IN THE MAGISTRATES COURT OF QUEENSLAND AT CAIRNS

IN THE MATTER OF AN INQUEST INTO THE CAUSE AND CIRCUMSTANCES OF DEATH OF:

CHARLES EDWARD BARLOW

PATRICK DOUGLAS LUSK

AND

EMILY JANE BAGGOTT

Examination of Witnesses:	27th March 2006 – 30th March 2006 at Cooktown 31st March 2006 – 7th April 2006 at Cairns 14th August 2006 - 22nd August 2006 at Cairns
Final Written Submissions Received:	13th September 2006
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Findings Delivered At:	Cairns
Coroner:	Ms. Tina Previtera

TABLE OF CONTENTS

"EVERYTHING CHANGES SO THAT EVERYTHING CAN STAY THE SAME"[1]

PART A

INTRODUCTION

I have been humbled to have become involved in conducting an inquiry and inquest into the circumstances and causes of death of each of Charles Edward Barlow, Patrick Douglas Lusk and Emily Jane Baggott. The inquest has now concluded and it is incumbent upon me, pursuant to the provisions of the Coroners Act 2003, to deliver requisite findings in open court.

Charles Edward Barlow was a 36 year old indigenous man who had lived a troubled life in the indigenous community of Yarrabah in Far North Queensland. Yarrabah is also where he died, in February 2004. Charles was very close to, and supported by, his sister Mona Barlow, with whom he lived until his death by suicide.

Patrick Douglas Lusk was a 66 year old father of two young boys at the time of his death by suicide in Cooktown in April 2005. He was a friendly, music-loving taxi-driver who was well known and well-liked in the community of Cooktown and who loved his sons, the most important people in his life. Together with his former wife, Cheryl Prigg, with whom the boys lived, he supported the two boys.

Emily Jane Baggott was 16 years old at the time of her death in Kuranda in October 2005. Emily was a beautiful, athletic, model who was friendly towards everyone she met and whom everyone loved when they met her. One of her treating doctors described her as "a very delightful woman who dealt with difficult circumstances in a courageous and remarkable way."[2] At the time of her death, Emily was planning on undertaking study at TAFE and appeared in every way to be looking towards the future with her father Anthony Baggott and her step-mother Faye Allen, with whom she had only recently been re-united after a significant number of years.

It is worth repeating that each of these persons was much loved by their family and friends and had a great deal to offer them and their communities. They each also lived with a mental illness and had some sort of mental health intervention/contact in the days/hours before their suicide death. Patrick Lusk had actually been a hospital inpatient in Cooktown where he lived, in the 48 hours prior to his death; Charles Barlow was refused admission to a health service prior to his death (despite his repeated requests to be sent from Yarrabah, to the Cairns Base Hospital Mental Health Unit); and Emily Baggott had contact with the Child Youth Mental Health Service in Cairns the day before her death.

In all three cases, significant life events had affected them. Charles Barlow's mother had died when Charles was young, his father was murdered and he had lost two brothers to suicide deaths; Patrick Lusk was troubled by what he perceived were

[1] Translated from the French Proverb "Tout se meut rien ne change".
[2] Evidence of Dr. Graham Edward Blom, psychiatrist, Kempsey.

financial problems and Emily Baggott had been the subject of child protection notifications and had engaged in deliberate self-harm over a period of time.

In all three cases, there were significant relative carers who were not involved in providing collateral information about them to the mental health system, were not informed of their level of risk of suicide, were not provided with information as to the care required to minimise a suicide risk, or were not contacted at all.

Charles Barlow was an indigenous man who had significant mental health and other admissions since he was a child of 4 years of age. He had previously attempted suicide.

Patrick Lusk had been referred to the Cooktown hospital by his General Practitioner specifically for admission, treatment and opinion. He had also previously attempted suicide.

Emily Baggott had only been released from a mental health unit in Kempsey in late August 2005, where she had been an inpatient for a significant period as a result of self-harming behaviour, against a background of mental illness and her significant life issues.

In none of the three cases was the mental health system able to contain their respective suicide ideations[3].

This inquest has directed itself from the outset to finding out why. In doing so, the individual qualities and personalities of these three people and their importance to their families and communities has not been forgotten and if any meaningful change is to occur as a result of this inquiry, they must also not be forgotten by those who must be charged with ensuring that the circumstances leading to the deaths of these three people are not repeated.

The court accepts that the period of time which has elapsed since the deaths of Charles, Patrick and Emily has also taken its toll on the family and friends of each of them. I mention particularly the next of kin Cheryl Prigg, Anthony Baggott, Faye Allen, Katherine Gibson and Mona Barlow, all of whom have participated in the lengthy and distressing inquest process.

I would at this stage like to express again my sympathy and condolences and that of the court to each of them for their loss and thank them for their significant contributions to the inquest. I would also like to thank Sergeant Michelle Dodds, the investigating police officer, who undertook a thorough investigation, provided me with comprehensive reports and who has been available throughout the inquiry process to provide valuable assistance in every respect.

I would also like to thank Mr. John Tate, Counsel assisting the inquiry, for his excellent attention to and follow-up of the numerous and complex issues which arose during the course of the inquiry and, of course, during the formal hearings of the inquest. This is an area of ongoing significant public interest, and public and individual safety that, despite numerous previous inquests, inquiries, reports and recommendations, continues to be a source of tragedies for members of the community suffering a mental illness, their families and their friends.

[3] Refer to the report of Sergeant Michelle Dodds Exhibit 105.

