Combined Form 20 & 28
Version 1
QUEENSLAND
CORONERS ACT 2003
(Sections 45, 46, 51 and 97(2))

RECORD OF CORONERS FINDINGS AND COMMENTS AND NOTICE OF COMPLETION OF CORONIAL INVESTIGATION

I, K.O. TAYLOR
(print name of coroner)

☐ State Coroner

☐ Deputy State Coroner

X Coroner

at: MAROOCHYDORE (Court location) Telephone No. 07 5470 8113

have completed my investigation *and make the following findings/ findings and comments (Note: comments can only be made when an inquest is held).*

A ☐ **Findings - Suspected Death** (applicable only if a suspected death is being investigated - see section 45(1)

I find that the suspected death of **(Name)** **(DOB)**

(Residential Address)

☐ **did not happen**

☐ **did happen**

(Note: If the finding is that the suspected death **did not** happen then Part B does not have to be completed – see section 45(2) and (3). If the finding is that the suspected death did happen then Part B must be completed.)

B X **Findings - Death** (applicable where a death or suspected death has happened (see section 45(2) and (3) and whether or not an inquest is held)

I find about the death of:

Details about the deceased *(complete known details)*:					
Surname:	JEFFERY	First Names:	Helen	Sex:	Female
Last Residential Address: 50/15 TRIBUNE STREET, SOUTHBANK					
Date of Birth:	25/03/1966		Age of deceased:	38 years	

that:

1. This is how the person died: Please see attached findings

(print the circumstances of the death - section 45(2)(b))

2. This is when the person died: 24th March 2005

(print when the person died - section 45(2)(c))

3. This is where the person died: Ward GE, Nambour General Hospital, Hospital Road, Nambour QLD 4560

(print where the person died - section 45(2) (d) - this should include (where possible) whether or not the deceased person died in Queensland. This is important for the registration of the death in Queensland.)

4. This is what caused the person to die:

Please see attached findings

(print what caused the person to die - section 45(2) (e) - this will usually (but does not have to be) the medical cause of death as disclosed by the autopsy.)

5. ☐ An inquest was not held

X An Inquest was held on 1st June 2006 at Maroochydore Coroner's Court, Maroochydore

A. **Comments** *(applicable only if an inquest is held – section 46)*

I am of the view that:

☐ the death was not reasonably preventable

☐ there are no procedural or systemic reforms likely to reduce the occurrence of similar deaths

☐ the inquest has not raised any issues pertinent to public health or the administration of Justice.

or

☒ The following comments are designed to reduce the incidents of similar deaths

I make the following comments *(use attachments if necessary)*:

refer to attached findings

B.

Date of Notice and of findings and comments: 13th November 2006

Signature of person making the findings and comments: [signature] Place: Maroochydore

X **Copy of Combined Form 20 & 28 forwarded to the Registrar, Birth Deaths and Marriages pursuant to section 97.**

(Note: Notice to Registrar, Birth Deaths and Marriage not required where finding that suspected death did not happen - see section 97(2))

X **Copy of Combined Form 20 & 28 forwarded to the District Officer of Police for notification purposes**

Forwarding of findings and comments (general):

These findings and comments *(if applicable)* have been given to: *(tick appropriate boxes)*

X The following family member who has indicated that he / she will accept the document for the deceased person's family *(applicable whether or not an inquest is held - section 45(4) (a) and section 46(2) (a) of the Coroners Act 2003).*

X Spouse (including de facto spouse): David Payne

of: 608 Cooroy Mountain Road, Cooroy QLD 4563 telephone: 5447 7152

☐ Adult child because a spouse not reasonably available:

of: telephone:

X Parent: John Graham Jeffery

of: 3 Rydal Mews Leadgate, Consett County Durham DH8 6EJ England telephone:

Refer further to the attached findings.

Transfer out of PICU

It has been said by witnesses in these proceedings, and it is of course commonly said, that if a person is determined to commit suicide eventually they will succeed. As a reflection of reality such an expression may be unobjectionable. As a manifestation of an attitude to a duty of care it would not only be callous but demonstrative of that level of indifference that would bring any breach of duty squarely within the ambit of section 285. The evidence here discloses that all of Helen's carers, to varying degrees, recognized the risk of Helen again attempting suicide but I am satisfied that none can be said to have been indifferent to that risk. I am satisfied that each of the witnesses who used the expression did so only to explain either why the treatment plan adopted was appropriate despite the risk or by way of comment on the likely effectiveness of measures that might have been adopted in this case or may be adopted in future.

In considering whether or not Helen's carers can be held to account under s.285 for electing to run the risk by releasing Helen from PICU regard must be had to the provisions of s.9, *Mental Health Act 2000* which is in the following terms

> **9 Principles for exercising powers and performing functions**
> A power or function under this Act relating to a person who has a mental illness must be exercised or performed so that –
> (a) the person's liberty and rights are adversely affected only if there is no less restrictive way to protect the person's health and safety or to protect others: and
> (b) any adverse effect on the person's liberty and rights is the minimum necessary in the circumstances.

