective. The concern arises from the fact that, once commenced, no opportunity was given for an adequate assessment of its efficacy.

However, the management of cases like Justin's raise particular challenges. Firstly, in the words of Dr Lawrence, there is a 'resource' context:

> … the current system of providing mental health care inevitably means that the bulk of serious, complex and difficult individuals with the most serious problems, including those of suicide risk, inevitably fall upon Public Mental Health services who are, themselves, usually limited in their resources. There is an inevitable pressure through the system to provide care as much as possible on a voluntary basis, and to limit time in hospital with early transfer to

Community resources, themselves under-resourced. This case undoubtedly reflects that situation.

The Townsville AMHS should be commended on the fact that Justin …, in fact, had a 2 month period of involuntary hospitalisation preceding his unfortunate demise. His earlier hospitalisation of about 10 days in December 2008 is more representative of the current approach. It could be conjectured that a longer period of hospitalisation to ensure that a treatment regime was firmly established with compliance and established follow up organised to ensure, as far as possible, ongoing compliance may have helped to avert the later developments. Our current system does not allow the luxury of time to achieve this standard. Access to longer term and safe facilities is also limited.

It was these comments and opinions that caused me to reflect on the case management methodologies applied to complex and challenging cases of this nature.

With this in mind, I posed the following question during the hearing:

How did the existing clinical structures and processes reduce the scope for differing diagnoses and treatment plans, particularly where there are significantly different outcomes for the risk of *self harm and whether there are opportunities for improvement.*

Dr Reilly responded with a comprehensive report addressing this question.

Firstly, he identified complexity in psychiatric assessment including different levels of involvement and multiple practitioner involvement at the intake stage, more than one internationally recognised disease classification system, and different training backgrounds to clinicians that may influence interpretation of the same symptoms.

Secondly, he identified varying degrees of documentation of assessments and reviews within intake processes while remaining substantially compliant with documentation standards.

Thirdly, Dr Reilly reported the absence of a ‘gold standard’ investigation which can act as check of diagnostic accuracy on clinical grounds.

Notwithstanding these limitations, Dr Reilly reported there were checks and balances against significant diagnostic error, including:

1. Formal training in diagnosis and calibration of diagnostic accuracy to ensure reliability and validity as during psychiatric training.
2 An expectation of clear written diagnosis and management plan being established or sanctioned by the psychiatrist.
3. Discussion with other members of the multi-disciplinary team within standard Clinical Review meetings.
4. Meetings between treating clinical team and consumer, family and other supports, at which diagnosis and management plans are outlined and feedback sought.
5. Formal discussion with a clinical supervisor.
6. Consideration of alternative options with psychiatrist peers either informally or in peer *review* meetings.
7. Seeking of formal second opinions for specific purposes. Such opinions are currently encouraged and *even* expected when ECT is being administered on

an involuntary basis, though *even* in this situation such second opinions are not legally required in Qld.
8. Diagnostic benchmarking: although technically possible this is not widely used.
9. High risk or complex case *review* panels, with formal criteria for referral, usually associated with identified high risk clinical situations.

Dr Reilly then discussed some of the strengths and weaknesses with each of these strategies as well as the extent to which they are or can be implemented.

As to the process for changing diagnoses on changing clinicians, Dr Reilly was not aware of any formal or structured guidelines for making those changes.

He reported:

> My general aim in efforts to improve systems where patients have had a change in psychiatric diagnoses would be to encourage and support psychiatrists and other clinicians in high standards of clinical care and documentation, enabling other clinicians to question diagnostic and management decisions of the psychiatrist while recognising the importance of doing so constructively.

Dr Reilly then reported:

> Consultant Psychiatrists changing diagnosis or specific management plans of other treating psychiatrists, particularly if the change is diagnostic and from a psychotic disorder to a non psychotic disorder, should be expected to take specific steps to: .
>
> - explicitly note their understanding of the rationale for the previous diagnosis or management and their own reasons for changing it;
> - consider with the patient / family / carers the option of seeking second (or more) diagnostic and/or management opinions; and
> - explicitly consider the change in diagnosis and/or management as a hypothesis or a trial, anticipating any potential harmful consequences if the change is incorrect, with the treating team, the patient and their family or other carers. . This should enable the development of strategies for appropriate management if this is the case. Routine management strategies such as a relapse prevention plan would support this process;
> - review this change in diagnosis or management plan in a formal Clinical Review meeting and document this.

Dr Reilly also discussed encouragement of second opinions, more formal use of peer review meetings for this purpose and creation of a Complex Case Review Panel process. He attached draft Terms of Reference for such a Panel to his report to the court. Dr Reilly envisages the treating team be empowered, during a Clinical Review, to refer a case to the Panel for review and feedback on diagnostic and management issue. The case would be presented by the Consulting Psychiatrist with both the Team Leader and Case Manager present. A structured diagnostic formulation with care plan incorporating a risk management plan would be before the Panel. Three senior clinicians including Clinical Director would constitute the Panel.

It was clear from the evidence of Dr Reilly that he is aware and pro-active in improving the support systems available to guide clinicians in the better management of long term complex and difficult patients. He is working within the constraints of a

public mental health service with limited resources available to further develop and implement his strategies. The resource limitations are a matter of public knowledge and record. The extent to which he has implemented these strategies is commendable and I would encourage further progress.

