QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of JJKD**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
DATE:	17 August 2017
FILE NO(s):	2016/8
FINDINGS OF:	James McDougall,Coroner
CATCHWORDS:	CORONERS: mental health treatment, community care team, clozapine
Counsel Assisting:	Ms Rhiannon Helsen

JJKD was 34 years of age at the time of his death. He suffered from long-standing mental health issues, having been diagnosed with schizoaffective disorder. As a result, he had been hospitalised on a number of occasions following manic and depressive episodes, as well as suicide attempts.

At around 6:00 am on 31 December 2015, JJKD was seen by a local fisherman to be standing with a surf board on the sand pumping jetty at the Spit. At the time, the surf was large and dangerous, and there were no other surfers in the water. JJKD told the fisherman that he planned to go surfing, although admitted that he hadn't done so for a few months. Despite warning him against it, JJKD was seen to jump into the water where he subsequently got hit by a number of big waves before being separated from his surfboard. The fisherman called triple 0 when he lost sight of him. At around 6:20 am, police attended the area, however, they could not locate JJKD.

At 10:20 am on 1 January 2016, JJKD's body was located in the water around Crusoe Island and recovered by Volunteer Marine Rescue with Gold Coast Water police in attendance.

Autopsy findings

On 5 January 2016, an external and partial internal post-mortem examination was conducted by a Pathologist. Further toxicological tests were also carried out.

The internal examination revealed features consistent with drowning, including a collection of fluid in the chest cavity and fluid in the stomach. No skeletal and bone injuries were found. A post-mortem CT scan showed bilateral pleural effusion, fluid in the sinuses and early changes of decomposition. The external examination also revealed features consistent with water immersion, including skin wrinkling.

Toxicological tests showed the presence of a small amount of alcohol (0.011%), which could be attributed entirely to formation of alcohol due to decomposition. No other drugs were detected.

The cause of death was found to be drowning.

Mental Health History

JJKD's first engagement with the public mental health system in Queensland was in 2008, when he briefly became a client of the Acute Care Team. He was subsequently admitted to a public Hospital Acute Adult Mental Health unit from 17 September 2008 until 30 September 2008, following a manic and depressive episode. It was at this time that he was diagnosed with Bipolar Affective Disorder. However, following a further two inpatient admissions, his diagnosis was revised in April 2009, to Schizoaffective Disorder when he presented with persistent delusions in the absence of mood symptoms. Accordingly, he was commenced on antipsychotic agents, quetiapine and lithium. His previous medications included sertraline (antidepressant), sodium valproate (antipsychotic agent) and risperidone (antipsychotic agent). JJKD's early warning signs, as identified by the mental health treating team during these admissions, were aggression often precipitated by non-compliance with his medication, and/or illicit drug use. At times of mental health deterioration, JJKD regularly experienced grandiose delusions. He was subsequently placed on an involuntary treatment order (ITO) after not taking his prescribed medication for a prolonged period of time, whilst using alcohol and illicit drugs.

From May 2009 until August 2013, JJKD's care was managed in the community by the Continuing Care Team (CCT) until he was readmitted due to deterioration in his mental state secondary to ongoing cannabis use, non-compliance with medication and non-attendance with appointments with his consulting psychiatrist. During this three-week admission, JJKD was recommenced on lithium and olanzapine, before being transferred back to the care of community CCT.

Between October 2013 and April 2014, JJKD was case managed in the community by a Community Mental Health Clinic (CMHC) with Psychiatrist, Dr IP as his treating physician. According to Dr IP, during this period, JJKD's mental state remained relatively stable, however, residual mood symptoms, psychotic symptoms and negative symptoms of schizophrenia prompted a change to clozapine. From 7 April 2014 until 1 May 2014, he was admitted by way of an ITO in order to commence clozapine therapy. Upon discharge, he was referred to a public clozapine clinic, whilst remaining on an ITO being case managed by the CCT.

JJKD's CCT case manager from October 2013 until his death was Nurse GK.

Post-discharge, JJKD was initially transported by his CCT case manager on a weekly basis to the clozapine clinic. However, from 23 June 2014, he reliably attended his monthly clozapine clinic appointments and associated blood tests on his own. Between September 2014 and December 2014, he attended the clinic and was prescribed 300 mg of clozapine. His clozapine levels during this time were recorded as being between 70 to 450 ug/L.