All of the legal representatives appearing before the inquest have each cooperated to the fullest extent possible, recognising that the time has now come for the issue of mental illness to be treated with the serious attention it deserves.

My role as Coroner is to find, if possible, whether or not a death in fact happened[4] and

(a) who the deceased person is;
(b) how the person died;
(c) when the person died;
(d) where the person died; and
(e) what caused the person to die.[5]

I am not permitted to include in my findings any statement that a person is, or may be

(a) guilty of an offence; or
(b) civilly liable for something.[6]

I am permitted, however, to comment on anything connected with a death investigated at an inquest that relates to-

(a) public health or safety;
(b) the administration of justice; or
(c) ways to prevent deaths from happening in similar circumstances in the future.[7] I intend by these reasons to make comments and recommendations, but in so doing, I must not include in the comments any statement that a person is, or may be –
    (i) guilty of an offence; or
    (ii) civilly liable for something.[8]

If, from information obtained while investigating any of the deaths, I reasonably suspect a person has committed an offence, I must give information to –

(a) for an indictable offence – the Director of Public Prosecutions; or
(b) for any other offence – the Chief Executive of the department in which the legislation creating the offence is administered.[9]

I state at the outset that I do not intend, by my findings, or in any event, to provide information to any of the persons mentioned above in relation to the commission of any offence/s by any person in relation to any of the deaths investigated.

Pursuant to the Coroners Act 2003, I may give information about a person's conduct in a profession or trade, obtained while investigating a death, to a disciplinary body for the person's profession or trade if I reasonably believe the information might cause the body to inquire into, or take steps in relation to, the conduct.[10] I intend to expand upon this issue when discussing in further detail, in relation to the death of

[4] S.45(1) Coroners Act 2003.
[5] S.45(2) Coroners Act 2003.
[6] S. 45(5) Coroners Act 2003.
[7] S.46 Coroners Act 2003.
[8] S. 46(3) Coroners Act 2003.
[9] S.48(2) Coroners Act 2003.
[10] S.48(4) Coroners Act 2003.

Patrick Lusk, whether or not Dr. Errol Van Rensburg, should be referred to the Medical Board of Queensland.

Throughout the Inquest I have been mindful of the observations of Toohey J in *Annetts v. McCann*[11] concerning the words of Lord Lane that *"…an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. .. It is an inquisitorial process, a process of investigation unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use"*.

Unfortunately, throughout the inquest, the evidence relating to the significant body of mental health policy that has been developed nationally and in Queensland over the last seventeen (17) years, crucial strategies of which remain to be implemented, gave this court cause to be reminded of a French proverb the translation of which means *"Everything keeps changing so that everything can stay the same*". [12]

SCOPE OF THE INQUEST

The inquest received into evidence 201 Exhibits (some comprising multiple documents) including; statements from numerous witnesses to the events surrounding the deaths, or otherwise involved in the care of Patrick, Charles and Emily; voluminous medical records relating to each of Patrick, Charles and Emily; Queensland Health guideline documents, directives, hospital/departmental policies/procedures, manuals, memoranda, reviews, reports (including sentinel event reports); medical articles/texts, National and State mental health standards/plans/strategies and other numerous relevant documents.[13]

These additional documents included submissions, not only from numerous medical and allied health professionals involved in the events surrounding the deaths, or otherwise employed at the respective mental health facilities, but other persons and organisations seeking that immediate and urgent attention be given to the need to implement change in the delivery of mental health services to the Queensland community so as to reduce the numbers of suicide deaths.[14]

The inquest also heard oral evidence from a large number of witnesses who provided statements, and from additional witnesses, not only in relation to the particular circumstances relevant to Patrick's, Charles' and Emily's deaths, but also in relation to the history of the delivery of mental health services in Queensland and the areas of Cairns, Yarrabah and Cooktown in particular.

The intention of the inquiry at the outset was to attempt to provide answers for the families of Patrick, Charles and Emily and also to attempt to address any failures of

[11] *Annetts v. McCann* 65 ALJR 167 at175.
[12] *"Tout se meut rien ne change"*
[13] See Attached Exhibit List – Annexure A.
[14] Exhibit. 195- submission of Dr. Simon Bridge, General Practitioner, Cairns;. Exhibit 196 – Report of Dr. Philip Morris, Gold Coast Institute of Mental Health; Exhibit 197 – Submission of White Wreath Association Ltd.

the system in relation to their deaths, so as to spare as few people and their families as possible from the grief and loss associated with deaths of this kind.

As a result, Counsel assisting, Mr. Tate, marshalled together a significant group of the most highly respected, qualified and/or experienced expert professionals in the areas of mental health clinical decision-making, clinical governance, strategic/policy and planning/reform and mental health service delivery issues generally.

These expert witnesses included the following:

1. The court-appointed expert psychiatrist Dr. William John Kingswell,[15] who provided three (3) separate reports in relation to each of the deaths,[16] which reports attached relevant Clinical Practice Guidelines of the Royal Australian and New Zealand College of Psychiatrists.[17]

2. Professor Ernest Hunter, Specialist Regional Psychiatrist, Rural and Remote Psychiatry for Aboriginal communities, Queensland Health,[18] who provided a report into the death of Charles Barlow,[19] a report containing a synthesis of recommendations arising from this and other inquiries held in North Queensland;[20] research studies documents relevant to the issues surrounding Mr. Barlow's death,[21] and Protocols for the Delivery of Mental Health Services in Far North Queensland Indigenous communities: Guidelines for Health Workers, Clinicians, Consumers and Carers.[22]

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[15] Director of Psychiatry for the Gold Coast Regional Mental Health Services; Chair of the Southern Area Mental Health Services Network; previous Director of the Park Centre for Mental Health (with 20 years experience working within Queensland Health); Senior Lecturer University of Queensland; Examiner for the College of Psychiatrists and an expert medical witness in previous coronial enquiries.