In relation to the management of Justin and the opinion of Dr Lawrence that the change of diagnosis and treatment plan was premature and should have awaited the benefit of any response from that initiated by Dr Finlay, I find her opinion does not establish a basis for concluding that the approach of Dr Argyle was inappropriate. Dr Lawrence's opinion was heavily qualified by the absence of personal involvement and the benefit of hindsight. On reviewing the lengthy and complex history of Justin, it is not surprising that Dr Argyle concluded that the approaches of former clinicians did not produce positive results and that he would pursue the course he considered appropriate. Clearly, there was an element of urgency about 'turning around' the deteriorating behaviour of Justin. Tragically, that was not achieved.

Environmental Risk Management – Inpatient Suicide - PICU

It will be recalled that the Root Cause Analysis report identified as a contributor the size of the soap and recommended the use of smaller bars to reduce the risk of airway obstruction.

However, the issue arises about how the Unit proactively manages the presence of potential hazards relevant to inpatient suicide.

In his report dated 7 December 2012, Dr Reilly addressed the issue of managing the risk of inpatient self harm and suicide in the following terms:

> Environmental risk needs to be managed but it must occur within a wider clinical context with a focus on the clinical management of the patient. To address environmental risk, ligature audits have been conducted in AMHU previously. An HDU ligature audit has been conducted again recently using the Worcestershire tool.
>
> Other environmental risk mitigating factors include the physical locked security of HDU, the use of lose observations when required and the reduced access to means in HDU.
>
> As previously noted, other actions initiated following the death of [Justin] have included the change-over to small soaps, ensuring that all doors in HDU had viewing panels and that the Medical Emergency Team (MET) responding to MET calls had swipe access and that an AMHU Medical Emergency Team (MET) responding to MET calls had swipe access and that an AMHU nurse is allocated to ensure additionally assist in MET access to the AMHU.

During the course of his evidence, Dr Reilly spoke about the fact that this incident was reported to the Chief Psychiatrists Office within Qld Health and that it was the normal practice for that office to disseminate any lessons to be learnt from incident to other like facilities. Further, staff of PICU's were vigilant about objects brought into the PICU that might be harmful to patients. However, he conceded there was not a systematic approach to the identification of hazards and assessment of risk associated with the hazards. There were no guidelines or lists to support periodic inspections of the Unit for hazards. On explanation of a systems approach to management of environmental hazards, Dr Reilly accepted that there was room for

improvement. He suggested any measures were best progressed through the Chief Psychiatrist Office which would provide for a larger catchment of occasional incidents that might be used to develop and refine best practices and disseminate lessons to be learnt.

It seems to me that there is an opportunity to proactively and systematically manage environmental factors that may contribute to inpatient suicide through the process of periodic inspections with checklists. This would enable staff to prospectively identify and eliminate environmental risks for inpatient suicide, heighten awareness of staff regarding environmental hazards and focus attention above and beyond routine matters. The checklists offer the advantage of having a cumulative effect, capturing and re-using the benefit of past incidents and findings of earlier inspections, particularly when conducted by different staff members bring a different perspective. Any hazards identified can be risk assessed and any corrective action recommended, or taken if urgent.

The limiting factor of personal experience is evident on the present facts. Although Dr Reilly, and presumably the RCA team, have no knowledge of a similar experience, once a proactive systematic approach is initiated, the development and implementation of checklists will involve research and the experiences of other like facilities globally can be tapped into.

Required Findings (s.45 Coroners Act 2003)

Who died: Justin

When he died: 3 May 2009

Where he died: The Townsville Hospital, Townsville

What caused his death: Choking due to impaction of soap in airway

How he died:

1. On 3 March 2009 Justin was admitted to the Acute Mental Health Unit at Townsville Hospital at the start of what evolved into an eventful, two month admission. His management was challenging, difficult and complex.
2. At about 7am on 3 May 2009 Justin was seen near the nurses station within the Psychiatric Intensive Care Unit. He returned to his room and lay on the bed with the blankets raised to neck level.
3. Period observations were made of Justin in his room up to and including 9.45am. On the check at 10am, he was seen to have an object protruding from his mouth, found to be a bar of soap. Justin was non-responsive and a medical emergency was initiated. The bar of soap was removed, resuscitation efforts started and a Medical Emergency Team attended. He was unable to be revived and was pronounced deceased.
4. The periodic observations of Justin in the hours preceding his death were reasonable and adequate in the context of the then standard practice. However, later investigation revealed an opportunity for improvement. More detailed observations are now

required and have been implemented with increased record keeping requirements about the features to be observed.

5. There were differences of opinion about the clinical diagnosis and treatment of Justin over the period of acute deterioration of his mental health during this admission. While there was a change in the diagnosis and treatment plan when Dr Argyle took over from Dr Finlay, I find that that decision was clinically open and management of the change was reasonable and appropriate.
6. I am satisfied that Dr Reilly, Director of the Acute Mental Health Unit, has in place and is continuing to improve the necessary structures, processes and strategies to reduce the prospect of diagnostic and treatment errors in management of long term, complex acute patients.

Comments/Recommendations

The Director of Mental Health in Qld Health (or Chief Psychiatrist) develop and implement an Environmental Risk Management System for the identification of hazards and assessment of associated risk for inpatient suicide and suicide attempts within Psychiatric Intensive Care Units. The starting point might be the development of checklists to guide staff conducting routine inspections to identify environmental hazards and to take appropriate corrective action. Periodic auditing of the outcome of inspections will facilitate the capture and dissemination of lessons to be learnt.