On 17 February 2015, JJKD's community based ITO was revoked by his consultant psychiatrist from the clozapine clinic, however, he continued to attend voluntarily.

Between March 2015 and July 2015, JJKD continued to attend the monthly clozapine clinic, however, his levels were found to be consistently sub-therapeutic ranging between 90 and 150 ug/L, which was attributed to clozapine non-compliance, as well as alcohol and cannabis misuse.

On 7 August 2015, a home visit was conducted by JJKD's CCT case manager during, which a plan was identified to discharge him from CCT case management to a general practitioner. He was also directed to continue to engage in monthly appointments with his private psychiatrist.

On 18 August 2015, JJKD attended the clozapine clinic where his dose was increased to 400 mg. The plan for this appointment was for the consumer to be discharged from the CCT and into the care of a private psychiatrist (who was the same as that at the clozapine clinic).

On 18 September 2015, JJKD and his CCT case manager attended his monthly clozapine appointment, where it was noted that he was taking 150 mg dose (below the therapeutic dose) and it was intended that he be reviewed in 2-3 weeks' time and for the CCT case manager to have monthly contact with him.

On 29 September 2015, JJKD's mother contacted the Queensland Ambulance Service (QAS) after he cut his wrist superficially with a retractable knife. He was placed under an Emergency Examination Order (EEO) and transported to hospital. JJKD disclosed that he had become increasingly frustrated over the past 3 days before deciding to cut his wrists. A Consumer Intake Assessment was undertaken by the Acute Care Team psychologist, during which his mother reported that he had

been well for the past few months and there had been a plan to reduce his dose of clozapine to 50 mg/month by his private treating psychologist with a view to ceasing the medication before commencing on an antidepressant. She also disclosed that a few days prior, JJKD used cannabis as he thought this may assist with his increasing agitation, which she supported.

Further assessment was conducted by the psychiatric registrar, who noted that JJKD denied any current thoughts of self-harm and stated that *'he did not want to die'*. He cut his wrists as he wanted to *'release the pain'*. He presented with a low mood with no evidence of psychosis. The case was discussed with the Consultant Psychiatrist and a plan was made to discharge him home under the care of his mother, and a notification of the presentation was sent to the CCT regarding this presentation.

On 30 September 2015, his mother contacted JJKD's CCT case manager and voiced concerns about his low mood over the previous 5 days. She also expressed the view that his clozapine dose had been reduced too quickly. The CCT case manager attended JJKD's residence for a home visit the following day, during which he denied any suicidal ideation or thoughts of self-harm, however, confirmed feeling paranoid. He was assessed as being a low to moderate risk to himself, a low risk to others and an ongoing risk due to recent situational crisis and impulsivity. It was decided that JJKD would have an appointment with his private consultant psychiatrist from the clozapine clinic the following week, with a medical review to be conducted with a community consultant psychiatrist in 3 weeks. Additionally, both JJKD and his mother were provided with the contact telephone number of the after-hours CCT.
On 6 October 2015, his mother contacted the CCT case manager and voiced concerns as to JJKD's deteriorating mental state over the past few days. She disclosed that her son was becoming more paranoid, his mood had declined and she did not believe his medication was assisting. The CCT case manager spoke to JJKD during which it was noted that his speech was slow and lethargic. He was unable to decide what treatment he required, however, confirmed that he didn't think the medications were presently working. He denied any plan in relation to suicide. The CCT case manager agreed to transport JJKD to his appointment with his private psychiatrist the following day.

On 7 October 2015, JJKD and his mother were transported by his CCT case manager to a private psychiatrist appointment at the clozapine clinic. There was no medical documentation generated following this consultation in JJKD's CIMHA records, however, according to the CCT records, JJKD had disclosed that he felt frustrated and had experienced a low mood for the last month. He denied any thoughts of deliberate self-harm or suicide, however, confirmed recent cannabis and alcohol use. His mother also indicated that JJKD's paranoia had increased, whilst his appetite and self-care had decreased. The case manager's impression was that he was suffering from depression without psychotic symptoms and ongoing cannabis and alcohol abuse. The plan was that JJKD would be transferred to the care of a community consultant psychiatrist and to continue to reduce his dose of clozapine over a period of time.

