OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of a Mental Patient**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 1797/05 (1)
DELIVERED ON:	17 August 2007
DELIVERED AT:	Brisbane
HEARING DATE(s):	5 February, 25 & 26 June 2007
FINDINGS OF:	Ms Christine Clements, Deputy State Coroner
CATCHWORDS:	CORONERS: Inquest, Mental Health, assessment of suicide risk, communication with family and hospital staff regarding risk, search of patient's property for dangerous items, hanging points.

REPRESENTATION:

Mr Craig Chowdhury of Counsel – appearing to assist the Coroner

Mr Scott McLeod of Counsel – representing Dr James Dodds; instructed by United Medical Protection

Mr John Allen of Counsel – representing the Belmont Hospital and staff, instructed by Minter Ellison Lawyers

CORONERS FINDINGS AND DECISION

The Coroner's Act 2003 applies

1. The *Coroners Act 2003* provides in s45 that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These are my findings in relation to the death of a mental patient. They will be distributed in accordance with the requirements of the Act and placed on the website of the Office of the State Coroner.

The Coroner's jurisdiction

2. Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The scope of the Coroner's inquiry and findings

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

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

4. There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

5. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-
It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires. [1]

6. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[2] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something.[3]

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[1] R *v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

[2] s46

[3] s45(5) and 46(3)

The admissibility of evidence and the standard of proof

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

8. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

9. A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

10. It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.[7] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[8] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

11. On application of the family and pursuant to s41(1), I prohibit publication of anything identifying the deceased person or the fact or actuality that he may have committed suicide.

Introduction

12. The patient was a self employed farmer. He was born in 1934 and died on 23 July 2005 at the age of seventy one years. He had the misfortune to suffer from depression over a number of years. Dr James Dodds, a psychiatrist, had been providing his specialist care for a period of about ten years. Dr Dodds was an experienced psychiatrist practising here in Queensland for twenty years.

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[4] R *v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[6] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[7] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[8] (1990) 65 ALJR 167 at 168

13. The patient's daughter provided a statement and gave evidence in the inquest.[9] On 18 July 2005 she received a phone call from her aunt, her father's older sister. The patient was staying with the aunt at the time. She said that the patient was hard to wake up that morning and had slurred speech. An ambulance had been called and he was taken to Greenslopes Private Hospital. The Emergency Centre nursing notes from the Greenslopes Hospital record the presenting problem as,

    "Patient states took "pills" at 6.30am (unsure of which ones-temazapam?)
    Sister tried to rouse patient at 7.30am. Found to be hard to rouse, slurred speech and disorientated. Sister called QAS. Patient very poor historian."

14. The clinical notes from Dr David Bennett at Greenslopes record as follows;

    "18 July 2005, 9.25am.
    Woke feeling anxious, won't say exactly why, worried re things at home. He decided to take normison, counted out 14 tablets and took them at 6.30am., didn't tell his family who remained unaware til he was in ec, they were concerned re the slurred speech.
    History of depression
    Shoulder reconstruction
    Medications- gopten, lithium, zanidep, arapax.
    Psychiatrist Dr Dodds at Belmont, was admitted there in May because of depression
    History from daughter, long history of depression, despite recent admission he remains with flat mood and effect, can't sleep, morning anxiety."

15. He was examined physically and assessed as appropriate to transfer to Belmont Private Hospital where a bed was secured. His daughter accompanied her father in the ambulance to Greenslopes Private Hospital where her father was assessed and monitored for a number of hours before transfer to Belmont Hospital. Dr Bennett indicated to her that he had spoken with Dr Dodds.

16. The source of the Temazepam remains unknown. I understand it to be a sleeping medication. The family could not explain the source and the patient appeared confused when Dr Bennett was trying to clarify the source.

17. Subsequently, when Dr Dodds assessed him on 19 July, he stated that he was unable to confirm this with him and it was "*never clear if he had taken the tablets, whether this overdose was with suicidal intent or simply an uninformed attempt to induce sleep".*[10]

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[9] Exhibit a 13
[10] Exhibit A3, page 2, paragraph 8.