Tragically, it is now known that Helen's health and safety could not have been protected by any means less restrictive than detaining her in the PICU. However, the circumstances against which the conduct of Helen's carers is to be considered under s.9, *Mental Health Act* and under s.285 *Criminal Code* are the circumstances known to or which ought reasonably to have been known by the person whose conduct is under consideration.

The evidence discloses that all carers had either made their own assessments or were quite reasonably relying on the assessments of other health professionals which assessments were made carefully and conscientiously. Dr. Miles was able to explain quite comprehensively and convincingly why he recommended that Helen be transferred out of the PICU and to the more pleasant environment of Ward GE. He explained his view that the aggressive and agitated patients in Ward LGE would have been disturbing to Helen and detrimental to her recovery; that contact between Helen and her daughter was important to her recovery and better facilitated by Ward GE; and most importantly, that Helen was displaying genuine insight into her delusional beliefs and did not hold any suicidal intent at that time. Dr Waugh's opinion on point supports the validity of those considerations and added further weight in his observation that, typically, facilitating contact between a mother and her daughter diminishes the risk of suicide. I am satisfied that in respect of no assessment by Helen's carers can it be said that matters were ignored that should not have been ignored, that undue consideration was given to matters irrelevant to Helen's health, or that there was a failure to consider appropriately all relevant matters. For present purposes the conduct of carers cannot be judged with the benefit of hindsight. The evidence discloses that orthodox professional judgment was brought to the decision to "run the risk" in furtherance of Helens recovery and it cannot be said that any of Helen's carers have made decisions in reckless disregard of the danger.

Attempted hanging in Nambour Hospital

Does a failure to prevent an attempt at suicide fall within the ambit of section 285?

It seems somewhat tautologous to say that life itself is necessary to life. In the case of a patient known to be suicidal, to fail to take all reasonable steps to prevent the patient taking her own life is to facilitate her death.

I have carefully considered the evidence but am unable to reach any factual conclusion on point other than that such an attempt is possible but unlikely.

Helen was found *post-mortem* to have scars on her neck. Although minor they are consistent with abrasions caused by a rope. Helen told David Payne and Graham Jeffrey that she had attempted to hang herself. She told Graham Jeffrey that the attempt was in hospital. Although Helen was suffering delusions she appears to have been capable of a reliable historical account of relevant issues outside the scope of her delusions. Injuries to Helen's neck were noticed by some witnesses but not others who had similar opportunity to observe. Both curious and disappointing is the fact that the injuries were not recorded at autopsy. They are quite obvious in *post-mortem* photos. There is no doubt Helen suffered those injuries some days prior to her death. They in no way contributed to her death. Although they are consistent with rope abrasions they are also consistent with the injuries she might have received when resisting Mr. Payne's rescue attempt in the pool. Clare Marie Catchlove (whose statement is Exhibit no.7B) saw red marks on Helen's neck on 29 March, 2005 when she visited Helen in the PICU. Helen told Ms. Catchlove that she received the injuries when she tried to drown herself. Other than the injuries to her neck the only evidence that Helen's had attempted suicide by hanging at the hospital is her statement to her father on the telephone.

The age of the injuries at death and the observations of those witnesses who saw the injuries establish that if they were received in Nambour Hospital it must have been prior to her transfer out of PICU. There is no hospital-record note of any such attempt and no evidence of any witness who saw such an attempt. Except for a short period on admission, prior to her transfer to Ward GE, Helen had spent all her time in PICU. It would only be through gross negligence or total systemic failure that any attempt at suicide by a patient in PICU would go either unnoticed or unrecorded. An unnoticed attempted suicide by hanging at the time of admission is possible, appears unlikely but is the only explanation for Helen's remark to her father if that remark was based on fact.

Being unable to reach any relevant factual conclusion I can offer no further comment.

Regularity of Observations

Helen was assessed as a suicide risk. It is likely that an attempt at suicide by the means successfully adopted on 24 March 2005 would have been unsuccessful had she remained in PICU even if she had a plastic bag to facilitate such an attempt. That is because in PICU Helen was closely observed by nursing staff. In Ward GE she was not. The medical staff involved in Helen's treatment maintained a direction that she be observed by nursing staff at intervals not exceeding 15 minutes. It is clear from the evidence of Dr. Ong that to effect death by the means chosen by Helen less than or little more than a minute would be required. At the time of death the intervals between observations was 30 minutes. The regularity of observations will be addressed in a different context later. For present purposes the difference in regularity between those intervals prescribed and those in practice at the time of death represent no more than a difference in degree. A 15-minute interval would still provide ample opportunity for suicide

As to the appropriateness or otherwise of the prescription of 15-minute observations by medical staff, I do not think I can usefully add any more to my observations and comments when considering the decision to transfer Helen from PICU.

As to whether Helen was, on the morning of her death, being observed by nursing staff as frequently as every 30 minutes, it must be noted that this Court is forced to rely on the recollections of nursing staff. More will be said of the absence of a system of documentary confirmation later. I am not satisfied that the *ad hoc* approach to night observations practiced by staff in Ward GE at the time allows absolute confidence in the assumptions of the witnesses Huth, Grant or O'Brien that Helen was observed at least every 30 minutes but I accept that each genuinely believe that to have been so and I have no reason to reject their evidence. I am satisfied that, although there were systemic deficiencies which I shall later address, none of those witnesses were indifferent to the risk of Helen's suicide.