CIMHA records suggest that later that day, JJKD's private consultant psychiatrist called the acting community CCT consultant psychiatrist to refer him back for community management. It was recommended that in the absence of psychotic symptoms, his dose of clozapine should be reduced and ceased, with a trial of antidepressant medication augmented with an antipsychotic to be commenced.

On 14 October 2015, JJKD attended a medical review with the community consultant psychiatrist and was noted to present with significant anxiety and negative symptoms of schizophrenia. Following consultation with JJKD's mother and JJKD, it could not be determined whether there had been any significant changes in his psychotic experiences or emotional distress whilst taking Seroquel, lithium or clozapine. The Psychiatrist was of the view that JJKD presented with ongoing systematised delusions, which trigger emotional distress and reinforce social phobia. JJKD agreed to engage in treatment, specifically targeting anxiety and frustration, including case management, medication and psychotherapy. His dose of clozapine was reduced to 50 mg daily and aripiprazole (antipsychotic agent) was introduced. A medical review was booked for 2 weeks, with a case management review to take place in a week.

On 16 October 2015, his mother contacted the CCT case manager with ongoing concerns related to her son's mental state. The case manager undertook a telephone assessment of JJKD, who denied any delusional content and paranoia, nor any thoughts or plans of suicide or self-harm. The community consultant psychiatrist was advised, and a plan was made for JJKD to attend an appointment the following week. On 19 October 2015, JJKD attended a medical review with community psychiatric registrar, Dr AR and his CCT case manager so as to consider his change from clozapine to aripiprazole. He indicated that there had been no acute changes to his residual paranoia and that he was frustrated and hopeless about his mental health condition. After venting his frustrations, he was provided with psychoeducation about the need for compliance with the antipsychotic medication in order to prevent relapse. He was advised to lower the dose of clozapine from 100 mg to 50 mg for one week before ceasing it all together. He was provided with a script for 10 mg aripiprazole tablets, which he was to commence once the clozapine was finished. His next medical review was scheduled for 2 weeks.

On 26 October 2015, JJKD called his CCT case manager as he had not slept for the last 3 nights and attributed this to ceasing his clozapine and missing 1-2 doses of aripiprazole. He denied any psychotic symptoms or suicidal ideation. It was decided that JJKD would be reviewed by the consultant community psychiatrist the following week, and was advised to attend his general practitioner for medication to aid his sleep.

On 3 November 2015, JJKD attended an appointment with his consultant community psychiatrist and CCT case manager. Following a mental state examination, it was noted that:

- Partially co-operative during the interview with limited eye contact and superficial rapport
- Speech was normal in flow, rate and volume
- Thought flow was largely goal directed
- Thought content showed evidence of delusions, denied any thoughts of suicide or harm to others
- His mood was said to be 'feeling better'
- Affect was restricted, minimally reactive, congruent
- Perceptual disturbances
- Had impaired insight and a poor understanding of illness
- Risk assessment was said to be low to self and others

It appeared that there had been little evidence of an improvement in JJKD's mental state since changing from clozapine to aripiprazole, although medication non-compliance was suspected. The plan was to increase the dose of aripiprazole to 15

mg a day, and to consider a depot medication if medication non-compliance was suspected. Weekly case management meetings, as well as medical review in 2 weeks' time were scheduled.

On 24 November 2015, JJKD's plan was discussed at the three monthly Consumer Care review by a Multidisciplinary CCT. It was decided that he was to be continued on aripiprazole and the anti-depressant couple with frequent medical review.

On 25 November 2015, JJKD attended an appointment with Dr AR and his CCT case manager. On assessment, he admitted that he felt much better since stopping all of his medication 4 days prior. He disclosed that he felt more energetic, had more clarity of thought, and was more goal orientated. JJKD reluctantly confirmed that he still had persecutory delusions, and disclosed that he was occasionally drinking and smoking cannabis. A discussion was had with Dr IP following which it was determined that there were no acute grounds for initiation of the *Mental Health Act* to enforce JJKD's admission to a mental health unit. It was decided that fortnightly CCT case manager meetings and a medical review in 3 weeks was the appropriate course.