18. The patient was admitted to the acute care ward of the Belmont Private Hospital which is a psychiatric care hospital. His wife and daughter were with him when he completed a self assessment form on his admission. [11] As his daughter stated in the inquest, the document revealed that he was feeling very low in mood. I note in particular, the following questions and answers;

    In the past two weeks:-
    Did you feel full of life? - A little of the time
    Have you felt so down in the dumps that nothing could cheer you up? - Good bit of the time
    Have you felt calm and peaceful? - None of the time
    Did you have a lot of energy? - None of the time
    Have you felt down? – Most of the time
    Did you feel worn out? – Most of the time
    Have you been a happy person? - Some of the time
    Did you feel tired? - Most of the time.

19. He also answered that during the past two weeks his physical or emotional health interfered with his social activities most of the time.

20. Despite this self assessment, the nurse completing the HoNOS or HoNOS65+ document does not seem to have rated many indicators above the minimum score. The highest scores seemed to reflect the difficulties that he was experiencing as a result of his physical restrictions due to a recent shoulder reconstruction and a knee injury.[12] Dr Dodds contacted the Belmont Hospital by phone and gave initial orders for medications and initial observations were set at fifteen minute intervals prior to his attendance upon and assessment of the patient on the morning of 19 July 2005.[13]

21. When asked whether Dr Dodds knew if nursing staff had conducted an assessment of his psychological status and whether he was at risk of suicide, Dr Dodds admitted that he did not know. He conceded that this would be a good practice and that the hospital admission process was now much more formalised. Subsequent evidence reviewing his treatment[14] reinforced the necessity and good practice of assessing a patient within two hours of admission. There was evidence from Belmont Hospital that they have significantly improved their admission process including assessment within two hours.[15]

22. When Dr Dodds saw the patient on 19 July, it was against a background of ten years knowledge and treatment of him. Although the record was not requested by this inquest, no doubt Dr Dodds would have held a

[11] D1
[12] page 71 exhibit D1
[13] page 54 medical record, exhibit D1
[14] Dr Powell
[15] Mr McGurran

medical record and file for the patient. He had been treated as a private patient and was only admitted to Belmont Hospital on one previous occasion during May 2005. Dr Dodds confirmed that throughout the period he treated him, he had been diagnosed as suffering a recurrent major depressive disorder with melancholic features. The mainstay of treatment had been medication namely Paroxetine. He explained that serotonin re-uptake inhibitors are the main method by which depression is treated. Different types of this medication vary in their side effects and prescription is largely assessing the efficacy of a particular drug for a particular patient balanced against side effects. Lithium Carbonate was an additional agent used to treat non responsive depression.

23. Dr Dodds told the inquest his treatment also included counselling the patient on each consultation. The frequency of consultation varied with the severity of his illness and also took into account the patient's ability to travel for appointments. Prior to May 2005, Dr Dodds stated that he had not expressed any suicidal ideation or intention.

24. The factors that re-triggered and exacerbated the patient's depressive illness appear to have been the physical injuries to his knee and shoulder. He had a farm accident where he had injured his knee and a short time later he underwent major surgery with a shoulder reconstruction. This meant he was physically debilitated and restricted in what he could do and this seriously impacted on his emotional and mental well being. Although an inquest often sadly does not reveal any sense of who the individual was, I gather that he was an active and independent man who keenly felt the restriction of his physical ability and loss of sense of usefulness. He was admitted to Belmont Hospital on 19 May 2005. During his admission, Dr Dodds considered the efficacy of electro convulsive therapy to assist in intervening in his illness. He confirmed that electro convulsive therapy is not common but used in emergency situations where there is a refusal to eat and where there is a severe suicide risk. It is also considered where usual therapy by medication is ineffective. He contacted the patient's orthopaedic surgeon. The surgeon was not happy with the proposed therapy as it can cause muscle spasm and tension even when administered under sedation. There was a risk of damage to the recently repaired shoulder joint. Therefore Dr Dodds added another anti depressant medication, Mianserin. He chose this particular medication because it also has the side effect of assisting with sleep. The patient had difficulty in remaining asleep in the early hours of the morning. The therapy seemed to have been effective and Dr Dodds said he was discharged on 8 June.