[16] Exhibit 151 – Report of Dr. Kingswell in the matter of Charles Edward Barlow, dated 8th August 2006; Exhibit 163 – Report of Dr. Kingswell in the matter of Patrick Douglas Lusk, dated 8th August 2006; Exhibit 172 - Report of Dr. Kingswell in the matter of Emily Jane Baggott, dated 8th August 2006.

[17] Exhibits 110 and 111 – Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines for the treatment of depression and the management of adult deliberate self-harm, respectively. Also attached to the Report of Charles Edward Barlow, the Royal Australian and New Zealand College of Psychiatrists clinical practice guidelines for the treatment of schizophrenia and related disorders received 21 May 2004, accepted 26th August 2004.

[18] Dr. Hunter is also Adjunct Professor, School of Population Health, University of Queensland. Professor Hunter is Fellow of the RANZCP Faculty of Child Psychiatry, a Diplomate of the American Board of Psychiatry and Neurology. He also holds the following qualifications: MBBS (University of WA); MA (University of Hawaii); Master of Public Health (University of Hawaii);Doctorate in Medicine (University of NSW); and is a Fellow of the ANZ College of Public Health Medicine. Professor Hunter's area of expertise is that of remote indigenous mental health and hence the court's request for his involvement and contribution to the inquiry. He has undertaken research into suicide deaths occurring in the remote aboriginal and Torres Strait islands over a 14 year period.

[19] Exhibit 148.

[20] Exhibit 198

[19] Exhibits 148 and 149 - An Analysis of Suicide in Indigenous Communities of North QLD – The Historical Cultural and Symbolic Landscape – Ernest Hunter, Joseph Reser, Mercy Baird, Paul Reser May 1999Australian Institute Aboriginal and Torres Strait Islander Studies, Research Discussion Paper – "Back to Redfern – Autonomy and the 'Middle E' in relation to Aboriginal Health, Dr. Ernest Hunter, No. 18 July 2006

[22] Exhibit 199.

3. Dr. Aaron Groves, Director of Mental Health, Queensland, who prepared a submission in relation to state-wide policy and system development strategies and developments in relation to same;[23] and crucially spoke at length to it, **the National Mental Health Strategy** and the **"National safety priorities in mental health: a national plan for reducing harm**"[24] Dr. Groves is a member of the important Safety and Quality Partnership /Group of the National Mental Health Working Group in the formulation of the **"National safety priorities in mental health: a national plan for reducing harm"** and has held significant and senior positions in mental health, and on committees advising on mental health, throughout Australia, since 1991.[25]

4. In addition, the Public Advocate, Ms. Michelle Howard successfully applied to intervene in the proceedings as a party with a sufficient interest in the subject-matter of the inquiry. The Office of the Public Advocate,[26] amongst other responsibilities, promotes, monitors and reviews the provision of services and facilities to adults who have impaired decision-making ability[27], including people with an illness/psychiatric disability. Ms. Howard's office prepared a significant and very comprehensive Issues Paper[28] and a Summary of Recommendations to be considered by this court.[29]

The court commends each of the above-mentioned reports to the reader, particularly to those persons within Queensland Health who will be charged with the responsibility of considering the recommendations arising from this inquest, the end result of which is intended to ensure that good mental health policy, already developed and developing, is implemented as a priority so as to meaningfully assist those who suffer from a mental illness and/or are a suicide risk, so as to reduce the numbers of suicide deaths.

The court was also assisted by evidence from medical and nursing personnel based in Cairns and familiar with the historical struggle for the delivery of services to that region, which includes the communities of Cooktown and Yarrabah. Those witnesses included:

1. Mr. Andrew Prentice Brownlie, Assistant Director of Nursing for Cairns Integrated Mental Health Service.
2. Dr. Richard Walter Streatfield, Acting Executive Director of Medical Services, Cairns Health Service District.

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[23] Exhibit 104- Submission of Director of Mental Health, dated 27th March 2006.
[24] Exhibit 185.
[25] Director of Psychiatric Emergency Team, WA; Director of the Psychiatric training program in Western Australia, Deputy Chief Psychiatrist, Western Australia; Director Metropolitan Mental Health Service, Western Australia; Chief Psychiatrist and Director of Mental health, Western Australia; member Board of practice standards of the College of Psychiatrists; Member of ethics committee of the College of Psychiatrists; Member, Examinations Committee of the College of Psychiatrists; Member and Deputy Chair of the National Mental Health Working Group; Chair, National Mental Health Information Strategy committee and Chair, safety and Quality group of National Mental Health Working Group; Chair of the Queensland Government Suicide Prevention Strategy.
[26] It was created under the Guardianship and Administration Act 2000 (QLD).
[27] Exhibit 154 Issues paper of the Office of the Public Advocate – Queensland at page 1 referring to the *Guardianship and Administration Act 2000* (Qld), Chapter 9
[28] Exhibit 154
[29] Exhibit 186.