Plastic bag

The plastic bag used by Helen to take her life was given to her by staff at Nambour Hospital. It was given to her for the purposes of transporting her clothes from PICU to Ward GE. Upon admission to Ward GE she was allowed to keep the bag in the room in which she was accommodated.

It was with a considerable degree of incredulity that I received the evidence of witnesses ranging from psychiatrists to nursing staff that with the exception of Killick, who was not on staff at the time of Helen's death, none identified a plastic bag as a method of suicide prior to Helen's death. Were it not for the evidence of Dr. Waugh that, before Helen's death he also did not associate a plastic bag with an increased suicide risk I am likely to have harboured considerable suspicion about the uniform assertions of ignorance by Helen's carers. Dr. Waugh has been called as the Court's own expert witness, is independent of the Nambour Hospital, and had no involvement in the circumstances of Helen's death other than *post mortem* investigations and report. Dr. Waugh is also a highly-credentialed and very experienced psychiatrist. I accept that Dr. Waugh lacked awareness on point and, although his evidence does nothing to lessen my surprise, I have no reason to expect Helen's carers to by anymore enlightened on point than a psychiatrist of Dr. Waugh's experience. Coroners have a far greater opportunity for knowledge of the means of suicide than do most in the community. However the evidence of Dr Ong is that death by such means is not uncommon. (I will note that the estimate offered by Dr Ong for South East Queensland appears to be understated. Most autopsies outside the Brisbane Metropolitan Area are not conducted at the John Tonge Centre and the incidence of plastic bag asphyxia appears to be even greater than that implied by Dr. Ong's estimate of approximately 1%) There is also evidence that for some years a certain internet web site has directed those interested to plastic bags as a convenient suicide tool. Perhaps it is the case that it is a brutally effective tool and those who resort to it are likely to succeed and thus the circumstances of their demise become known to those caught up in their death but not to health-care professionals who would otherwise have become involved. Health-care professionals would have no excuse for not learning from the experience of failed suicides but cannot be expected to have that knowledge which is gained from experience of successful suicides.

In addressing this issue I reject as irrelevant the suggestion that Helen would have been able to access plastic bags from elsewhere in Ward GE if she did not have the one she used. The bag Helen used was given to her by staff of the Hospital and was known to be in her possession throughout her stay in the Ward.

Are there grounds for a "reasonable suspicion" that any of Helen's carers demonstrated a reckless disregard of the danger presented by the plastic bag or an indifference to an obvious risk?

I have deliberated searchingly on point but amunable to find that there are grounds for such a reasonable suspicion. I am unable to find that Helen's carers either knew or had the information available to them that might have reasonably required them to know that a plastic bag increased the risk of successful suicide. In my view Helen's family and the community are entitled to be disappointed that staff knowledge on point was so deficient – and I will have more to say on that later – but I am unable to conclude that any of Helen's carers either knew or ought to have known of the increased risk and so cannot be said to have been indifferent to it.

INDICTABLE OFFENCES: ss.288, 289 *Criminal Code*

s.288.

Section 288 requires a person who undertakes medical treatment to "have reasonable skill and to use reasonable care in doing such act", and provides that "the person is held to have caused any consequences which result to the life or health of any person by reason of any omission to observe or perform that duty."

That duty falls to be considered in respect of both the decision of Dr. Miles to transfer Helen out of PICU and the conduct of nursing staff in respect of observations of Helen and in the supply of a plastic bag.

Section 288 requires each of Helen's carers to "have reasonable skill." As regards medical treatment, what may or may not be reasonable skill is largely determined by those regulatory authorities that certify the competency of medical and nursing staff. Here each of Helen's carers was certified to a level of skill commensurate with the role they played in her care: in some cases, to a level of skill considerable in excess of the minimum essential to their position. Furthermore, without exception, they each brought to their ministrations a significant practical experience, in some cases great experience.

I am satisfied that they each had "reasonable skill".

Did they all use reasonable care?

Dr. Miles explained why he recommended that Helen be transferred not only out of PICU but to Ward GE. He explained the basis for his opinion that the risk of suicide had diminished sufficiently to render the constant observation of PICU unnecessary and that the ward environment of Ward LGE was detrimental to Helen's recovery. I have summarised his explanation earlier. I am satisfied that Dr. Miles brought careful and conscientious professional deliberation to the formulation of that opinion and that it was an opinion supported by the facts then available to Dr. Miles, uninfluenced by irrelevant facts, and one formed without disregard of any relevant fact. It was an opinion which reconciled with that expressed by Dr. Muir a day earlier and with that formed independently by experienced nursing staff. Subsequent events tragically proved the assessment on which that opinion was based to have been wrong but I am nevertheless satisfied that it was an assessment and opinion which accorded with the exercise of orthodox professional judgment. I am satisfied that Dr. Miles exercised reasonable care in reaching that decision.