25. When Dr Dodds saw the patient on 19 July, he assessed his overall risk of suicide in hospital as low. He did so by administering a standard diagnostic tool called the Montgomery and Asberg Depression Rating Scale. He scored him at 32, falling into the moderate range of depression. He confirmed the diagnosis of major depressive illness with melancholic features. He noted the additional factors of concurrent

medical conditions (the recently reconstructed shoulder and knee injury). He further noted the psychological and social stressors of these conditions which restricted his independence.

26. The note he made in the record reads;
"Recent overdose - possibly not taken with suicidal intent, most related to increased distress due to insomnia, but not sure this is truly the case. Reports increased depression over the last two weeks. No apparent reason but was only taking 10mg tolvan not 20mg and serum lithium was less than .2mmol/l suggesting compliance difficulties for some reason - (He denies this.) Recheck lithium level after 5 days on regular intake. Increase tolvan to 30mg at night to help sleep and assist with mood. May need ECT but assess response to medication first. Orthopaedic surgeon was not keen for him to have ECT given fragile nature of shoulder. He currently denies suicidal intention and I assess risk in hospital as low. Can be on 60 minute obs."[16]

27. His other standard medication was also ordered to be restarted.

28. During the July admission, his family visited and noted his low mood and sense of alienation in the hospital environment where there was nothing much to engage his interest. Family members considered that he might be better off if he was able to be with family, where he would at least be involved in daily contact and activities rather than socially isolated in a room with little appropriate activity available to him. His daughter's memory was that she spoke with Dr Dodds by phone on 20 July about taking him home. She wondered whether her father should seek a second opinion about his care. She raised concern at the inquest about the uncertainty that remained about taking the Temazepam. She also felt that her father's condition was deteriorating because he was remaining idle and socially isolated.

29. Her recollection was that Dr Dodds was perhaps unwilling to discuss matters with her and indicated that he would discuss the issues with the patient's wife. He also expressed the view to her that he had a "duty of care" to the patient.

30. Dr Dodds does not disagree that there might have been a phone call that occurred directly with his daughter but he thought, on reviewing the notes that he had been told by staff about the daughter's wishes to have her father discharged home on 20 July.

31. The critical issue here is not whether Dr Dodds was speaking directly to the daughter or not but rather what each of them wanted to convey to the other. The issue of communication between treating physicians and the involvement with family members in accessing information and input into decisions is raised frequently at inquests, particularly in mental health maters. Families remain one of the best additional and

[16] page 24-25 exhibit D1

corroborating sources of information for a clinician to access but a patient's right to privacy remains, despite mental illness. Families often seek more restrictive or interventionist treatment because they are in the best position to judge how their loved one's behaviour has changed. The treating doctor must make clinical decisions based on assessing the patient and all reasonable sources of additional information. In accordance with current practice, the clinician is bound to provide the least interventionist form of treatment available to address the patient's illness. The patient had the good fortune of having wide family support but this might sometimes present a difficult situation for the treating team. Dr Dodds appears to have focused his communication via the patient's wife who would of course, be the nearest relative. There remains however, a primary responsibility on the clinician to ensure that important information is conveyed to the appropriate family member when it is necessary. One can imagine situations where the legal next of kin may be so distressed or less capable than another family member, to absorb and deal with medical advice and information.

32. Dr Dodds has told this inquest and recorded in the medical record that he had serious reservations about whether it was safe and appropriate for the patient to be discharged home on 20 July. He visited him in hospital that day and recorded in the chart his reservations. This record did not state that he considered he should be placed under involuntary treatment but showed Dr Dodds had misgivings about whether or not the patient might be harbouring unvoiced suicidal ideation or intent.