Coroner Kevin Priestly
Cairns
2 July 2013

Medical and Psychiatric Chronology

The chronology was adopted and edited from the summary prepared by Dr Lawrence. Although detailed, a conflict of expert opinion as to the diagnosis of Justin's condition was unable to be resolved and the chronology should be treated as indicative only of the complexity of his condition and its treatment.

1997	Emergency – presented claiming an electric shock from a welder – no evidence of any damage.
1998	Emergency – presented claiming he was assaulted but did not wait to be seen.
Jan 2001	Emergency – presented claiming he was assaulted 5 days earlier – no abnormality found.
Nov 2002	Emergency – presented with a fractured leg - reported that he was jumping on a trampoline, attempting to slam dunk basketballs and landed awkwardly on his right leg - underwent a closed reduction of a fractured right tibia fibula - uncomplicated post-operative recovery and remained an inpatient until 13 November 2002.
Mar 2005	Emergency – presented claiming another electric shock (earlier admissions with similar reports) whilst welding at work and continued to complain of chest pain thereafter and repeatedly sought reassurance about his cardiac status.
Nov 2005	Physiotherapy treatment obtained – reported a history of 10 years of neck pain, commencing when he was an apprentice and doing a lot of carrying and complained of intermittent problems ever since – reported working as a boilermaker/sheet metal worker – complained of constant headaches, strain, particularly around the eyes, described sleep disturbance throughout the night and complained of being aggravated by everything with the aggravation constant, eased by alcohol - difficulties appeared to be associated with poor posture and some muscular imbalance - appropriate exercises and education was planned but he did not attend follow up appointments - discharged in January 2006 because of failure to attend.
April 2006	Presented complaining of increased pain (non-specific)
May 2006	Presented complaining of a back and neck injury from work, treated by his GP and wanting ED to change information on the GP's medical certificate (declined).
Jul 2007	Presented complaining of further traumatic injury to his eye.
Sept 2007	Presentation for toothache - seemed he was seeking analgesia.
14 Oct 2007	Presented to the Emergency Department complaining of several months of chest pain and requesting ECG, as he was going out of town - said he had been very stressed over the past 2 days - history did not support a cardiac pain nor was it found to be associated with chest well palpation and was attributed, after full assessment, to a likely depressive/stress/anxiety component - was referred back to his GP with a letter from the treating doctor - admitted to his mood was low - had unfilled prescriptions for his antidepressant, Zoloft - denied any desire to harm himself or others.

Jul 2008	Presented to Dr Basil James, Psychiatrist - first seen on 18 July 2008 -diagnosed a severe Major Depressive Disorder present for many months, if not longer, and escalating – initially treated with the antidepressant, Avanza, said to be ineffective, and changed to Efexor 225mg daily - unable to work and had had to move in temporarily with his mother to be in her overall care - by the end of August 2008, Dr James noted that his Depression was so severe that he had recommended a course of ECT as an outpatient at Townsville Hospital, then being undertaken - Dr James wrote that he had reviewed Justin after his 4th ECT and was of the opinion that “there was a very slight improvement in his state and his mother agreed with that observation.” The patient himself did not think so and he did remain quite significantly depressed. Further ECT treatments were booked. Elsewhere, it is reported that he had undergone approximately 16 ECT with only mild and transient benefit.
Nov 2008	Dr Basil James, referred Justin, along with his GP, to a Musculoskeletal Practitioner, Dr R R D Watson, who reported that he presented “with the most salient feature of a very complex problem being crippling headache seeming to follow a session with a physiotherapy at JCU on 17 October. He was crying with pain and not able to be consoled. He has long standing neck pain problems, probably precipitated by his apprenticeship years ago in which he was repeatedly lifting heavy weights, often to a height. Dr Watson described his findings and thought that the basis of the recent problem was cervical mechanical dysfunction plus a secondary central Hypersensitivity Syndrome.” He recommended the use of the neuropathic pain agent, Lyrica, which appeared initially to provide great improvement within days and the Psychiatrist, Dr James is reported to have rung 2 days later to say that a miraculous recovery had occurred and that his mood had improved.
19 Dec 2008	Brought in by his mother to ED with the information that he was depressed and suicidal - no definite plan - on medication but said that they were not working - had a history of depression and he was said to be on Lyrica and Cymbalta - referred to the Psychiatric Registrar for assessment and review - placed on an Involuntary Treatment Order (ITO) on 20 December 2008 by Psychiatrist, Dr Russell Finlay – noted he had a past history of depression, was currently very anxious and thought disordered and had thoughts of killing himself - Treatment was available but Justin wanted to leave hospital due to his poor insight – Hence, involuntary detention -it was reported that “Justin … had been threatening suicide or self-harm and had initially accepted voluntary admission to stabilise his symptoms. He subsequently became anxious and agitated and was demanding immediate discharge. He presented as very disorganised and perplexed but denied he has no further plan (sic) to attempt suicide or self-harm. Client safety is compromised at this time and he requires ongoing assessment and treatment.” He was reported as having, “a history of mixed Depression and Anxiety and had threatened to strangle himself. He was unhappy about staying in hospital, denied that there was anything wrong with him and presented as disorganised, flat with restricted affect. His parents were concerned about the deterioration of his mental health, presenting with restlessness, anxiety, mood swings, decreased memory, stating, ‘I cannot relax. All I want to do is to die’.” On 29 December 2008 the ITO was revoked by R. Molineux – showing no aggressive behaviour towards others or any intent to harm himself - accepting of an appropriate treatment program – presumable discharge from hospital.