Helen's medical treatment included her recuperation in Ward GE. She was there not only to convalesce but also for continuing assessment and management of her illness. The medical treatment team included the staff of Ward GE. I am satisfied that it cannot be said that the staff failed to exercise reasonable care in the regularity of observations of Helen. (For the sake of completeness it should be noted that, even if it were otherwise, in the absence of constant observation, it could not be said that the length of interval between observations was causative of death). The staff was following a practice adopted at the Hospital and cannot bear any personal responsibility for any shortcomings in Hospital policy. As to the provision of the plastic bag I do not think I can take the matter any further than I have already. To know of the increased risk presented by a plastic bag and yet to give it to Helen could not be said to be consistent with the exercise of reasonable care. But as I have already said I cannot find there was such knowledge and although it is an objective standard by which the discharge of a persons duty under section 288 is to be judged is can only be applied in the context of the facts peculiar to each particular case one of those facts being the contemporaneous knowledge of the person whose conduct is under consideration.

s.289.

Section 289 casts a duty on every person who has charge or control of anything that "in the absence of care or precaution in its use or management, the life, safety, or health, of any person may be endangered, to use reasonable care and take reasonable precautions to avoid such danger..."

That duty falls to be also considered in respect of the supply of the plastic bag. I am satisfied on the authority of *R v. Dabelstein* (1966) Qd R 411 that the plastic bag was a dangerous thing for the purposes of section 289. As to whether or not the nursing staff failed in the duty cast upon each by section 289, for the reasons given when considering section 288, I am unable to find any grounds for "reasonable suspicion."

For the reasons given I am satisfied that there are no grounds for a reasonable suspicion that any person has committed an indictable offence.

ANY OTHER OFFENCE

Treatment Plan

In addressing paragraph 48(2)(b) *Coroners Act* I do so on the premise that when the Legislature uses the word "must", as it does in the provisions of section 110, *Mental Health Act*, it intends compliance by those to whom the requirement is directed.

I have opened with that comment because I do not intend to address Part 8, Chapter 14, *Mental Health Act* the provisions of which qualify statutory obligations stated in absolute terms. Nor do I intend addressing the scope of s.518 of that Act other than to note that an essential element of an offence created by that section is "ill-treatment" which is said to include wilful neglect. Wilful neglect or conduct analogous thereto would appear to encompass the same considerations as those already addressed when considering s.285, *Criminal Code.*

Section 110, *Mental Health Act* directs that "The authorised doctor must ensure a treatment plan for the patient." Part 2, Chapter 4 of the Act sets out what such a plan must include.

Included in Helen's Patient-Record (Exhibit 40) is a form headed:

> Treatment plan- Sunshine Coast and Gympie Districts
> *Mental Health Act 2000 Queensland*
> *Section 124*

Notwithstanding a personal plea by some unidentified person – evidenced by a large yellow tag attached to the top front of the form to "PLEASE COMPLETE" – no entry whatsoever has been added to the printed form.

This omission was the cause of consternation to several of the nursing staff who believe that the Act requires that form to be completed. That belief is understandable. The creation of a special-purpose form so headed invites a belief that the Act requires that form to be completed. The psychiatrists who have given evidence in these proceedings, including Dr. Waugh have expressed the opinion that a discrete plan is too inflexible and cannot accommodate the changing therapeutic needs of a patient. Their view is that only a record such as that contained in the "PROGRESS NOTES" and associated notes in Helen's patient-record provides both a historic record and a useful record of the future treatment proposed for the management of a patient's condition. Their view has great merit. What does the Act require?

Notwithstanding the therapeutic inefficiencies of a discrete plan, having regard to the primary purpose of such a plan and to several statutory provisions, I am inclined to the view that the Legislature had in mind a discretely documented plan when settling upon the statutory provisions.

In my view, the primary purpose of the "treatment plan" required by section 110 is to justify the continuing deprivation of liberty of the person admitted for treatment. The Act establishes a statutory regime to ensure that a person's detention is justified by reason of circumstances leading up to admission of the patient. The treatment plan is designed to ensure that the patient's continuing detention is justified both by the need for treatment and for the purposes of treatment. In my view, although the "treatment plan" required by section 110 is required to be prepared by an authorised doctor, it was not the intention of the Legislature that it be prepared primarily for the information of medical and nursing staff. Its primary purpose is to inform the patient, the patient's representative ("allied person", ch.9), hospital administrators and others charged with a responsibility to supervise the

administration of the Act ("approved officer", ch.13). When due regard is had to that purpose the need for a concise discrete document becomes clear. The alternative - a 'plan' contained within the patient's records - would require the patient and ~~those~~ others entitled to such information to trawl through the patient's record and deduce what they can with whatever level of comprehension they bring to the task.

In reaching this view I am conscious of the risk of inconsistencies developing between a discrete 'plan' which is prepared upon admission on the one hand and, on the other, the variety of records, including progress notes, necessary to ensure the relevancy of treatment to rapidly changing patient-needs. It may well be that there is a potential for serious consequences where the discrete plan conflicts with the progress notes and the discrete plan is used in a treatment decision without reference to the progress notes. I shall return later to that risk and to the view expressed by medical practitioners as to the usefulness of a discrete plan.