3. Dr. Jillian Mary Newland, Director of Clinical Support, Northern Area Health Service.
4. Dr. Janet Susan Bayley, Clinical Director, Cairns Integrated Mental Health Service.
5. Dr. Roy West, Consultant Psychiatrist and member of the Sentinel Event Team which reviewed the death of Mr. Lusk. Dr. West also provided a report.[30]

The seriousness with which these persons, and by implication, Queensland Health, treated the proceedings was confirmed by the presence, throughout the entirety of the evidence, of at least one or more executive members and medical specialists of the Cairns District Health Service and the patient safety centre, and included Dr. Jill Newland, Dr. Janet Bayley, Dr. Roy West, Ms. Judy Skalicky, Dr. Streatfield and Mr. Freele. Dr. Kingswell also travelled to Cooktown to hear and observe the evidence of crucial medical witnesses in the matter of Patrick Douglas Lusk, and together with Dr. Aaron Groves, was present during significant portions of the evidence taken in Cairns.

I also had an opportunity, together with my Assistant Mr. Tate and the relevant legal representatives and certain of the interested parties involved, to view the premises of the Community Health Centre in Cooktown, the Cooktown Hospital, and the Community Health Centre in Yarrabah as well as the site where Mr. Barlow took his life.

BACKGROUND INFORMATION IN RELATION TO THE DELIVERY OF MENTAL HEALTH SERVICES IN QUEENSLAND

Prior to the deaths of Charles Barlow, Patrick Lusk and Emily Baggott, significant mental health policy had already been developed in relation to issues relevant to the delivery of mental health services to persons suffering a mental health disorder and treated either as an inpatient upon referral from a general practitioner, or in the community.

Indeed, a number of significant events have occurred in Queensland and nationally in relation to mental health issues since 1990.

1. In 1990, the Burdekin Inquiry**,** a national inquiry into the Human Rights of People with Mental Illness was commenced. It was instigated when research confirmed a failure in the protection and provision of appropriate care for those affected by psychiatric disorders, such that human rights of individuals affected by mental illness were either being ignored, eroded or seriously violated. The Burdekin Inquiry Report ultimately identified serious neglect of persons affected by mental illness as a result of violations of their most fundamental rights. Recommendations to the States of Australia included:

    - Health departments should ensure an adequate number of trained psychiatric emergency or crisis teams – on call for 24 hours / 7 days a week – in each health region in Australia. In areas where this is impracticable because of distance or small population, alternative

[30] Report, Dr. Roy West – Exhibit 190.

mechanisms should be established using, for example, local general hospital staff, a GP or a community nurse, with telephone access to a consultant psychiatrist.

- Where a mentally disturbed or distressed person seeks admission to an inpatient psychiatric facility but does not appear to meet admission criteria, they should be afforded 'asylum' for one night, or, at the very least, referred to mental health personnel or an appropriate agency which can provide immediate support. I**n no circumstance, should individuals be turned away without any assistance.**[31]

2. In 1992, as a result of the Burdekin Inquiry, all Australian Health Ministers agreed to a National Mental Health Strategy, which represented an attempt to coordinate mental health care reform at a national level. Its priority areas included consumer rights, the relationship between mental health services and the general health sector, promotion and prevention, carers, monitoring and accountability.

3. In 1996, a 10 Year Mental Health Strategy for Queensland was formulated.

4. Also in 1996, National Standards for Mental Health Services were endorsed by the Australian Health Ministers' Advisory Council.[32] These standards included standards in relation to safety,[33] consumer and carer participation,[34] privacy and confidentiality,[35] prevention and mental health promotion,[36] cultural awareness,[37] integration,[38] assessment and review,[39] treatment and support,[40] community living,[41] inpatient care,[42] and planning for Exit.[43]

5. In 1998, the 2nd National Mental Health Plan in Australia was implemented. Among its many recommendations, it highlighted the need to improve partnerships between general practitioners and mental health services.[44] As a consequence, the Royal Australian and New Zealand College of Psychiatrists (RANZCP) developed the Referred Patient Assessment and Management Plan Guidelines for use between general practitioners and mental health services. [45] It also published a position statement *"The Role of GPs in the Delivery of Mental Health Services to the Australian Community".*[46]

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[31] Taken from references in the report of Sergeant Michelle Dodds, Exhibit 105.
[32] Exhibit 154 Issues Paper of the Office of the Public Advocate, Appendix 1.
[33] Standard 2.
[34] Standard 3.
[35] Standard 5.
[36] Standard 6.
[37] Standard 7.
[38] Standard 8.
[39] Standard 11.3
[40] Standard 11.4
[41] Standard 11.4A.
[42] Standard11.4E.
[43] Standard 11.5.
[44] Appendix A-6 of Exhibit 154.
[45] Appendix A-6 Exhibit 154.
[46] Appendix A-6 Exhibit 154.