6 Feb 2009	Dr James reported for QSuper Income Protection purposes, that the depressive condition had fluctuated - whilst there had only been brief periods when he had not been depressed, the overall trend was towards a slow and gradual improvement - at that time, he was prescribed the antidepressant, Cymbalta, 30mg mane, the anti-anxiety agent, Diazepam, 5mg bd and night sedative Oxazepam, 60mg each night, together with the neuropathic pain agent, Lyrica, recommended by Dr Watson - Dr James discussed the plan to introduce a CBT element to his overall supportive psychotherapy and was initiating discussions about the possibility of rehabilitation - he was continuing to monitor Justin on a virtually weekly basis. About this time, Dr James applied for authority to use Dexamphetamine Sulphate in the treatment of Justin … - he diagnosed a longstanding Dysthymic Disorder or Double Depression with super added, treatment resistant Major Depressive Disorder and recorded the treatments to date: 12 ECT, 4 antidepressants, 2 neuroleptics and Lithium had not been of assistance - he explained his rationale for the treatment in these circumstances - authority to use was refused - treated by Dr James until at least the end of February.
3 Mar 2009	Justin shot himself in the left lower chest with a nail gun. He had also consumed approximately 8 Mersyndol over 3-4 hours. He called the Ambulance who found him and recorded the penetrating chest and cardiac injury. He was short of breath, complaining of pain in the left ribs. He gave the history of self-inflicting the injury and also stated that he just wanted to go to sleep. He was taken to the hospital and required surgery as his haemodynamics were deteriorating. Median Sternotomy exploration was performed and a 3 inch nail was found embedded in the "left ventricle lateral to the LAD near the apex." He was treated in Intensive Care thereafter.
5 March 2009	Nursing entry: "Justin had had some physical concerns during the day. He had been pleasant and cooperative throughout. His father and brother visited him at 11.30 and he became, then, quite aggressive and verbally abusive towards his family and the nursing staff. He punched his father in the shoulder, and threatening the nursing staff. His family consequently were asked to leave. Family were very understanding and quite upset by the whole episode. Patient was difficult to settle most of the afternoon. Frequently requesting to ring the Police for reasons not stated, speak to the doctors and to climb out of bed. At the time of the entry (18.20), he was resting quietly in bed with a very flat affect and had been crying. Paranoid behaviour at times stating that 'the nurses are going to kill me'."
6 Mar 2009	Admitted psychiatrically under Dr Russell Finlay. History including collateral information from family was collated. The Registrar noted that whilst Justin was cooperative in the ward and subjectively claimed to be okay in mood, he was objectively Dysphoric. He continued to maintain that it was not a suicide attempt but an accident and claimed that he wanted to be a carpenter and therefore had bought the nail gun to practice with it. He denied suicidal ideation but also said that there could be some staff members who would like to kill him. He refused to elaborate on that. Hallucinations were denied and he was fully orientated but seemed to have "partial judgement." Consultation with Dr James occurred. He recounted the deterioration in the past few months and expressed concern about his safety. He considered that Justin's act would have been with the deliberate intention of ending his life. Dr James recommended that Justin be treated under the public system with an ITO be used if necessary.
7 Mar 2009	Psychiatric assessment completed and it was concluded he was not suicidal and his

	assurance that he would not harm himself was accepted. It was accepted that he had the capacity to consent so he was to be discharged from the Request and Recommendation under the Mental Health Act. It was thought he had long term pathology and a combination of Seroquel and Lamictal might be worth a trial. No treatment instituted.
10 Mar 2009	Transferred from Medical to Mental Health Unit. Justin had been having episodes of being teary, agitated, complaining of pain and had been voicing suicidal ideation to the nursing staff as well as to the Psychiatry Registrar reviewing him. He was denying psychotic symptoms. There was no formal thought disorder noted, although it was said to be difficult to assess. He was preoccupied about being locked up. He was responding to prn Diazepam, voicing suicidal ideation and expressing concerns that he was not getting the right medication and complaining that the Psychiatrists were going to lock him up. Childish mannerisms were noted. His Dysphoric mood was noted. Whilst denying suicidal ideation and denying any psychotic symptoms, it was noted that it was difficult to assess his ideation because he was preoccupied about being locked up.
11 Mar 2009	Dr Finlay spoke to the mother on the phone and recorded a detailed history describing deterioration in Justin's mental state over 3-4 months, especially since about June 2008. Whilst he had always been a bit angry, this increased and he was complaining increasingly of pain, including mental pain. He tended to blame others for difficulties. Dr Finlay interviewed Justin and recorded that Justin demonstrated a degree of agitation, ambivalence, contradiction, demands, denial of suicidal intent by shooting himself with a nail gun, having his feelings hurt by a person at work and demands for x-rays and treatment for his neck pain and further demands for expensive investigations for his neck pain which had already been investigated. He also requested drugs and denied using street drugs. Justin was making some unusual statements such as, "I'm scared the scar will be torn open. I want the best treatment. I can kill you if I want to." Dr Finlay recorded his impression was that Justin is psychotic with intellectual disability. Antipsychotics, Risperidone, were prescribed. His Valium was increased substantially to 40mg per day plus prn and enquires about his physical condition were to be made. He was placed on an ITO. The nursing notes report that he seemed more settled after the interview but again his agitation began to escalate in the afternoon with anger, impatience and increasingly agitated behaviour, verbally and physically. His behaviour seemed to moderate over the **next few days** sufficiently for him to be transferred back to the Open Ward on 14 March 2009. His surgical condition appeared to be stable and the nursing notes appear to reflect the fact that he continued to be demanding at times, frequently seeking medication for pain and resisting reassurance that he had just had some.
16 Mar 2009	PHO, Dr Kinnane Campbell, records a lengthy interview with Justin, conducted by Dr Finlay, Psychiatrist. Justin initially continued to assert that the nail gun incident had been an accident caused by not reading the instructions but went on to report having a lot of stress in his life and explaining that he was feeling down and depressed and that is why he shot himself. He attributed this to being upset because he was not able to see his daughter and had a difficult relationship with his family. He reported concerns about co-patients, being afraid, sedated from painkillers. He claimed that his neck pain was relieved by being active. He complained of difficulties with concentration and concern about being "locked up" in the Unit. "When the Psychiatrist asked Justin to tell him what was going on inside his head, Justin stated that, "if he shot himself in the chest, he would start life again. He would be resurrected as Justin as God cares. Justin wanted to become a 7th Day Adventist. Justin does not go to church presently. Which God was given …… he resurrected you. The 7th Day Adventist's God." Justin reports that he was pretty sure he was going to be resurrected by the 7th Day Adventist God. Justin tells the Psychiatrist, "I will say what you want me to say." The Psychiatrist explained it was not what the Psychiatrist wanted to hear but his own words. Justin states that he is very confident that he was going to be resurrected and his troubles would be better. His friends, his money, and his situation with his daughter. "I would not try to harm myself because I have no energy. Okay, I'm going to forget about the church thing."