Section 110 refers to the preparation of a treatment plan. It does not just direct that an authorised doctor have a plan, but that that doctor must prepare a plan. Clearly some written record is required. Section 115 casts a duty upon an administrator to ensure a patient is treated in accordance with the plan. Section 124 directs what a treatment plan must state. Sections 125-127 refer to changes to the plan. In my view these statutory provisions imply that there must be a discrete document that is a "treatment plan" not a collection of notes that provide the equivalent information.

I am here considering, for the purposes of section 48, *Coroners Act*, whether or not the failure to complete a discrete document matching the description of a "treatment plan" constitutes an offence. Notwithstanding the view I have just expressed as to the apparent intention of the Legislature, I am not able to conclude that the Act creates that degree of certainty required to meet the demands of the criminal law. It is the case here that there was a treatment plan prepared for Helen that addressed those matters required by s.124, *Mental Health Act* and that plan was recorded. In the absence of any clearer statutory expression than that contained in s.110 I do not think prosecution for an offence is available particularly so given that wilful neglect is an element of an offence. (For the sake of completeness it might also be noted that, even if prosecution would otherwise be justified, the time limited for prosecution has expired.) Finally, on point, I should emphasise that the conduct of medical staff in Helen's case was at all times *bona fide* and the failure to complete a discrete treatment plan was in no any way detrimental to Helen's treatment. I am satisfied there was no wilful neglect.

CORONERS COMMENTS: ***s.46, Coroners Act***

Section 46 invites a coroner to comment on anything connected with a death that relates to –

(a) public health of safety; or

(b) the administration of justice; or

(c) ways to prevent deaths from happening in similar circumstances in the future.

Although couched in discretionary terms it is of course an invitation that a coroner must take up in proper exercise of the jurisdiction where circumstances require a comment.

Treatment Plan

The evidence discloses that at least many medical practitioners do not consider a discrete treatment plan to be of any use in the continuing management of a patient's illness. It does not allow the flexibility and scope that the much more extensive progress notes and associated records allow. The form of treatment plan developed for the Sunshine Coast and Gympie Districts, and, I understand, typically, does not allow a clear direct link between the planned treatment and the assessment on which the plan is based or between any change of plan and the assessment of changed symptoms or

circumstances that required the change. I have noted earlier what I consider to be a potential danger should the 'progress notes' progress beyond the 'treatment plan' leaving the latter inaccurate and possibly misleading.

Furthermore, as already noted, the relevant provisions of the *Mental Health Act* fail to establish with any clarity what is required by law. The Act on point provides the authority and justification for detaining a citizen by writ of State. In my view the authority for so doing must be contained in terms that are certain.

I recommend to The Honourable, The Minister for Health that an appropriate committee be set up to consider:

Recommendation 1	(1)	the suitability of the concept of a discrete document as a record of a treatment plan;
Recommendation 2	(2)	an alternative which would reconcile the need for a useful essential record of a patient's continuing treatment and the need to meet what I have termed the primary purpose of a treatment plan under the Act;
Recommendation 3	(3)	once the first two are settled upon, the statutory provisions that would establish the required regime with clarity.

If my view as to the primary purpose of the treatment plan is accepted then the necessary steps must be taken to ensure that all medical practitioners are informed of that fact. It is not to be expected that medical practitioners will address statutory requirements in the manner expected of lawyers and I feel sure they do not like to think of themselves as custodians. However when medical practitioners, in discharge of their obligation under the *Mental Health Act* detain a patient for treatment they are custodians and their only authority to do so is the Act. The only protection against what would otherwise be an unlawful act, civilly or criminally, is that afforded by the Act and that protection is dependant upon compliance with the statutory provisions. I have already referred to the lack of certainty in the statutory provisions. I would suggest that whilst it remains uncertain the only safe course is to complete a discrete document that identifies itself as a "treatment plan". In making this suggestion I refer to the observation of Dr. Waugh that there is risk associated with developing a form for that purpose which is more complex than that required by the Act.

I recommend to The Honourable, The Minister for Health that:

Recommendation 4	(4)	Pending statutory changes on point, appropriate measures be taken to inform medical practitioners - with strong emphasis - that it may well be a statutory requirement but, in any case, it is most desirable, that a discrete document that identifies itself as a 'treatment plan' be completed.

Visual observations

It is essential that a patient be observed by carers regularly in order to ensure appropriate attention to a patient's therapeutic needs and to ensure the safety of the patients as regards risk of self-harm, risk of harm to other patients and absconding. I accept the evidence of Dr. Miles and Dr. Waugh that visual observations have no therapeutic benefit unless the carer engages the patient but it is apparent that, as regards patients admitted under the *Mental Health* Act regularity of observations is intended to address the safety issue as much, if not more than, the therapeutic issue.