6. Deaths by suicide continued to occur, with 1554 deaths by suicide occurring in Queensland between 1999 and 2001.[47]

7. In 2002, following an external review of forensic mental health services in Queensland it was recommended within Queensland Health *"That greater uniformity be encouraged in risk assessment and management strategies across the forensic and general mental health services,"*[48] as a result of which a Risk Assessment check list[49] and a Risk Assessment Tool[50] were developed by Queensland Health. The memoranda distributing these tools advised that the use of risk screening questions should be incorporated into a policy which outlines the framework for risk assessment, management, and documentation by each mental health service; that this information should be included as a routine component of staff orientation and that this information should be communicated between services when making referrals. Brief guidelines for using the risk screening questions were also distributed, which guidelines make it very clear that the screening questions are not a checklist, but a starting point for determining the need for more comprehensive assessment.[51] Finally, it was stated that *"More comprehensive risk management training will be provided across the state in 2003."*[52]

8. Also in 2002, the Queensland Government implemented a Suicide Prevention Strategy 2003-2008 specifically to reduce the rate of suicides in Queensland. At that time, Queensland had a suicide rate consistently greater than the national average.[53]

9. Responding to that strategy, Queensland Health produced guidelines for the management of patients with suicidal behaviour or risk, the over-arching principles of which included:

- Clinicians should involve the family or support people of the suicidal person wherever possible
- All patients should receive a comprehensive mental health and risk assessment
- Assessment should be seen as a process and not a one-off event
- The right of confidentiality is not absolute and rights of confidentiality are not intended to compromise the quality of clinical care[54]
- Documentation must be made of the formal assessment and include a clear description of all clinical decisions and the reasons for these decisions
- If a staff member is in doubt about the potential for suicide, they must first ensure the patient's safety and then consult a more experienced colleague

[47] See Exhibit 105, the Report of Sergeant Dodds.
[48] Exhibit 202 Memorandum Peggy Brown, Director of Mental Health dated 30th September 2002
[49] Exhibit 202
[50] Exhibit 112.
[51] Numerous other departmental and RANZCP guidelines/texts make it clear also that screening questions and check lists are not a replacement for clinical judgement. See exhibits 101 and 117.
[52] Exhibit 202 above.
[53] Exhibit 117 – Guidelines for the management of patients with suicidal behaviour or risk.Paragraph 3.
[54] Exhibit 117 at page 4.

- Hospital protocols should specify lines of responsibility and how to access senior medical clinicians for assessment, second opinions, and treatment planning
- A contract by a patient not to harm him/herself may provide a false sense of security rather than representing a genuine commitment not to self-harm by the patient
- Suicide prevention contracts are not recommended for use in emergency settings or with newly admitted or unknown patients.
- Discharge and follow-up protocols.[55]

11. Also in 2002, the Mullen-Chettleburgh Review[56] enquired into the delivery of forensic mental health services in Queensland and made a number of recommendations in relation to the provision of training in the management of risk, including the risk of suicide. Recommendations included that Queensland continue to emphasis education and training of staff in risk management;[57]that greater uniformity be encouraged in risk assessment and management strategies across the forensic and general mental health services;[58] and that a multi-disciplinary approach to risk management be given real effect in clinical practice.[59]

12. In 2002, the Mental Health Council of Australia released its Not For Service Report into Mental Health.[60]

13. In August 2002, Queensland Health reviewed the Service Eligibility Intake and Referral Procedure-Child Youth Mental Health Services to provide equitable and consistent intake criteria which would ensure appropriate access to Cairns Child and Youth Mental Health Services for children and young people. Significant supporting policy drove the process.[61]

14. In September 2002, the Australian Health Minister's Advisory Council National Mental Health Working Group endorsed the National Practice Standards for the Mental Health Workforce**.**[62] These standards included standards for safety and privacy,[63] consumer and carer participation,[64] promotion and prevention,[65] early detection and intervention,[66] assessment, treatment, relapse prevention and

[55] The strategy was informed by QGYSPS recommendations for the development of a 5 years strategic plan; National and State Suicide Prevention Strategies and Initiatives; Risk Factors for Suicide and Suicide attempts (Cth 2000) and Pathways to Suicide (Cth 2000). Exhibit 154 – Issues Paper of the Public Advocate Volume 2 of Referenced Papers and Dcouments.
[56] Mullen,P.E & Chettleburgh,K (2002) Review of Queensland forensic mental health services.
[57] Recommendation 36.
[58] Recommendation 37.
[59] Recommendation 38.
[60] Mental Health Council of Australia
[61] Exhibit 101. National Standards for Mental Health Service Delivery.
[62] Exhibit 154 Issues Paper of the Office of the Public Advocate, Appendix 1.
[63] Standard 1.
[64] Standard 2.
[65] Standard 4.
[66] Standard 6.

support,[67] service planning, integration and support,[68] and documentation and information systems.[69] No jurisdiction has, however, implemented them.[70]

15. The National Mental Health Strategy and National Mental Health Plan 2003-08 have identified that reforms relating to improving access to mental health services for Indigenous people should be aligned with the Social and Emotional Well Being framework developed by the National Mental Health Working Group and the National Aboriginal and Torres Strait Islander Health Council.[71]

16. In March 2003, Queensland Health, in response to the Mullen-Chettleburgh Review, commissioned the State-wide Clinical Risk Assessment and Management Training Project to develop a training package in risk management to be provided to district clinicians across Queensland. That package was called Clinical Risk Assessment and Management – A Guide to Clinical Risk Assessment and Management for Violence, Suicide and Absence without Permission[72]. This document outlines various risk factors for suicide.[73]

17. Also in March 2003, an Evaluation of the 2nd National Mental Health Plan was prepared for the Australian Health Ministers' Advisory Council. The report summarised international commentary, national community consultations, the Mental Health Report of 2002 and a review of Mental Health in the Australian Health Care Agreements undertaken by an expert reference group.[74]

18. In September 2003, the State-wide Clinical Risk Assessment and Management Training Project-Mental Health Report[75] of the training package referred to in 7 above stated that the objectives included;