	The Psychiatrist explained to Justin that he was going to be placed on a depot every 2 weeks. Justin was told that he may be discharged in 2-3 weeks and his Valium would be reduced by 5mg every 2 days. Under the Mental State Examination, it was noted that he was superficially cooperative and he was anxious and had a mask-like face. He spoke in a monotone but with normal rate and rhythm. In mood and affect he was described as Dysthymic with significantly decreased facial expression, flattening of affect. He reported no suicide intent as he had no energy, though was still considered at risk of suicide. There was no evidence of responding to internal stimuli. However, under Thought, Form and Process, it was noted that thought disorder was present - ? thought block, occasional and delusional themes about his ability to be resurrected by God and that resurrection would solve all of his problems. His behaviour seemed to be less anxious and agitated for a time and he did complain of being very sedated. He was given his Risperidone Consta Depot without incident. He was sleeping better, indeed, perhaps was a bit over-sedated.
19 Mar 2009	Dr Campbell reported, presumably for Dr Finlay, the Pain Specialist should be consulted about the chronic neck pain. However, at present, he was content to continue treating the current episode as his first psychotic episode. He was to have no leave and the Risperidone Consta was to be repeated in 11 days. Dr Campbell reported on advice about past opinions and investigations of neck pain and recorded his mental state examination, described as childlike in behaviour, irritable, flattened affect, denying suicidal ideation. No evidence of responding to internal stimuli but his thoughts were of negative outlook with ongoing concern about being locked up forever. It was thought that his Psychotic Disorder was aggravating his mood state and Venlafaxine was to be introduced as his Benzodiazepines were decreased as from 20 March 2009.
23 Mar 2009	PHO recorded that he was now recanting his resurrection story and he complained of being overly sedated. He appeared flat in affect and low in mood and no evidence of perceptual disturbance or responding to internal stimuli. His Venlafaxine dose was to be increased and a further family meeting was to be arranged.
26 Mar 2009	Dr Finlay and the team reviewed Justin. Risperidone Consta was to be continued. The program of gradual reduction of benzodiazepines, including with the use of the long-acting Diazepam, was to be continued. There was no plan to increase his Lyrica for neuropathic pain. The diagnosis remained Schizophrenia, possibly Substance Seeking Behaviour, with a notation that he appeared to seek Panadeine Forte and it was possible that there were somatic delusions, i.e., psychotic in origin. His normal MRI of cervical spine was again noted. He maintained, at this time, that though he had shot himself, it was an accident and a mistake and changed the subject to his energy, which he said he lacked and tended to refer again to his pain. His request for sleeping tablets and complaints about other pains appeared to be reported but his requests were resisted and the plan was being maintained. By the end of the interview, Justin was admitting that he wanted to die when he shot himself. His low mood continued. He also said that people looked different to him. They looked at him in a funny way and thought that he was weird. He thought he was trapped in here and he had bad memory of his uncle who died in hospital with Bipolar Disorder. He said he did not want to join his uncle. He had tried to kill himself and he regretted it. He then started talking about a problem with his girlfriend. He also stated that his concerns were about his child, his daughter who was with her mother, and she was now a teenager. Overall, he appeared to be generally more settled in behaviour and presentation but continued with a rather low and flattened affect. This behaviour pattern appears to have continued, it could be summarised that he remained rather isolative in his room, appeared anxious at times but not agitated or with bizarre or disruptive behaviour as he had previously. There were no reports of the periods of agitation previously recorded. He appeared to be sleeping all through the night, though would sometimes complain that he was not. He complained of being stressed and continued to seek prn benzodiazepines from time to time but when the matter was broached, he appeared to continue to