The practice of the Mental Health Unit at Nambour Hospital at the time of Helen's death was that although the regularity of observations were prescribed by a medical practitioner and although, except

for night shift, that direction would guide staff no record of each observation was made. Even the most conscientious carer can be distracted, whether by emergent circumstances or otherwise, from the task at hand. Should such a distraction draw the carer away form an intended observation of a patient then it is only to be expected that, without the benefit of a recorded prompt, that carer might well overlook the uncompleted task. If, by way of example, in respect of the unfortunate patient the next scheduled observation is similarly missed then that patient remains unobserved for a period three-times longer than that considered appropriate by the medical practitioner.

I accept the concern expressed by Dr. Waugh that there is a risk that completing a log of observations will distract carers from the therapeutic element of their task I will note my observation that the nursing staff who have given evidence in this matter have left the impression that such is unlikely to happen. It is a risk that can be adequately addressed by education. Whatever the risk of that nature I am satisfied that the risk associated with a haphazard unrecorded observation regime is much greater.

The practice at Nambour Hospital has now changed. The Nursing Director now requires nursing staff to complete a log of observations, called a "Visual Observation Chart" (Exhibits 47-48), which is not only required to be completed but also audited to ensure compliance. Importantly, the log not only provides a record of what has been done but also a prompt to staff should they be distracted from their task. I am satisfied the reforms introduced adequately addresses the problems associated with the haphazard procedure previously in place at Nambour Mental Health Unit.

However, although the evidence before me addressed only practices at Nambour Hospital, it is apparent that those problems are not unique. I am reluctant to wander outside the scope of my enquiry but I can think of no reason why what is an appropriate practice in this area in Nambour is not also appropriate in any other Mental Health facility. For that reason I am emboldened to make this further recommendation.

I recommend to The Honourable the Minister for Health:

Recommendation 5 (5) That a requirement of nursing staff to maintain a log of all visual observations of patients be introduced to all Mental Health facilities.

The problem I shall now address arose principally in respect of confusion among nursing staff as to the practice in place in respect of visual observations. That problem has been overcome at Nambour Mental Health Unit with the changes to which I just referred. However the source of the problem remains. Nursing is a very demanding and complex vocation. Its exponents require a high level of education and training to prepare them for their profession. A very influential part of that preparation is the practical training received either leading up to accreditation or in the early years of their professional nursing. As with society generally nurses are quite mobile and the opportunity for retraining in a busy public hospital environment is limited. It is inevitable that a nurse will bring to a new nursing environment the routine practices of the last. The nursing practices of the new environment may be different. If they are irreconcilable then it is to be expected that the difference will quickly come to the newcomer's attention and adjustment made. However if the differences are important but subtle then it may take a long time for the newcomer to learn of the difference.

To a certain extent this is not a bad thing. Indeed, the resulting exchange of ideas is likely to be valuable. However where it leads to misunderstandings in respect of essential nursing requirements there is a risk of harm to patients. The confusion as to the visual observation practice at Nambour Hospital at the time of Helen's death provides an example of the risk to which I referred.

I acknowledge that I no not have the evidence before me that would allow other than a tenuous foray into the field I am about to address and I am conscious of the vacuousness of introducing uniformity if it serves no other purpose, however I am satisfied that the evidence does allow me to make the following recommendation.

I recommend to The Honourable, The Minister for Health:

Recommendation 6: (6) That the Director-General, Queensland Health, or other person or committee nominated by the Minister examine the practicability of introducing to State Mental Health facilities uniform nursing practices in respect of those areas considered essential to the proper care of patients.

Face Shields

The witness O'Brien, the first person to discover the deceased after her death, gave evidence that administration of emergency CPR by her was delayed to allow Ms O'Brien to obtain a face shield to protect her from transmission of disease in the course of its administration. Ms O'Brien cannot be criticised for taking that precaution: regrettably the risk of transference of serious communicable diseases is now ever present in the community and Mental Health facilities are no exception. On the evidence there is absolutely no reason to think that the delay made any difference to Helen's chances of survival. However, in different circumstances it may. Although the face shield available to nursing staff at the time is small enough and light enough to allow staff to carry it on their person at all times it is large enough to cause some minor inconvenience and discomfort in so doing. A device carrying the brand and description "Laedral Face Shield" has been produced to the Court (Exhibit 49). The device comprising a shield and carrying pouch is very small, very light. It appears most unlikely that its carriage would cause any discomfort or inconvenience whatsoever. There may be other devices on the market.

The benefit of a nurse's skill and training in the administration of CPR and the immediacy of a nurse's presence are considerably compromised by a need to go searching for a face mask in order to put those skills into effect and the time taken, even if only seconds, might make a critical difference.

A face shield device of some kind should be provided to all nursing staff personally and the carriage of that device whilst on duty should be required.

Nursing staff of Nambour Hospital Mental Health Unit are now issued with the Laedral Face Shield. Ms. O'Brien demonstrated some reservations about the protective capability of the device. Whether or not those reservations are well founded, it is a reservation she and other nurses are entitled to hold until provided with sufficient information to allay concern.

I recommend to The Honourable, The Minister for Health:

Recommendation 7: 7. (a) That a protective face shield for the administration of CPR be issued personally to all nurses together with the technical information that establishes its effectiveness;

(b) That such devices be of no greater weight and size than practicably necessary;

(c) That each nurse be required to carry such device at all times when directly involved in the care of patients.