33. What he recorded in the notes indicated that if the family insisted on discharge for the patient then they should be warned of his fears to safeguard the patient. The entry reads:

    "*20/7/2005*
    Slept somewhat better. Mood unchanged. Very uncertain as to what happened the other day. His daughter is strongly pushing him to be D/C (discharged) today. I am not sure why the urgency but despite the plausible reasons (he can be with family, go for walks etc) I have suspicions that there is another motivation. I have told him that I would be ordinarily planning his discharge today - that he needs observation and assessment of mood and suicide risk. There are no grounds to detain him so if he really wants to go then can't stop him. Family would need to know that he perhaps is secretly more suicidal than he is admitting and observe closely."[17]

34. The following nursing entry on the same day is recorded at 2.15pm:

    "Visited by family today. Patient reports mood remains low, depressed themes and anxiety evident. Importance of assessment and hospitalisation explained, patient agreed with same. Taken for walk - encouraged with groups."

35. The final nursing entry that evening records:

[17] page 29 medical record

"Says feels that maybe some improvement in his mood - denies suicidal thoughts. Difficult to engage in conversation - Flat affect and mood low. Settled evening."

36. A nursing entry made on 21 July, the next day, when his daughter took him out on day leave is noted at 1.25pm. It reads:
"Settled. Collected by daughter at 9.00am for day leave - will return this evening."

37. An entry later that day states:
"Sleeping better on Tolvon 30mg at night. Mood melancholic. Not suicidal. Check his lithium tomorrow."

38. An entry was made after his return to the ward from day leave on the evening of 21 July. It reads:
"Quiet on return from leave isolating in room, Intervention, brief staff contact. Outcome - settled."

39. Dr Dodds confirmed the daughter's evidence that the family was unaware of his concerns and that Dr Dodds did not himself inform the family. He told the inquest that he expected and relied on nursing staff to do this as he would not necessarily be on hand in the hospital when the family visited. He went further in his evidence. He expected that nursing staff would warn the family to be appropriately cautious if and when the patient went out on day leave.

40. I accept the family did not receive this advice either from Dr Dodds or from nursing staff. The notation in the record merely notes that the patient's daughter picked up her father at 9.00am on 21 July for day leave to be returned by the evening.

41. With the benefit of hindsight, it is clear that on 20 July Dr Dodds did have an unsubstantiated fear that the patient was possibly concealing the level of his distress and may be harbouring thoughts of suicide. He documented his concern and assumed that this was sufficient direction for the nurses to interpret his intention, namely to warn the family to be observant during any period of leave, or indeed, if early discharge occurred. In evidence to the inquest he stated that he expected the nurses would access and interpret this information as necessary to be passed on to the family in the event of day leave, as well as in the event of early discharge.[18]

42. The nurses' notes record their observations and indeed some level of positive intervention and action with the patient by way of conversation, assessment and counselling when they thought he was low in mood. They did not assess that he indicated or acknowledged thoughts or plans of suicide. They did not record informing the family members of any variation in his mood or of Dr Dodds' concerns.

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[18] Answer to question form counsel assisting, Mr Chowdhury

43. For the future it appears to be necessary that a doctor specifically direct nurses to convey messages to family members via written notes. Ideally of course, as commented upon by Dr Jacinta Powell, it would be expected that the treating doctor would take the initiative of directly contacting family members regarding a matter of such significance. As Dr Powell stated, a phone call could be made to the appropriate family member alerting them to the doctor's current assessment. Dr Powell is a psychiatrist and District Manager of the Northern Area Mental Health Service. She agreed to review the written records and provide expert comment on the patient's care.

44. Another issue raised by Dr Powell was the overall brevity of notes made by Dr Dodds in the hospital record. She did not necessarily disagree with the assessment that the patient was a low suicide risk at the time Dr Dodds examined him and assessed him on admission to Belmont. Her concern was that the record was inadequate in detail. The point of her criticism was that the notes in the hospital record are the mechanism by which the treating team is informed of the psychiatrist's assessment and basis of assessment. Dr Dodds no doubt had personal knowledge of the patient from a ten year history of treatment. He would also have more notes on his private records but the information needs to be accessible to the treating team in hospital and be updated and reviewed where appropriate.