	deny suicidal intent with his nail gun incident, whilst admitting it ultimately. His mood remained consistently low and his affect flattened. The improvement appeared to be continuing until on 30 March 2009.
30 Mar 2009	New treating Psychiatrist appointed: Dr Argyle as well as a new Psychiatric Registrar. At the interview, Justin … was complaining of blurred vision, stated that he wanted to get out of hospital, that he had been suffering dramas before coming to hospital due to arguments with parents and family and was frustrated about his medications for depression, which he said he had been suffering for quite a long time. He then complained that the current medication of Efexor had not helped him. He thought that he was only slightly depressed. He complained of being drowsy. He stated that he had had 'an event' - ? trying to harm himself. This was reported to the medical staff. Further discussions with the mother on 1 April 2009 (p. 742-3) reinforced both parents' concerns about Justin's ongoing stated suicidal intention, his ways of doing it, his fixation on his physical health, his seeking of medication, and his morbid thoughts with high level of anxiety. She wanted the medication to continue for a time before being willing to try him on any leave. Justin initially seemed to accept this. He continued, however, to deny suicidal intent to the medical team, complain about his treatment with Efexor and Risperidone and wanting his preferred form of benzodiazepine and his claims about not sleeping. Dr Argyle conducted a family interview at which Justin's mother expressed concern about his depression, his low motivation and expressed her view that he had been unwell for 2 years. His mother was unhappy about the prospect of Justin getting night time leave. The plan then was for him to have 2-4 hours of day leave with his family. His antidepressant, Venlafaxine, was to be stopped and changed to Dothiepin.
2 Apr 2009	There was a clinical review in which it was clearly stated, "He does not look like psychotic." There were no hallucinations or thought disorder. Entries indicate that Justin … was not compliant attending gym, joining groups and remained in his room most of the day in bed. "He continues to express statements of self-harm and other negative themes. … He presents as teary, distressed atopic and isolative. … Justin is demanding and crying for getting out of here." He was described as demanding, slow movement, crying, mood and affect low. He stated that he wanted to kill himself to get out of here. He was also frustrated because he could not convince his parents of that. He attended a one-on-one stress management session and cried throughout.
3 Apr 2009	Resident recorded of Justin, "He thinks he is different from other people and he is strange so he does not want to engage in conversations with other people." He continued to be demanding, trying to get out of here and the plan was persisted with. His parents remained unwilling to take him on leave. This pattern continued. One nursing report says that, "he continues to show signs of improvement objectively but subjectively, he continues to express negativity. Unwilling to consider alternate means of relaxation apart from medication." He continued to seek extra medication saying he felt agitated and restless.
4 Apr 2009	PHO Dr Campbell, was asked to see Justin because he was complaining of muscular discomfort and tightness in the strap muscles of the neck. He was examined carefully with no findings. It was specifically noted that there were no extrapyramidal symptoms, commenting that, in fact, his Risperidone had been decreased. The symptoms were considered secondary to tension and anxiety. His requests for Diazepam and complaints about anxiety, shakes and being unable to cope appear to be somewhat increased.
5 Apr 2009	Justin went out on leave with his mother. Later that afternoon Justin is admitted to the Emergency Department after having jumped out of a moving car at 60kph and sustained a head injury and multiple bruises on both arms and legs, brought in by the Ambulance. The QAS report stated that he wanted to die and that everything was wrong. His mother reported that he had climbed out of the motor vehicle travelling at approximately 60kph and landed head first on the road. He was sitting up when the ambulance arrived with his head

	being supported by his mother. He was extremely emotional, kept repeating that he wanted to die. The Police were also on the scene trying to console the patient. He was slightly more cooperative with the Ambulance. He still insisted that he wanted to die, however, he let the ambulance treat him. He complained of no neck pain and his GCS was 15. He was returned to the Mental Health Unit after being cleared medically, reported as suicide attempt to the ED staff, was demanding Diazepam but was calm, fairly settled and continued to seek medication in the ward.
6 Apr 2009	Psychiatric PHO checked Justin the following morning when he confirmed the intention to die when he jumped out of his mother's vehicle the previous night. His mental state remained Dysthymic, irritable, anxious and his behaviour petulant and childlike. He was noted to have mild psychomotor agitation. Again, it was said that there was no evidence he was responding to internal stimuli. His increased suicide risk was noted. The diagnosis remained Depressive Disorder and Dysthymic Disorder and he was on 15 minute observations because of suicide risk. At review by his Psychiatrist and other teams, he acknowledged his behaviour, stating that he "had had enough" but, by now, denying suicidal ideation. He disregarded advice to join groups and the gym and to do positive things and focussed on wanting his parents to get him out of hospital. His antidepressant, Dothiepin (?), was to be increased to 100mg the following day and leave was denied. This pattern continued.
8 Apr 2009	At an interview with his mother and sister, Justin appeared to have made some progress and had been a bit more active. The plan was to remain on the ITO in hospital, focus on his increasing activity. The antidepressants were to be increased and he was not ready for leave.
9 Apr 2009	At a clinical review it was considered that he tried to get help from his mother but became more pathetic. He was thought to have a dysfunctional relationship with his mother. It was thought that there had been some progress or improvement. His Dothiepin was to be increased further to 125mg and his regular Paracetamol was reduced. It was considered that they may use Quetiapine. It also was considered that he might have personality problems. The GP was said to be willing to be involved in his follow up at discharge, though he was not, at that stage, ready for day leave. This presentation continued.
10 Apr 2009	His Risperidone was changed to Quetiapine, a different antipsychotic but all in low dose. There is evidence that his mother was questioning staff about the possibility that his antidepressant was causing his agitation and tremor, which was now continuing and evident at meal times. This was not confirmed by the staff. The staff considered that he was displaying histrionic behaviours during his mother's visit, which ceased when the family left. His mother continued to express concern about allowing leave and was voicing a premonition that he would soon be dead and feels, if he is given any leave, he will immediately try to harm himself. Staff noted that he continued to express helpless, hopeless themes while seeking out staff on a regular basis.
13 Apr 2009	Meeting of staff with Justin and his father. The father was saying many positive and encouraging things about Justin. Justin was mildly histrionic but not as bad as when with his mother. He was, by now, denying any ideas of self-harm and reiterated a desire for discharge. His reported behaviour and complaints appear to have continued in much the same way. He did emerge from his room but was reported as being intrusive on the staff as well as demanding. At times, he appeared to be shaking and tremulous and the staff reports seem to indicate that there was a voluntary component to that. However, there was a persistent expression of feelings of helplessness and hopelessness, feeling his thoughts were chaotic and clogged up and asking for Paracetamol for his tension.
16 Apr 2009	Justin told the Clinical Nurse that his thoughts were "chaotic and clogged up." He told Dr Argyle that something happened in his head while he was watching TV the previous day. It was thought that he was improving. He once again denied thoughts of self-harm. The positive approach was continued to be encouraged. His Lyrica was to be decreased. He was allowed escorted leave with the staff. Justin himself requested ECT but was advised it was not the solution for him.