Suicide aids

I have already expressed my great surprise to learn that none of the medical or nursing staff who gave evidence in this matter identified a plastic bag as a suicide aid prior to Helen's death.

They of course have learned from the experience.

There is no reason to think that their lack of awareness on point was unique to them or to staff at the Nambour Mental Health Unit. It must be assumed that it was common among nursing staff throughout the State and that, as regards those who have not learned from this experience, it is an unawareness that persists.

A situation that allows those charged with the responsibility of caring for patients at risk of suicide to unwittingly give the patient an aid to suicide is absolutely intolerable. That all manner of things might be used as an aid to suicide does not excuse a failure to exercise control over those objects which are commonly associated with suicide.

Further, Part 3, Chapter 10, *Mental Health Act* establishes a power to search for "harmful things". The effectiveness of an exercise of that power is dependant upon the searchers knowing what they are looking for, *i.e.* what a "harmful thing" is.

A plastic bag is such an object. I have already noted that although, at the time of Helen's death her carers did not know that, it was a fact that was known by many and it was a fact that was easily discoverable by access to internet. I understand there is a publication, Derek Humphry, *Final Exit*, that also offers this type of information.[1] Those charged with the responsibility I am about to recommend can get their information from the internet if no other source is available. I would think a much better source is the Australian Institute of Suicide Research and Prevention. In making this recommendation I have had regard to the concern expressed by the witness Dr. Muir that to remove common objects which are ordinarily available to patients in a domestic environment increases a patient's sense of isolation, and that together with a perceived absence of trust is detrimental to a patient's recovery. However the most essential element of recovery is the patient's survival.

I shall make one further observation: At times throughout the hearing I have felt somewhat uneasy about what I shall, for the sake of convenience, term a fatalistic professional attitude towards suicide risk, that attitude being, if a person is intent on suicide they will find a way. I have commented earlier that as an expression of reality such an assertion is unobjectionable and I am satisfied that none of Helen's carers brought any such attitude to their personal ministrations to Helens's needs. However, if the following recommendation is to be adopted then any fatalistic attitude of that kind must be completely discarded by those charged with the task.

I recommend to The Honourable, The Minister for Health:

Recommendation 8: (8) (a) That, to the maximum extent consistent with nursing needs, all objects that have been identified as being of a kind not uncommonly used as a means of suicide or attempted suicide be excluded from State mental health care facilities;

(b) That nursing staff of such facilities be immediately informed of those devices and of their common use;

(c) That management practices be established that ensure a continuing audit of facilities and information dissemination.

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[1] This publication has only come to my notice on 7.11.06. It was information contained in a publication of Monash University National Centre for Coronial Information *National NCIS Database Search: Suicide by Plastic Bag Asphyxiation July 2000 – 23rd September 2002.* This was provided to me by Ms. McMillan of Counsel with the consent of all Counsel who appeared in this Inquest. Section 37, *Coroners Act* allows me to have regard to such information. However, although informative, that report, regrettably does not incorporate any Queensland data and has been of no direct assistance on issues explored in this inquest.

Remote pulse-monitoring device

Mr. Payne has raised the prospect of a device to be attached to a patient's wrist that allows the patients pulse to be monitored at a central point no matter where, within range, the patient may be.

I have carefully considered whether this is an appropriate subject for a recommendation. The evidence does not allow the subject to be categorised as anything other than a concept. However it is an exciting concept that, if practicably feasible, would have wide-ranging life-preserving potential and be a most valuable innovation. It would appear to offer benefits not only in the area of mental health care where it would help monitor those patients at risk of suicide and/or of absconding but also patients in other areas of nursing.

Because of the novelty of the idea all of the experts who have given evidence in this inquiry have been taken by surprise when confronted with the concept and unable to express a considered view as to its desirability or practicability. The spontaneous response appears to weigh towards the negative. Some of the doubts address the practicability of such a device if it was available. One doubt addresses the difficulty of ensuring a patient does not remove it. I understand that it is still general practice in hospitals for patients admitted for other than outpatient care to be required to wear a plastic identification band around their wrist. Once it is fitted it can be removed only with great ingenuity or a pair of scissors. That it can be removed does not appear to have caused concerns about its usefulness whilst worn. A device such as that suggested by Mr Payne is likely to be similarly capable of removal but that presents no more than a problem of inconvenience. If removed the pulse is lost, the nursing staff is alerted, and a replacement can be fitted. With advances in material and technological development there may well be an even more secure method of fitting available.

Concern has been expressed that such a device may encourage nursing staff to sit in front of a monitor rather than engage patients. This concern appears to be primarily based on what I understand to be a misconception. The concept is not a device that allows a patient to be tracked on a screen but a device which simply alerts staff that there is no longer a pulse being monitored in respect of each identifiable patient. In so much as there is a risk of undue staff reliance on such a facility that can be addressed by education.

Concern has been expressed that a requirement to wear such a device may compromise the bond of trust between the patient and staff and undermine a patient's sense of dignity. It would appear to be essential that a patient not be deceived as to the capabilities and purpose of such a device but on the scant evidence on point before me I am not persuaded that, having been informed, a patient is likely to regard it as any more demeaning than the identification tags presently being worn.