45. Dr Powell raised specific issues when she considered Dr Dodds' assessment of the patient as "low" suicide risk, including the following undocumented questions and answers:
    What was it that the patient was worried about when he took the Temezapam?
    Where did the Temazepam come from?
    Why did he take it as he did?
    Collateral history from family members to get more detail and history.

46. Without this information documented, she could not really review the assessment as appropriate or not but the absence of information on the record affected the adequacy of the assessment in her view.

47. Dr Dodds himself agreed that the much more detailed and formalised admission and assessment process now in place at the Belmont Hospital is an improvement.

48. Dr Dodds explained to the inquest how he made the assessment that initially the patient was a low category risk of suicide. He explained that he was demonstrating a major depressive illness with melancholic features. Additionally, he had concurrent physical medical conditions which were exacerbating the situation. This was reinforced with psychological and social stressors due to his reduced independence. Dr Dodds said he records his conclusions in the notes after making his clinical assessment of the patient based on his examination and

questioning. He agreed that patients suffering depressive illness, who may be at risk of self harm, need to be continually reassessed rather than assessment being a one off exercise.

49. He was unsure whether the recent overdose was indeed a suicide attempt but it was possible. Dr Powell did not disagree with the overall assessment or with the initial level of observations at fifteen minute intervals. Dr Dodds reduced this to hourly intervals because he knew the patient and he was compliant with treatment and with remaining in hospital. There was no expression of suicidal thought or intent at this time. Placement in an acute care ward was sufficient to manage his care - there was no indication he required the restrictions of a secure ward. Dr Dodds recalled speaking with the patient's wife after admission but he could not recall speaking with family members after this time. He could not recall speaking with his daughter although he conceded that this may have occurred.

50. Dr Dodds acknowledged that patients are at elevated risk of suicide in the period immediately after admission to hospital but he did not consider that the patient demonstrated such risk. He was known to the hospital from his recent admission and was agreeing to treatment.

51. Dr Dodds said as far as he knew, the practice at the time of the patient's admission was that searches of patient's belongings were only undertaken if there was a very high risk of suicide. It was a question of balancing rights to privacy with safety concerns for the patient and other people.

52. I note that Dr Dodds was aware that the hospital had undertaken a formal root cause analysis process reviewing treatment and management of the patient at Belmont Hospital. As this is a review, it necessarily is at arms length from those involved in the patient's care but, as I have noted on other occasions, it is my view that the conclusions and comments as well as actions arising from such a root cause analysis should be communicated back to those who were involved with a particular patient. This is an opportunity for reflection and learning consequent upon accurate and appropriate feedback. It is not just the hospital administration that needs to review and change policies but also visiting clinicians who need to be informed about changes.

53. I accept that Dr Dodds was deeply shocked and disturbed when he was informed that the patient had died. I accept that he attempted to contact the family by phone but unfortunately, that communication was not made. With hindsight, Dr Dodds acknowledged that the family would have appreciated a letter from him.

54. Dr Dodds and Dr Powell agreed about the philosophical and legal framework within which psychiatry is practiced, in that the least intrusive and least restrictive method of treatment is to be employed to advance

a patient's care. However, there are of course circumstances where a treating psychiatrist can use the *Mental Health Act 2000* to order treatment and detention of a patient without their consent. Dr Dodds and Dr Powell both confirmed that this was not an avenue that was required for the patient as he was agreeable to hospitalisation and treatment.

55. Mr John Moodie is an experienced registered mental health nurse who discovered the patient hanging from the shower rail in the ensuite. His room[19] was in close proximity to the nurse's station but it was the last room on the round of observations that Mr Moodie undertook commencing at 5.00am on 22 July 2005. The patient was on hourly observations at the time. Mr Moodie explained that during the night when patients are sleeping, it is not the practice to waken them. He checked their welfare by entering the room and shining the torch onto the ceiling to reflect subdued light. Upon observing a patient in bed, he would observe visual and oral sounds of breathing and then leave them undisturbed.