On 1 December 2015, JJKD's CCT case manager conducted a home visit. His mother disclosed that he'd had a bad weekend, and had been arrested and charged in relation to an incident at McDonalds. He had also allegedly not been sleeping or taking his medication. On assessment, his speech was found to be normal with no delusional content or paranoia voiced. He denied any thoughts of suicide or self-harm. It was decided that a medical review should be undertaken in 3 weeks' time.

On 19 December 2015, JJKD's sister and mother contacted the ACT by telephone with concern regarding the consumer's behaviour over the previous fortnight. No acute issues were identified by the ACT clinician that required immediate review, and as such, the information was referred back to CCT for ongoing management.

On 22 December 2015, the CCT case manager contacted JJKD's mother during which she disclosed that she remained concerned about JJKD's drug use (cannabis and methamphetamine) and his deteriorating mental state over recent weeks. The CCT case manager attempted to contact JJKD, however, was unsuccessful.

On 23 December 2015, JJKD attended a medical review with Dr IP, his CT case manager and CCT team leader. He disclosed that he had stopped taking his medication for an unknown period of time and wanted to find employment and get off his Disability Support Pension. His mother and sister were concerned as to his deteriorating mental state, which included poor self-care and increased drug use. During the mental state examination it was noted that:

- Partially cooperative with interview, limited eye contact, and only superficial rapport initially adamant that he wanted to leave MHS.
- Speech was normal
- His thought form/flow largely goal directed
- Thought content showed evidence of delusions, denied thoughts suicide or harm to others
- His mood was dysphoric with affect – restricted, minimally reactive and congruent
- Perceptual disturbances were not evident
- Insight appeared to be impaired with poor understanding of illness/symptomology
- Risk assessment – he was found to be of low harm to others and his self

- Poor self-care as mental state deteriorates was high

Dr IP's impression following his assessment was that JJKD had ongoing positive and negative symptoms, with deterioration in his judgment. He agreed to a depot injection of aripiprazole, which was administered. The plan following the consultation was for weekly case management with a medical review to take place in 4 to 6 weeks' time.

McDonald's incident on 29 November 2015

QP9's were subsequently obtained in relation to the incident at McDonald's shortly before JJKD's death.

According to these records, JJKD was charged with one count of commit a public nuisance, trespass and unauthorised dealing with shop goods in relation to an incident that took place on 29 November 2015 at the Oxenford McDonalds. It seems that at around 8:00 am, JJKD went through the drive through and placed an order, which was dispatched. He then entered the store and abused and verbally threatened staff, whilst making allegations as to missing items from his order. Despite attempts to placate him, JJKD refused to calm down and would not leave the store. Police were then called. During this time, JJKD walked behind the front counter and took a large amount of Hash Browns before decamping on foot from the store. The incident was captured on CCTV footage.

On 11 December 2015, JJKD plead guilty in the Southport Magistrates Court to all of the offences for which he was sentenced to a good behaviour period of 3 months and fined $300.

Family concerns

During the course of the coronial investigation, JJKD's mother has raised a number of concerns as to the adequacy of the care and treatment provided to her son by a Community Mental Health Clinic (CMHC). Essentially, she claims that JJKD was failed by the mental health system as he was not admitted to inpatient care on a number of occasions, despite exhibiting psychotic systems and multiple requests for treatment. She also raises concern about JJKD being prescribed clozapine in the months prior to his death, which was then rapidly ceased. This is said to have led to a rapid decline in his mental state, which he occasionally managed by using cannabis. His mother claims that all of the requests she made to have JJKD admitted to hospital for treatment in the months prior to his death were ignored.

I have considered all of the concerns and matters raised by JJKD's mother during the course of the coronial investigation when reaching my conclusions regarding her son's death.

Office of the Health Ombudsman complaint

Following JJKD's death, his mother also made a complaint to the Office of the Health Ombudsman (OHO) challenging the adequacy of the care and treatment provided to her son by the Community Mental Health Clinic (CMHC).

By way of summary, JJKD's mother alleges that the CMHC failed on 3 separate occasions between October 2015 and 22 December 2015, to admit JJKD to hospital after it became apparent that his condition was worsening. She also raised concern

as to JJKD having to engage with multiple different psychiatrists during his engagement with a CMHC.