There is not a lot to be gained by commenting on points raised in the rudimentary manner in which they have been raised on the evidence before me. However I am of the view that such is the life saving potential of the device, should the concept be capable of realisation, that the idea should not be allowed to wilt without proper consideration of its merits.

I recommend to The Honourable, The Minister for Health:

Recommendation 9: (9) That the concept of a remote pulse-monitoring device be referred by the Minister to a person or body with the capacity to discover the technological feasibility, the nursing value, and the economic practicability of such a device.

ANCILLARY OBSERVATIONS

There have been several issues explored in the course of this enquiry in respect of which no comment under section 46, *Coroners Act* is warranted.

Need for beds

It was suggested by some early in the investigation of Helen's death that her transfer out of PICU was motivated by a need for a bed in that unit. I am satisfied on the evidence that is not the case.

The evidence discloses that bed availability is often a problem to be overcome by one means or another. It appears that is not a problem unique to Nambour and it is a matter of vigorous public debate. There is no comment I can make on the evidence that would add anything to that debate.

Transfer between Wards

As to the transfer of Helen from PICU to Ward GE, that has been addressed earlier. As to general nursing practice, Mr Ian McLeish and Dr. Waugh made certain recommendations in their report of 30/03/05 (Exhibit 37) which I recommend to administrators of the Nambour Mental Health Unit and to administrators of all other Mental Health facilities in the state in so far as the recommendations are applicable to any particular facility. These recommendations either have been implemented or are in the process of implementation and, other to the extent already addressed, the evidence does not allow me to offer any supplementary recommendation.

Improvement of nursing protocols and practice

Here I make specific reference to Recommendations numbered 6 to 10 in the Report, Exhibit 37. These relate to matters which I have already addressed or to matters that were canvassed only incidentally in the course of this enquiry.

The Police Investigation

It has been submitted on behalf of Queensland Health and on behalf of the nurses of Ward GE during Helen's brief stay that a critical finding in respect of the manner in which Snr. Sgt. Zohn carried out his investigation is warranted. It is suggested that Zohn was abrasive, insensitive and intimidating in his dealing with the witnesses. It is also suggested that not only was that inappropriate but it was also counterproductive because it put the witnesses on the defensive and resulted in a culture of blame-shifting and accusation among staff.

As to the last suggestion I will say that although it may well be the case that an accusatory approach to an investigation might put even a blameless person on the defensive it is difficult to see how the accuser can be held responsible for any blame-shifting or false accusation which might result. It seems likely in this case that the culture of blame-shifting and accusation only prolonged the investigation and fuelled its vigour.

As to Zohn's style it was certainly direct and, perhaps, relentless. To the extent that he proceeded on an assumption that nursing staff were unlikely to be greatly moved by the death of a patient it can be said that he failed to demonstrate a level of sensitivity commensurate with the actual circumstances. However the actual circumstances were not known to Zohn in the initial stages of his investigation and in considering Zohn's investigative approach due regard must be had to that which he was investigating. A patient had made a determined attempt at suicide by drowning. She was prevented only by the intervention of another and ultimately by members of the Queensland Police Force. She was admitted to the Nambour Mental Health Unit as an involuntary patient under the provisions of the *Mental Health Act*. Five days later she committed suicide in a ward of that Unit by use of a plastic bag given to her by Hospital staff. I would think that the patient's family, and, indeed, the community at large, would expect an investigation into such an incident to commence with some vigour.

It does appear that Zohn embarked upon his investigation with considerable cynicism and suspicion but, from my experience in various jurisdictions, it appears that for investigating police officers not to do so would be the exception rather than the rule. It also appears that there was a level of intensity and persistence that coaxed factual assertions out of witnesses which they might not have offered without such encouragement and about which they now feel uncomfortable but, again from my experience, that

is an investigative style that, although frequently irritating to a tribunal-of-fact, is so common, even entrenched, that this example warrants no special comment.

The matter of complaint relates only to Zohn's investigative style and no specific contravention of the law or even of Police procedures or guidelines has been suggested.

I have considered whether I should recommend to the Commissioner for Police that an investigation protocol for deaths in similar circumstance be developed. This investigation involved distressed and tired nursing staff and exposed vulnerable patients to disruption and distress over a long an intense period of time. In considering this course I am conscious of the fact that rarely is it the case that police are called to investigate a death in circumstances where there is not distressed and vulnerable persons necessarily involved in the investigation. Any recommendation would have to be based on knowledge of, *inter alia,* protocols already in place, training issues, resource issues and resource allocation issues. I do not have before me the evidence that would allow me to make any credible or useful recommendation on investigation protocols.

There is no basis upon which any recommendation can be made.

Those are my findings on the cause and circumstances of the death of Helen Jeffrey

As required by s.47 I direct that a written copy of these findings and comments by given to –

- The Attorney general;
- The Minister for Health;
- The Director General, Queensland Health

The Inquest is now closed.

(K.O. Taylor)
Coroner