56. On that morning, Mr Moodie checked thirty-five patients over about ten minutes. It was at about seven minutes past five that he entered the patient's room. The bed was unoccupied and he called out. There was no response from the ensuite and so he presumed that the patient was elsewhere in the ward. He immediately went to check in the tea room and smokers' area. Not finding him, he returned to his room and entered the ensuite and discovered the patient. He lifted him to take the weight off the rope, activated the call button and called out for help. Registered nurse Field attended. Initial attempts to release the patient were unsuccessful until a knife was obtained from the secure ward to cut the ligature.

57. the patient was released and immediate efforts at resuscitation were instigated. He did take some breaths but remained unconscious. He was taken by ambulance to the Princess Alexandra Hospital.

58. It is only with hindsight that we can say that Mr Moodie might have considered opening the bathroom door when he first discovered the patient was not in his bed. He called out and on not hearing a reply presumed that he was elsewhere in the ward and searched. When he could not find him, Mr Moodie returned within a short period of time and opened the bathroom door. There is no medical evidence that this period of time was critical to the patient's chance of survival. He was transferred for treatment and subsequently died.

59. Mr Moodie told the inquest that when he was the admitting nurse, it was his practice to do a quick search of a patient's belongings. He would do this with another staff person as it was an invasive procedure. If there

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[19] Room B23

was any item of concern or medication that could be a problem, it would be removed.

60. Dr Jacinta Powell assisted this inquest with her review of the records and her report.[20] She agreed with Dr Dodds' diagnosis of major depressive illness but was uncertain about the appropriateness of the assessment of "low" suicide risk. This was due to the brevity of the record on issues which she considered relevant to making a proper assessment. Dr Powell's view was that an adequate clinical assessment of suicide risk necessarily requires there to be adequate documentation. As earlier indicated, the primary value in comprehensive detail in the hospital record of the psychiatrist's ongoing assessments of the patient is in explaining the basis of the assessment of risk to inform and direct the treating team.

61. She agreed with the initial level of observations although she was a bit surprised that the level was authorised by Dr Dodds to be decreased the following day to hourly intervals. She could not see anything in the record to explain this change but acknowledged that she did not have the benefit of having a long clinical association with the patient.

62. She had reviewed the changes to risk assessment made by the hospital in their policy and considered them to be appropriate and positive. These risk assessments are now to be undertaken within two hours of admission.

63. I have already indicated that Dr Powell considered that Dr Dodds should have personally spoken to family members when he became concerned that the patient might be harbouring secret thoughts of suicide and there was some pressure from the family to discharge him home to their care.

64. Dr Powell would also have expected more by way of documentation authorising leave from the hospital. She expected a notation from the nurses indicating their assessment at the time of leave for such leave to occur.

65. As tragically demonstrated, Dr Dodds' concern was not misplaced, although it had not crystallized into any voiced thought or intent being expressed by the patient. In Dr Dodds' experience he was aware there was an elevated risk in the period after admission to hospital. He had not formed an opinion that the patient would attempt self harm in that environment particularly when he had agreed to treatment.

66. Dr Powell noted there had been audits and changes to the Belmont Hospital to reduce the weight bearing load of shower rails to 15 kilograms. She acknowledged this to be a positive step but emphasized the vital importance of there being a sufficiently resourced and trained staff to deliver the services and perform observations and interactions

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[20] Exhibit B1

with patients. This was the necessary underlying requirement to deliver patient safety at optimum levels. Accurately predicting the risk of suicide remains a difficult task requiring an initial thorough assessment and ongoing review of the patient's well being. Dr Powell also noted that accessing all relevant information is important, including in this case, from the Greenslopes Hospital, his family, from previous admissions and the treating doctor's record.

67. Belmont Hospital provided evidence via the Director of Nursing, Mr McGurrin. He had a long history of working at Belmont Hospital and had been acting in the position of Director of Nursing since April 2005. The hospital has 89 beds for patients with psychiatric illness.

68. He was asked to respond to the family's concern that the patient was left in his room for long periods of time without sufficient diversion or activity. Mr McGurrin said it was initially difficult to engage with a patient who was depressed and withdrawn. It takes some time to develop rapport with a patient to encourage their participation in activities. He acknowledged that at the time there were not many activities likely to be suitable for the patient.