Root Cause Analysis

Following JJKD's death, a Root Cause Analysis (RCA) was conducted by the Hospital and Health Service. An RCA is a quality improvement tool, which involves a systematic process for analysing serious clinical incidents in order to identity what and why an event happened and how it could have been prevented. A report detailing the findings of the RCA was subsequently provided for the purposes of the coronial investigation.

A number of *relevant findings* were made by the review team following their investigation, including:

- Cause of death: During the review process, the review team spoke to JJKD's family, who noted that he hadn't surfed for many years. As a consequence, given the surf conditions on the day of his death, the review team considered that JJKD's decision to go surfing may have been intentionally reckless, and attributed this unsafe act to his poor judgment.

- clozapine clinic: Overall, the review team found that the clinical documentation for JJKD's clozapine clinic appointments was substandard and not consistent with the guidelines within the HHS *'CIMHA Clinical Documentation Standards'* procedure. A recommendation, however, was not provided by the review team as the issue will be resolved by the reallocation of public clozapine consumers to the community treating team.

- clozapine management: JJKD successfully engaged with the clozapine program from April 2014 until 7 October 2015, and his clozapine levels were routinely suboptimal. On 7 October 2015, following recent weaning (reduction in dosage) of clozapine, the private consultant psychiatrist (clozapine clinic) determined that it was necessary to refer JJKD back to the community mental health team for ongoing management.

  The review team acknowledged that clozapine is a strong antipsychotic medication and down-titration of such a medication requires close management, however, it questioned whether JJKD received the level of supervision necessary for such a significant medication change. It was considered that optimum management of JJKD would have included: involvement of a single treating team to lead such a significant medication change, a documented plan outlining the timeframe and dosage for reducing his clozapine, documented evidence of education given to him on the medication change and the involvement of a pharmacist.

  Two treating teams were involved in reducing JJKD's clozapine, and when he was transitioned solely to the community treating team he was seen by three different medical officers over a 3-month period. During this time, there was only one documented conversation between the two treating teams, however, there was no agreed shared model of care documented, which increased the fragmentation in his care.

  The review team determined that more emphasis should have been placed on the reduction of JJKD's clozapine and the introduction of alternative

medications and that this should have involved a multidisciplinary team approach, inclusive of a pharmacist and increased medication awareness education for JJKD.

- Case Management: The review team identified that there was a period of 5 months when JJKD did not receive CCT case management, however, was not formally discharged from the CCT model of care, either via referral to the private clozapine clinic or to a GP. This was determined to be due to the fact that JJKD was attending the public clozapine clinic on a monthly basis independently, and therefore it wasn't thought to be necessary for a secondary review by a case manager to take place, despite failure to enact a formal discharge. Consequently, from April 2014 until 7 October 2015, JJKD was under the care of two treating teams simultaneously, which was highlighted by the review team as a systemic vulnerability for his care, as no shared care agreement between the two treating teams was available.

  As a result, the review team recommended that all community case managed consumers on clozapine are managed by the closest geographical community treating team until a time when they no longer require case management, and can then be formally referred and discharged to the private clozapine clinic, a private psychiatrist or a GP. Recent increases in the number of consultant psychiatrists within the community, new structures for prescribing clozapine in the public health service and changes to allow private consultant psychiatrists consumers and external follow-up.

  Concurrently, this recommendation will ensure that when clozapine therapy proves to be unsuccessful or not suitable, the consumer will continue to be managed by a multidisciplinary team, which is not available at the private clozapine clinic.

- HHS procedure: In accordance with the HHS *'Case management for Mental Health Services'* Procedure, the report felt that there was proactive follow-up of JJKD by the CCT case manager after the telephone calls made by his concerned family members. There was however uncertainly as to what extent this collateral information formed part of his overall risk assessment, as the review team considered that this was one of a number of potential warning signs for the consumer's deterioration. The investigation outlined: medication non-compliance (or at least suspected) as an early warning sign for his deterioration, in addition to the concerns expressed by his family members.

  Furthermore, two significant events were highlighted by the review team – firstly, the incident at McDonald's in December 2015 and his want to cease his disability pension and seek employment as mentioned on 23 December 2015, as each indicated deterioration in his judgment. The report felt that each of these factors warranted closer monitoring of JJKD than what had occurred as each identified a change in his health or presentation. According to the HHS *'Case Management for mental Health Services*' Procedure, a *'Clinical Case Review'* should be undertaken if a case manager identifies such a dramatic change in a consumer's health or presentation.