17 Apr 2009	The Occupational Therapist reports that he appeared to be more relaxed and attended a morning walk. His behaviour and participation was appropriate. He appeared to be more interactive and conversational than previously. By lunch time, however, he was reported as very low in mood, again - hopeless and gloomy – nothing was working. He was worried about the reduction of his Lyrica.
20 Apr 2009	A Mental Health Review Tribunal hearing was held reviewing his ITO. He did not spontaneously shower or shave that morning and continued to express themes of hopelessness and helplessness. He became distressed during the Tribunal Hearing to the point where he experienced a nose bleed. He eventually settled. He was placed on 15 minute observations because of his level of impulsivity and distress at times. Dr Argyle reported that he coped with the Tribunal initially but was predictably upset at the decision. The sister gave a longitudinal perception that Justin had always had trouble coping with minor events in his life and involving older family members to assist. She did not consider that he was ready for discharge. It was thought that he made more significant efforts to be positive following the Tribunal Hearing, participating more in activities with other groups and given positive reinforcement for his efforts. He also expressed concern about the decrease in his neuropathic pain tablets. The Management Plan towards discharge by displaying increasing positive behaviour was once again explained to him and to his father with the encouragement to be continued on discharge.
22 Apr 2009	A clinical review was conducted. This reported slow progress saying that he needed someone to take him out on day leave and the family were not happy to do so. Unescorted leave was then considered, although no decision apparently made. Again, efforts to help him use relaxation methods to deal with anxiety are recorded but with little evidence of acceptance. Again, there is evidence of his rejection of prescribed medication and requests for medication of his choice, including Phenergan at night. 15 minute observations ceased.
24 Apr 2009	After being pressured to shower and shave, he stated that he wanted to be discharged so he could kill himself. He was reluctant but eventually complied with some requests from staff. He appeared to have unrealistic expectations being conveyed to the staff. Dr Argyle reported that Justin reported himself as improving in his mood, which was then said to be 3 out of 10. He was denying suicidal ideas or intention and continued to complain of tremor. His Dothiepin was decreased further and the Phenergan was added to his Quetiapine. Activity was continued. He appeared to be sleeping well at this stage, though he did, from time to time, state the opposite.
25 Apr 2009	During the morning, Justin presented frequently to the staff seeking Diazepam and rejected all other coping strategies suggested. When the doctors arrived on the ward, he requested to see them because he felt he had been misdiagnosed and was hearing voices. The nursing staff spent time discussing his diagnosis with him. He had not been seen by the medical staff during the morning. Justin absconded from the Mental Health Unit and took a taxi to his mothers. She reported his absconding to the Unit. Justin then went to his sister's house nearby and took his car. According to the Ambulance report, drove his car along the Flinders Highway and crashed into a bridge at high speed - unclear if he had fallen asleep or crashed it on purpose. Afterwards, he was seen to walk around the road trying to be hit by a car on the road. He then sat on the edge of the bridge and when someone approached him, he leaned back and fell backwards approximately 2 metres into water or swamp-like grass. He got up out of the water and walked up to the side of the road. The patient was lying on a stretcher, conscious and alert but very quiet. There was extensive damage to the car. The windscreen had a large hole where his head hit the screen. No seatbelt was worn. He did not want to say what had happened and he was not wanting to talk about it. He complained of lower back pain. His GCS was 15 but he chose not to talk too much. Justin was taken to the Emergency Department and medically cleared before returning to the Mental Health Unit. On return to the Unit, Justin claimed that he had left because the place was 'making him more mad'. He tried himself to kill himself, as the medications were not helping