69. He thought that Dr Dodds would have been spoken to in the course of the root cause analysis.

70. On the issue of searching a patient's belongings he said there should be some manner of checking dependent on circumstances. The patient check list was a cue to staff to consider the issue. That patient checklist document was not located on the medical record for the patient when the record was examined by Mr McGurrin in the witness box. However, counsel for the hospital indicated that upon earlier inspection of the hospital record there had been such a form in the record but it was blank.

71. I infer therefore, that the document was not completed in the course of the admission and that it should have been.

72. Mr McGurrin emphasized it needed to be a consensual checking rather than a search unless there was an overwhelming reason to invade privacy. Had he been the nurse admitting the patient and the physiotherapy aid (a rope) was discovered, he would have made further inquiry and considered what was appropriate and safe. After considering all the information, he agreed that it seemed most likely it was the rope used for physiotherapy that had been used by the patient and that this was with him at time of admission. He could not explain what had happened to the item after the patient was taken to the Princess Alexandra Hospital. He admitted that the retention of such an item would be important for investigative purposes.

73. There was evidence provided to the inquest detailing the more detailed and specific form required to be completed on an admission and on

further assessment of the patient. There were particular cues provided to ensure more thorough documentation was available on file for the management of a patient’s care. The transcript details these matters.

74. I am satisfied on the basis of those documents that the hospital has reviewed admission and assessment procedures and improved these areas. Audit of compliance is of course, necessary particularly where nursing staff can be supplied by agencies and may not have accessed initial training on new procedures. The documents also are more specific regarding checking of a patient’s belongings, using the language;
“Check belongings and remove any potential items of self harm.”

75. The hospital had undergone an audit of shower rails and since July 2005, another hanging point audit was undertaken. It is incumbent on the hospital to take action on such audits given their specific patient clientele.

Family concerns

76. The family voiced their concerns through the evidence of the patient’s daughter and finally, through his son-in-law. I will summarize some of the issues raised. The family were concerned that there was no minimum standard of care across public and private mental health care facilities.

77. They were concerned that the patient had not been properly assessed because they considered that information available from family members and from Greenslopes Hospital had not been obtained or was not sufficiently documented. They expressed the view often voiced in similar inquests that family members can help with vital information and should be kept informed to assist in appropriate treatment.

78. There was also some concern over communication between the psychiatrist and hospital staff and a lack of clarity about whose responsibility and role it was at various times to make decisions. Their expectation was that patients would necessarily be subject to search upon admission. They were aware that the first week of admission was a time of elevated risk and that the hospital should broaden its efforts to assist patients. Fixed televisions and radios in every room might assist, as well as a broader range of activities. They also raised the possibility of appropriate camera surveillance could assist nurses in maintaining safety of patients.

79. Their emphasis was on a minimum standard of care, on issues of accountability, documentation and communication.

Pursuant to s45 Corners Act 2003 the formal findings of this inquest are;

80. The patient died in the Princess Alexandra Hospital on 23 July 2005.

81. The cause of death was hypoxic brain injury due to hanging.

82. The patient was suffering severe depression and had been admitted to Belmont Hospital from Greenslopes Hospital on 18 July 2005. These admissions followed an episode of overdose of medication. It was not definitively clarified whether or not the overdose was inadvertent or an attempt at suicide. It was for this reason that he was admitted to Belmont Hospital under the care of his existing psychiatrist, Dr Dodds for assessment and treatment.

83. Electro convulsive therapy was considered but discounted as unsuitable due to his physical condition after recent shoulder surgery. Medication was reviewed, re-instated and extended. Observations were ordered. On 20 July 2005, Dr Dodds suspected that the patient may be harbouring thoughts of suicide although this was denied by him. Dr Dodds documented his concern to alert nursing staff to observe the patient and warned against early discharge, indicating that family should be warned of possible risk if an early discharge was insisted upon. There were no grounds to detain him against his will. The frequency of observation was not increased and remained hourly. On 21 July, the patient left the hospital with family members on day leave and returned in the evening without any adverse event.