- Determining that all districts have incorporated the risk screening questions into their processes
- Reviewing the utility and usage of the questions
- Allocating key clinicians to ongoing training and education in clinical risk assessment
- Providing training boosters for experienced and/or trained clinicians
- Providing extension training for non-mental health clinicians, particularly in rural and remote areas
- Targeting the under-representation of medical staff in training.
- Furthermore, it reported that "*while training packages inevitably become dated, it is often the case that they expire long before their used by date as little is put in*

[67] Standard 7.
[68] Standard 9.
[69] Standard 10.
[70] Evidence of Dr. Aaron Groves, Director of Mental Health, Queensland.
[71] Exhibit 154 - Issues paper of the Office of the Public Advocate – Queensland at page 16 acknowledging the information is from Hon. Terry Roberts, SA Minister for Aboriginal Affairs, 13 November 2003, L*aunch of 'better medication management for aboriginal people with mental health disorders'*. at www.health.gov.au/internet/wcms/publishing.nsf/Content/health-mediarel-yr2003-tw-twsp1 downloaded 4 August 2006.
[72] See Exhibit 105 Report of Sergeant Michelle Dodds.
[73] Appendix F.
[74] Exhibit 154. Volume 2 of Referenced documents and papers to the Issues Paper of the Public Advocate.
[75] Exhibit 117.

place to ensure that they continue to be used. The production of comprehensive multi-media training materials plus support from the community Forensic Mental Health Service and the State-wide Forensic Network will ensure that this risk is ameliorated."

19. Surprisingly and alarmingly, however, the report concluded that the project had met its outlined objectives and expected outcomes. *"The overwhelmingly positive evaluations of the training provide support for the objective of increasing the knowledge and skill level of mental health clinicians in risk assessment and intervention. Quality-training materials have been developed and disseminated to district mental health services to facilitate the continuation of training in district mental health services with the support of Community Forensic Mental Health Services. ..Finally, the project has promoted a more uniform approach to assessment and management of risk across mental health services in Queensland."*[76]

20. In 2003 Queensland Health and the Royal Flying Doctor Service published a Primary Clinical Care Manual which clearly sets out in Section 3, Mental Health, [77]a detailed list of issues to be addressed when assessing an individual for the first time; how the information can be gathered; what steps need to be taken; observations to be made; questions to be asked; assessment questionnaires available; decision trees; management information; referral criteria; follow up strategies and much more clinical information and guidance. *"Sometimes it is not possible to organise an immediate assessment with a mental health specialist. For this reason it is important for the primary care health worker to be able to carry out their own assessment of the individual so as to determine the severity and nature of the individual's problems and the risk of danger to self or others. .."*[78]

21. The evidence of the Director of Mental Health was that "*All Queensland Health staff working in rural and remote ambulatory care settings are required to adopt the health management protocols contained in the Manual as their guide to best practice. Section 3 of the Manual is dedicated to Mental Health and Substance Misuse. The Section is 50 pages long, and covers topics including 'Assessment of Mental Health Problems; and Management of Suicidal Behaviour or Risk'.*[79]

22. Drs. Kingswell and West opined that all doctors, as a basic competency, are trained, are expected and should be able to conduct a mental health assessment which includes a mental state examination and risk assessment, whatever their position within the health system and whatever the presentation of the patient.

23. In February 2004, the Director-General of Queensland Health established a committee to undertake the Queensland Review of Fatal Mental Health Sentinel Events. The 45 deaths examined included suicides and unexpected deaths of people receiving mental health assessment or treatment in acute inpatient units.

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[76] Exhibit 117 at page 21.
[77] Pages 293-328
[78] Exhibit 102 page 293.
[79] Exhibit 104 Submission of the Director of Mental Health, page 13.

24. Also in February 2004, Charles Edward Barlow, an indigenous man of 36 years of age, died in the indigenous community of Yarrabah in North Queensland, having been refused a request for admission to Cairns Base Hospital Mental Health Unit.

25. In March 2004, the Queensland Health document, ***"Guidelines for the management of patients with suicidal behaviour or risk***"[80] was reviewed, the aim being to ***"to provide state-wide guidelines for the management of people assessed to be at risk of suicide presenting to hospital and mental health services".*** The results were formulated by reference to policies and procedures developed over a four year period. [81]

26. It was made quite clear in that review that a comprehensive assessment of suicide behaviour or risk integrates all available information, including interview(s) with the patient, observation of the patient, collateral information from the family, carers and other involved parties and medical records. It also repeated that "*Documentation must be made of the formal assessment and include a clear description of all clinical decision and the reason for these decisions"*[82].

27. On 21 May 2003, the Royal Australian and New Zealand College of Psychiatrists, funded under the Australian National Mental Health Strategy and the New Zealand Health Funding Authority, published Clinical Practice Guidelines for the management of adult deliberate self-harm.[83]

28. On 30th March 2004, the Royal Australian and New Zealand College of Psychiatrists, funded under the Australian National Mental Health Strategy and the New Zealand Ministry of Health, published Clinical Practice Guidelines for Depression.[84]

29. On 26th August 2004, the Royal Australian and New Zealand College of Psychiatrists, funded under the Australian National Mental Health Strategy and the New Zealand Health Funding Authority, published Clinical Practice Guidelines for the Treatment of Schizophrenia and Related Disorders.[85]

30. In its Annual Report to the Queensland Parliament in 2003-04, the Office of the Public Advocate made the following recommendations in relation to the delivery of mental health services in Queensland:

- There should be a system for independent and public reporting of mental health deaths, as occurs in other jurisdictions.
- This reporting should include not only deaths that occur while a person is an inpatient, but suicide deaths that also occur while a person is receiving treatment

[80] Exhibit 117
[81] The Logan-Beaudesert District Health Service Suicidality Assessment Policy and procedure of **2000**; the Royal Brisbane Hospital Division of Mental Health Services patient discharge policy, March **2003**; the Integrated Mental health Services "Point in Suicide Risk Assessment revised **28/1/04**; and the North Burnett Health Service District Suicide Risk Assessment Policy.
[82] Exhibit 117 page 10.
[83] Exhibit 111.
[84] Exhibit 110.
[85] Attachment to the report of Dr. Kingswell in the matter of Charles Edward Barlow.

as a patient in the community, or after the person has been refused admission/treatment by a health service (i.e. after contact with a health service).

- Queensland should adopt the Australian Council for Safety and Quality in Health Care's "Open Disclosure" standard, in relation to open communication by hospitals following the death of a patient.
- Queensland's Suicide Prevention Strategy, endorsed in 2003, should mandate specific actions aimed at decreasing the suicide rate of mental health patients.
- District mental health services should adhere to the National Standards for mental health service on discharge planning. Under the Standards, there are nine specific criteria for discharge planning.[86]
- Where mental health deaths do occur, there should be a sentinel report investigation and a root cause analysis.
- That in all of the above recommendations, the focus should be on "creating a learning culture within the mental health system, embedded within a no-blame environment"[87].

31. In September 2004 the National Institute of Clinical Studies (NICS) launched the Emergency Care Mental Health Interface Initiative.[88]

32. In December 2004, the medical journal, Australasian Psychiatry,[89] published a clinical psychiatry article *"Changeability, confidence, commonsense and corroboration: comprehensive suicide risk assessment"*[90]in which the authors developed the subject assessment framework. The paper was significantly researched and Dr. Kingswell spoke to it during his evidence, commending it as a significant work.

33. In March 2005, the Report "Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events"[91] was submitted to the Director-General, Queensland Health. There were 60 Recommendations, including the following 9 key recommendations;

- Develop core state-wide standardised processes for mental health assessment, risk assessment and treatment accompanied by appropriate education and training. Particular attention should be given to addressing non-compliance with treatment.
- Give high priority to developing an information system to ensure the access of emergency department and mental health staff across health service districts to timely, accurate clinical information.
- Transfer the responsibility for alcohol and drug treatment services to mental health services.

[86] Refer to Appendix 3 of the Issues Paper of the Office of the Public Advocate – Exhibit 154.
[87] See Exhibit 154- The Issues Paper of the Public Advocate.
[88] Exhibit 104 page 12.
[89] Volume 12, No.4
[90] Authors Nick O'Connor, Monica Warby, Beverley Raphael and Tony Vassallo.
[91] Exhibit 179

- Explore alternative models for the delivery of emergency mental health assessment and treatment to clients with mental health problems currently presenting to emergency departments.
- Develop models for continuing support of general practitioners when patients with major mental illness are discharged from mental health services to their care.
- Remove potential means of suicide wherever possible by implementing searching procedures in accordance with the Mental Health Act 2000 and correcting potential structural factors in all inpatient mental health units and their immediate environment.
- Establish an ongoing process for monitoring the results of analyses of mental health sentinel events at the corporate level to determine trends and communicate these to the services.
- Accelerate the implementation of the 10 Year Mental Health Strategy for Queensland, 1996 in relation to staffing and bed resources. Particular emphasis should be given to recruitment and retention of clinical staff and provision of acute inpatient beds, complemented by access to additional secure beds and supported accommodation, in areas of high morbidity and high growth.
- Provide standardised competency training for staff who perform functions under the Mental Health Act 2000 with particular emphasis on management of forensic order patients (including persons of special notification), and liaise with the Mental Health Review Tribunal regarding the conditions of limited community treatment for patients under the Mental Health Act 2000.

34. The Report highlighted the significant issues facing mental health services, including the increasing level of acuity of mental health patients with high levels of co-morbid drug and alcohol abuse, and low numbers of skilled staff, particularly in inpatient units and in high growth, low socio-economic districts.

35. "It is the decision-making, which may have appeared reasonable at a given time but which, in retrospect, comprised errors of judgement, with which the Review was concerned, with a view to highlighting systemic issues which appear to be common to the cases investigated"[92]

36. In April 2005, Patrick Douglas Lusk, a 66 year old father of two young boys died less than 48 hours after discharge from the Cooktown hospital.

37. In its Annual Report to the Queensland Parliament in 2004-05, the Office of the Public Advocate repeated its recommendations made in 2003-04 in relation to the delivery of mental health services in Queensland.

38. In July 2005, implementation of the recommendations of the Achieving Balance report began. This is expected to continue until December 2009. Dr. Aaron Groves chairs, as Director of Mental Health, a steering committee to oversee the implementation, and a three (3) member Sentinel Events Implementation Secretariat has been established to provide support to the Steering Committee.