- CCT staffing: The review team determined that recurrently the CCT case manager's contact with JJKD did not align with planned case management in accordance with medical officer requests. This was of particular importance

following the medical review that occurred on 23 December 2015, whereby a one week CCT case management review was requested and did not occur.

CCT staffing was thought to have contributed to this lack of scheduled follow up, particularly as the scheduled review was between Christmas Day and New Year's Eve. During this time, 3 CCT staff members were on leave, which is usually only limited to 2 staff at any one time. As a consequence, JJKD's CCT case manager was expected, on top of his usual case load of 32 consumers, to additionally follow up colleague's complex consumers and administer scheduled depot injections.

- Manager workload: The CCT case manager had a workload of 32 consumers at the time of this clinical incident. The investigation ascertained that the average caseload for a case manager at another CCT within the same HHS was between 18 to 20 consumers, and for a senior clinician it was an average of 15. The review team considered that JJKD's CCT case manager was a senior clinician.

  The review team considered that a case load of 32 consumers was too excessive for effective case management to occur, and agreed that there should be some consistency for case load expectations across the multiple geographical locations for the CCT within the HHS. It was therefore recommended that there be a review of the current caseloads and workload for all CCT case managers to ensure that they can safely manage their consumers, and consider the introduction of case load parameters to ensure consistency amongst MH community teams across the HHS and to promote optimal consumer management.

- Caseload review: The review team considered the current caseload review process that was in place for case managers to support them in their role in the management of multiple complex consumers. The review team considered that closer supervision of workload and performance is required for all CCT case managers to support decision-making and reflection on professional practice. It was recommended that the introduction of a monthly random 5 chart audit undertaken by the CCT team leader and a CCT senior clinician that enables the monitoring of the quality of documentation and the compliance of scheduled reviews by case managers.

- Medical management: The review team expressed concern as to the repetitious documentation about JJKD's lack, or suspected lack, of compliance with his medication, and the lack of rationale for commencing the depot earlier in his treatment plan. The review team found that the management of JJKD's medications was suboptimal and should have involved an entire multi-disciplinary approach given the very nature of the medications involved, and a recommendation has been included to address this.

- Failure to recognise: The review team considered that there were a number of identified early warnings for JJKD that were either potentially not recognised or not acted upon by both the case manager and medical team. The incident at McDonalds was considered to have been a missed opportunity for increased surveillance or possible grounds for inpatient admission. Also on 23 December, it was documented that JJKD had indicated that he wanted to return to work and terminate his pension. This was considered by the review team to be another obvious sign of his mental health deterioration, although

were unable to conclusively determine by interview and review of the documentation, whether JJKD would have warranted admission.

The review team considered that both interactions provided evidence to support JJKD's deterioration in his mental health state and judgment, and therefore, given he had not been surfing for approximately 4 years, his decision to go surfing on 31 December 2015 was potentially a consequence of poor judgment precipitated by his deteriorating mental state.

- Care review & plan: In accordance with the HHS *'Case Management for Mental Health Services'* procedure, a *'Consumer Care Review Summary and Plan'* should be completed at least every 90 days. The investigation identified that a *'Consumer Care Review Summary and Plan'* for JJKD was completed on 24 April 2015 and then on 24 November 2015, leaving 7 months' gap, which meant that his case was not discussed by a multidisciplinary team for the same period.

  Two safety systems are in place to remind clinicians for when this summary is due or overdue for completion, an automated system alert in CIMHA and a generation of a monthly due and overdue report by an administration officer, which is distributed to CCT. The review team felt that compliance with these scheduled 3 monthly MDT process may have allowed for a more structured management of JJKD's medications.

  In November, when the *'Consumer Care Review Summary and Plan'* was completed, it was found to contain numerous inaccuracies. On review, it seems that the information in the 2014 review was transcribed into the November document, which was attributed to human error. As this was not normal practice for this to occur, no recommendation was made to address it.