84. At about 5.10am on 22 July 2005, the patient was discovered unconscious hanging from the shower rail in the ensuite. A rope that had been in his possession on his admission to hospital had been used by him. The rope was for the purpose of physiotherapy rehabilitation after shoulder surgery. He was resuscitated and transferred to Princes Alexandra Hospital. He died the next day.

Comments pursuant to s46 Coroners Act

85. Theses comments are made where consideration might be given to prevent a death occurring in similar circumstances.

86. They also acknowledge the issues raised by the family.

87. Through the course of the inquest the hospital has acknowledged that they have made various changes to policy and procedure after reviewing the course of the patient's admission via the root cause analysis. I have already referred to these matters and commented that feedback to provide an opportunity for reflection and learning needs to occur to all who were involved in the patient's admission. Then of course, changes need to be considered, training and resources provided and compliance measured via audit. These measures should alert administration of any need for further discussion or training to ensure that checklists have been completed.

88. The hospital has responded to concerns about the physical environment and reviewed shower rails. Their counsel also acknowledged a

willingness to further consider audit for any hanging points. I am aware from another inquest that the hospital is also open to consideration of cameras in such areas as hallways. Clearly, there are concerns with any further intrusion into a person's privacy beyond this possibility.

89. At inquests there are always issues arising from limited communication and this was highlighted here where there was an imperfect understanding between a doctor and nurses about what should occur as a result of the doctor's heightened concern that the patient might be harbouring thoughts of suicide. The hospital record is the primary tool for communication between a variable team and it is vital that it be maintained in a timely, detailed and accurate manner to enable proper care to be provided.

90. There is also a greater demand placed on medical personnel to communicate with family members where a person is suffering from mental illness and may be at risk of suicide. Those closest to a patient are invaluable sources of information. No doubt a doctor is placed in a difficult position in discussing a patient's private treatment and there must be due regard to the constraints on this. Where there is an extended family group, it is not unreasonable for a doctor to limit communication to the next of kin or person deemed the most appropriate. There has been an acknowledgment here that the doctor's heightened concern for that patient was not communicated to his family.

91. A submission was made that the blank checklist does not mean the check of belongings was not made. I find it highly unlikely that had there been a check of the patient's belongings on admission that further inquiry and removal for safekeeping would not have occurred. There is no evidence of knowledge of the existence of the rope by staff members prior to 22 July. I conclude on all the information (including from the patient's daughter) that the rope was brought in with his belongings as a physiotherapy aid for his shoulder recovery. I infer that its presence was not known to staff prior to 22 July. I find it highly unlikely that had such an item been discovered it would have remained with a patient who had been admitted for assessment and observation after a suspected suicide attempt.

92. Proper care is of course far more than completion of set procedures which are merely tools to prompt and document good clinical care. Looking after those with a mental illness remains an enormous challenge, particularly if the illness is longstanding.

93. There was no fundamental criticism of Dr Dodds' diagnosis and regime of care. When the patient was re-admitted a short time after a recent admission and after a possible suicide attempt, he considered the efficacy of electric shock treatment. This was precluded by the patient's shoulder. He therefore adjusted the medication and continued his care and observation in hospital. He clearly did not consider that the patient was well enough to be discharged.

94. Unfortunately, there is no single diagnostic test or method by which a person can be accurately assessed as being at a dangerous risk of suicide. Despite Dr Dodds' long association with the patient, he clearly did not anticipate what happened. Although he considered the recent overdose might be a suicide attempt, he also thought it might be an inappropriate response to his problem with sleeping. Dr Dodds was shocked and dismayed as were the family. The patient was clearly a well loved and respected member of his family and sadly missed. I formally extend condolences to his family and friends.

95. I note that private hospitals are required to be accredited and that this process includes minimum standards of facility, staffing and procedures.

I thank counsel assisting and all counsel as well as members of the patient's family for their thoughtful contributions to the inquest which is now closed.

Chris Clements
Deputy State Coroner
17 August 2007