	him. He denied feeling suicidal at that stage. "I shouldn't have done that. I want to live." However, he wanted to have adjustment or change of his medications. He denied the use of alcohol or drugs. He was now complaining of pain over his back from the accident.
26 Apr 2009	Psychiatric Registrar-on-call reviewed Justin in the PICU. He was tearful, admitted that he was trying to kill himself. He was complaining of pains and aches. He was prescribed bed rest and anti-inflammatories and pain relief. He was regarded as an acute and chronic depression with considerable anxiety. It was a serious suicide attempt. He was on an ITO. There had been a poor response to medications. There was limited engagement with psychological strategies and there were no psychotic symptoms. The Registrar described him as having a Dysthymic mood with decreased reactivity of affect but no formal thought disorder. However, his content was very much focussed on himself – medications not working – wishing this hadn't happened – unwilling to consider other approaches and with limited insight and impaired judgment. He acknowledged that he had lied to his mother about being on leave when he had, in fact, absconded. He was advised that he would be detained in the hospital until his risks were reduced. The need for an antidepressant was continued. He himself was now requesting antipsychotic medication and admitted thoughts of harming himself and others. He also described other thoughts opposing self-harm. It was noted that Justin was questioning his diagnosis and that he seemed to be wanting the diagnosis to be a Psychotic Disorder. He is not able to accept any positive news or remarks. It was decided to continue Dothiepin at 75mg to see if his mood was lifting and, if not, to consider adjunctive therapy such as anticonvulsants. Dr Argyle had a phone call with his mother. The doctor discussed her concerns about medication issues and explained his own medication strategy. He also discussed with her psychological approaches. Justin's back fractures were under review with advice from the Orthopaedic and Neurosurgical Registrars. A brace was recommended and, until that time, bed rest was to be followed.
	His mental state continued to be described as Dysthymic with no formal thought disorder, complaints of seeking benzodiazepines and nobody caring for him. No evidence of perceptual disturbance. His behaviour continued to be non-compliant, i.e., getting out of bed when he was on bed rest, having various complaints, requesting opiates but with rapid resolution of these complaints when his requests were not met. His prn dose of Quetiapine had been increased to 100mg. On 29 April 2009 he was fitted with a brace which allowed greater mobility. Its use was explained to him. His behaviour continued, as before – angry, irritable, superficially cooperative, sad affect and mood – preoccupations with suicide or assistance to suicide. Life is terrible – negative thoughts. He claimed to have a split or multiple personality. The medication and management approach remained unchanged with Dothiepin 75mg, Quetiapine 100mg at night. His medication from the 28 April 2009 was Pregabalin (Lyrica) 75mg bd, Dothiepin 75mg nocte, Panadeine Forte x 2 - 6th hourly, which was ceased on 30 April, 2mg of Risperidone at night, 5mg of Diazepam at night, Paracetamol x 2, 6th hourly for pain, Coloxyl with senna for constipation. He also received Benztropine and Promathizine on 2 May 2009 as a one-off prn medication (presumably for side effects not clarified).
29 April 2009	Dr Argyle reviewed his medication strategy. This was to persist with the Dothiepin but it was suggested that no increase be done because it was thought that he did not tolerate higher doses. The decision was made to re-start low dose Risperidone as an 'adjunct medication', given this odd presentation and agitation. Reduction of the Benzodiazepines as possibly contributing to chronic depression. Reduce analgesics as back ?? in brace. Aim to reduce the frequency of discussions about medication as distraction from other approaches. If above unsuccessful, move to an adjunctive mood stabiliser. His condition remained unchanged. This review of his medication was discussed with him and recorded. During this discussion, it was recorded that Justin was questioning the Consultant about having euthanasia. At one stage, he is also recorded as saying that he was complaining of having several thoughts running through his mind at present. Justin is recorded as being concerned about being teased by his co-patients. He continued to claim that he has a brain ? Justin was

	informed of the plan for his treatment, informed that he has to put in some work to help himself, explained that he needed to be on fewer medications.
30 April 2009	A clinical review recorded that he was still seeking Quetiapine and had been given some the previous night. The plan was to simplify his medication and stop his benzodiazepines by the following week. He was now back on Risperidone 2mg daily. He was encouraged to do personal things for himself and encouraged to do activities but he needed an escort if he was to go into the open ward. It was commented that, "He may have avoidant / dependent personality." His behaviour continued, disturbed with drug seeking, depressed affect and mood, feelings of total hopelessness or helplessness and regression to childlike behaviour when he didn't get his way.
1 May 2009	He was reviewed with a lengthy interview recorded by Dr Campbell. He appears to have reviewed Justin's life with him, whilst providing some psychological education as well. He says his mood had improved to 4 out of 10 and that he was able to enjoy the visits of his family. However, he stated that he felt that the Mental Health system wanted to keep him there permanently. The advice was that he should stay in the PICU but could attend activities in the Open Unit. It was also noted that if the Acute Ward became filled on the weekend, he could be moved to the Open Unit. Justin told staff that his mood had been terrible, attributed to his meeting with Dr Argyle, and continued to attempt to discuss this with other staff. He was given escorted time on the Open Ward and participated briefly in some activities before returning to PICU and lying on his bed.
2 May 2009	On review, he was very unsettled, banging his head and demanding medication. He was banging his head against the open window. He was not able to be reasoned with. He was seen lying on his bed in the foetal position. There was said to be no psychotic symptoms and it was very difficult to explore his depression. He was secluded at 11.10 hours because of further head banging. He was observed at 15 minute intervals and, on becoming calmer, at 12.15 hours, seclusion was terminated. He was visited by his mother that day but remained miserable and tearful but was able to concentrate on a card game. His mother again requested treatment of hair lice which had proved a problem in the past. His affect appeared to improve a little as the day went on.
2 May 2009	At 22.00 hours, Justin requested and was given 100mg of Seroquel and appeared to sleep soundly until about 03.00 hours when he woke and requested more sedation, which was refused. He quickly became argumentative and accusatory at the staff. He appeared to sleep soundly for the remainder of his shift (recorded at 06.00 hours on 3 May 2009).
3 May 2009	The next entry is entered 10.30 hours by the PHO when he had been found with a bar of soap in his mouth, occluding his airway. He was blue and pulseless. CPR was conducted over a period of 35 to 40 minutes without benefit.