- Family meeting: Members of the review team met with JJKD's mother on 17 February 2016, to allow her an opportunity for information gathering from the family's perspective. JJKD's mother expressed concerns about her son's care, particularly from the time of his suicide attempt (September 2015). In her opinion, she felt that there were numerous occasions from this time onwards when her son should have been admitted to hospital for inpatient mental health assessment and management, and was adamant that with inpatient management her son would still be alive. She expressed concern about his medication management, as well as occasions when she felt she wasn't being listened to after contacting MH services to express concerns about JJKD's deterioration.

Accordingly, the following contributing factor recommendations were made to address the issues identified:

I. Recommend that all public community case managed consumers on clozapine are managed by the geographical community treating team until a time when they no longer require case management. At this point, referral should be made for the consumer to transition to the private clozapine clinic.

This recommendation was made to recognise that the absence of a formal clinical handover process and shared clinical documentation between the CCT and clozapine clinic meant that JJKD was transitioned from clozapine by multiple medical practitioners resulting in fragmented clinical care. This led to

a delay in recognising and coordinating the management of his deteriorating mental state exemplified by non-compliance with medication and known illicit drug use.

II. *Recommend the introduction of a monthly random 5 chart audit undertaken by the CCT clinical lead and senior CCT clinician that enables the monitoring of the quality of documentation and the compliance of scheduled reviews by case managers. The actions arising from the random audit will be fed back to the relevant case manager on a one-on-one basis.*

The non-compliance with the structure of the case manager caseload review process meant that the frequency of CCT case management and subsequent consumer assessment was insufficient and not in alignment with the prescribed clinical management plan and HHS *'Case Management for Mental Health Services'* Procedure. This resulted in a delay in the recognition and coordinated management of the consumer's deterioration exemplified by a known episode of aggression, non-compliance with medication, known illicit drug use and concerns raised by his family members.

III. *Recommend review of the current caseloads and workload for all CCT case managers to ensure that they can safely manage their consumers, and consider the introduction of case load parameters to ensure standardisation amongst mental health community teams across the HHS and to promote optimal consumer management.*

The frequency of CCT case management and subsequent consumer assessment was insufficient and not in alignment with the prescribed clinical management plan and HHS *'Case Management for Mental Health Services*' Procedure. This resulted in a delay in recognition and coordinated management of the consumer's deterioration, exemplified by a known episode of aggression, non-compliance with medication, known illicit drug use and concerns raised by his family members. This meant that the consumer's intentionally unsafe act as a result of poor judgment and precipitated by a deteriorating mental state, may have contributed to the reasonably unexpected death of the 34-year-old consumer by drowning.

In relation to the implementation of the above recommendations by the HHS, the following actions were proposed:

I. <u>*Recommendation 1:*</u>

As of 12 June 2016, all consumers who are case managed are allocated a geographical consultant following a directive from the MHSS Clinical Director.

MHSS clozapine Administration Procedure (PRO0898) is currently being reviewed and updated to reflect the ongoing case management and discharge from the community. This updated draft procedure has been provided for consultation across the MHSS.

A copy of the proposed procedure includes specific provisions in relation to when and how a consumer should be referred to the private sector from CCT. It is noted that this should only be done through MDT case review after a consumer has reached stability for a reasonable period, are voluntary on

maintenance therapy with no case management needs. The clozapine nurse is to facilitate the transfer to the new centre. Case management support should also continue for a negotiated period to ensure that patient is successfully engaged with private clinic before closure to CCT. The transition plans are now to be recorded in CIMHA, and a discharge summary is to be completed once successfully engaged into the new clozapine centre.

Titration and monitoring of vital signs for consumers in relation to therapy interruptions are also specifically established. A consumer's suitability for community re-commencement is also outlined, which specifies that the treating team MUST discuss recommencement plans with the clozapine CNC prior to re-commencement in order to develop a treatment plan.

A mandatory auditing strategy is also set out.

II. *Recommendation 2:*

A standardised monthly case load review spreadsheet is currently being created. The monthly case load review that is to be established will include:

- Completion of the standardised case load review spreadsheet monthly with each clinician in a team; and

- Audit of a random clinical record from the clinician's case load.

The change in process and draft template was discussed at HHS's Community Team Leaders Meeting – Adult and Older Persons Mental Health on 1 August 2016, so as to seek further feedback and discuss the process for endorsement and implementation.

The draft documentation currently for review and consultation notes that the present proposal is to develop a standardised monthly Case Load Review process, which includes a template to be completed by the team leader with the clinician, and an audit of a random clinical record from the clinician's case load. The senior delegated officer to provide evidence of case load review undertaken monthly to the team leader. A file note is also to be kept if any issues arise in a case load review and management of the same as per usual process, which can be escalated to the Team Leader as appropriate.

III. *Recommendation 3:*

The MHSS intends to work through the Business Planning Framework tool, which is used to determine staffing resources, to manage activity. This is a lengthy process and has not been used in the community to date at the HHS or across Queensland.

There is no current State-wide benchmark in place regarding case management numbers. The current Queensland Health Community Care Team Model of Service discusses caseloads, the size of which is to be developed based upon consideration of a range of factors, including complexity of need, local population and demography, size of the team, he needs and function of the MH teams in the area, current position vacancies

and the skill mix of the team. The Queensland MHAOD Branch are in the process of reviewing this model of service.

In the meantime, modifications have been made to the HHS MHSS case load management and team review processes to improve efficiency and to provide more support and guidance for case managers. Team allocations have been reviewed and geographical teams increased from 3 to 5 teams to streamline the process and improve efficiency and communication.

Case management for Mental Health Services Procedure (PRO0897), which is forwarded to all MHSS, relates to the procedure for HHS community MH services to deliver a case management service. The procedure is intended to support a service delivery model that will aim to ensure that people with mental illness have timely access to the services they need, and are supported with opportunities for growth and recovery. It specifically sets out the case management service provision criteria and exit criteria. It also details the roles and responsibilities of case managers, which includes the need for care planning, crisis intervention, assertive follow-up, advocacy for the consumer and monitoring/review. Co-ordination of care and discharge planning is also specifically set out. Allocation of case management and caseload monitoring, as well as the Clinical Care Review Guidelines, are also established.

Recent advice received from the HHS confirms that all of the recommendations have now been implemented.

Conclusions

JJKD was 34 years of age when he drowned on 31 December 2015, after attempting to go surfing at the Spit during dangerous conditions.

Tragically, JJKD suffered from schizoaffective disorder, which caused him to have manic and depressive episodes, for which inpatient treatment had been required on a number of occasions. Unfortunately, it seems that management of his ongoing mental health condition was complex and, at times, resistant to various medications trialled.

Whilst I accept that the management of JJKD's condition was difficult, fragmentation in the care and treatment he received from public and private mental health services seems to have led to an inconsistent approach to his care and medication management. This in-turn contributed to the delay in acting upon indicators of JJKD's deteriorating mental state and judgment. This was particularly so following the incident at McDonald's in December shortly before his death, which exemplified the aggressive behaviour known to be a signal of his mental deterioration. Despite concerns raised by JJKD's family, his non-compliance with medication and a return to illicit drug use, relatively little action was taken to address and manage his declining condition.

I find that the RCA undertaken by the HHS following JJKD's death was comprehensive, and clearly identified each of the deficiencies evident in his management and treatment by the public mental health service. The findings made by the review team reflect the concerns raised by JJKD's mother in relation to the circumstances of her son's death, particularly the perceived inaction of CCT to appropriately respond to her concerns as to his deteriorating mental state, and the

unsuitable down-titration of his clozapine dosage. It seems that the review team agreed with her assertion that there were a number of occasions where consideration should have been given to admitting JJKD to an inpatient facility having recognised his worsening mental state. Issues as to caseloads and staffing also clearly played a pivotal role in the ability of CCT staff to properly respond to JJKD's needs, and provide optimal consumer management.

Unfortunately, it seems likely that JJKD's decision to go surfing in unsafe conditions on 31 December 2015, was as a result of his poor judgment precipitated by his deteriorating mental state. There is no evidence to suggest that he deliberately committed suicide.

I am satisfied that the recommendations and actions taken by the HHS following the RCA, sufficiently address the clinical concerns that arise in relation to the care and treatment provided to JJKD. As such, I am of the view that an inquest would not be in the public interest and the coronial investigation can be closed.

James McDougall
Coroner
CORONERS COURT OF QUEENSLAND
SOUTHERN REGION
17 August 2017