[92] Exhhibit 117

39. In each of October 2005, March 2006 and July 2006, updates of the Implementation of the Achieving Balance Report were published.[93] Update No.1 of October 2005 indicated that a comprehensive review estimated that the suicide rate for individuals with serious mental illness is 7-10 times that in the general population. Update No. 2 of March 2006 [94] indicated that districts have been requested to provide current relevant documentation in relation to risk assessment; and that a state-wide information system is being investigated. Update No. 3 of July 2006[95] indicated that yet another analysis of clinical forms, risk assessment and intake/triage/initial/comprehensive assessment is taking place. *"Risk assessment will not be solely a tick and flick approach, but will record clinical decision making and force analysis of data and use of clinical judgement."*[96] Support has been given to an integrated service model in smaller, rural and remote services; and enhanced capacity to provide community-based triage, assessment and brief treatment components of emergency mental health services up to 7 days per week. Positions of General Practice Liaison Officer will be created. There are no timeframes stipulated, however, within which the policy objectives are to be achieved.

40. A number of significant recommendations have also been made by Coroners conducting inquests into other suicide deaths.[97] Deputy State Coroner Christine Clements, in her recommendations arising from the Inquest into the death of Philip John Boadle in August 2004[98] recommended that *"all patient notes and records for people being treated in the community be integrated so that hospital records incorporate consultation notes regarding the patient from community mental health and outreach/after hour's services".* She repeated the recommendation in the Inquest into the death of Bo Roland Amalm in December 2004.

41. Coroner Annette Hennessy, in her recommendations arising from the Inquest into the death of Jye Perry recommended in November 2005 that *"Qld Health progress as soon as possible a mental health information system that interfaces with the Emergency Department Information System to allow sufficient access for staff to both a person's mental health records and health records, particularly the person's status under the Act and any flags in relation to treatment plans and condition in order to allow for appropriate and effective treatment of the person's presenting issues, based on accurate and complete medical and psychiatric information"*[99]

42. Coroner Annette Hennessy further recommended that *"Queensland Health review and implement changes to the present confidentiality provisions to ensure that confidentiality of the person receiving treatment is balanced with the rights of the*

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[93] Exhibit 180.
[94] Exhibit 180 March 2006 page 2.
[95] Exhibit 180
[96] Exhibit 180.
[97] Inquest into the death of Jye Conrad Perry (a child), findings delivered 16th November 2005, Exhibit 178; Inquest into the cause and circumstances of Vivian Margaret Crane 28th October 2004 as referred to in the report of Dr. Kingswell in the matter of Patrick Douglas Lusk.
[98] See the report of Dr. Kingswell in the matter of Patrick Douglas Lusk.
[99] Recommendation No. 1 of Coroner Annette Hennessy's findings dated 16th November 2005.

public to protection against the risk of harm, including the persons who have responsibility to care for and support the person and other members of the household, in particular, that there be sufficient provision in the Health Services Act to provide for mental health staff sharing information regarding the patient with key people in certain circumstances".

43. There are numerous other coronial inquiries which have also dealt with the issue of suicide deaths, the findings and recommendations from which are available from the State Coroner's website.

44. In October 2005, the Australian Health Ministers' Advisory Council endorsed the "National safety priorities in mental health: a national plan for reducing harm".[100] It contains significant relevant principles,[101] and discusses the importance of clinical governance**,** clinical audit and leadership.[102] *"..clinical governance is essential to improving quality and safety. Good clinical governance implies that there are well articulated processes for clinical performance and evaluation,* ***clinical risk management*****,** **clinical audit**, *ongoing professional development, and full consumer and carer participation in quality improvement processes. Failure of a system to react appropriately to adverse events often points to inadequacies of leadership and accountability, and in particular to a lack of clarity about reporting processes"*[103]

45. The above plan also highlights priority areas, including reducing suicide and deliberate self-harm in mental health services and related health service settings.[104] The following strategies are stated:

- "Identify and disseminate good practice in suicide risk assessment and management, and review existing protocols and clinical guidelines of mental health services and related health services. This will include examining good discharge planning, risk assessment, and outcomes measurement. This will include consideration of variations in good practice related to particular settings, eg child and adolescent mental health services.
- Identify good practice services/leaders and facilitate their role in influencing clinical and service management change system-wide.
- Implement and use incident monitoring and management systems for monitoring instances of deliberate self-harm, suicide attempts and suicides.
- If a sentinel event of 'suicide in an inpatient unit' occurs ensure that the relevant service policy on open disclosure is followed and post suicide bereavement information resources are available to families and significant others. Ensure appropriate processes are in place to support staff.
- Investigate, using tools such as root cause analysis, all suicides that occur whilst consumers are in the care of hospitals (mental health services and other parts of the hospital) and community components of public specialist mental health services.

[100] Exhibit 185.
[101] Exhibit 185, pages 5 and 6.
[102] Exhibit 185 at page 4.
[103] Exhibit 185.
[104] Exhibit 185 pages 13-16.

- Investigate, using tools such as root cause analysis, all suicides that are known to have occurred within one year post-discharge from acute care or specialist mental health service care.
- Develop education and training strategies for supporting services to use tools such as root cause analysis after suicides.
- Develop nationally consistent measures for recording, classifying and reporting of all suicides of mental health consumers in the care of mental health services and acute care, as well as for reporting of suicides within one year of discharge.
- Implement existing clinical practice guidelines for the management of deliberate self-harm.
- Ensure that systems are in place to automatically consider Coroner's findings, disseminate lessons, and ensure appropriate changes to systems.
- Evaluate changes in practice and outcomes".[105]

46. Unfortunately and again, no timeframe has been stipulated for the implementation of these strategies or other priorities and principles of the plan.[106]

47. In October 2005 additional funding of approximately $201 million for community mental health services, forensic mental health positions, high pressure areas and non-government mental health services was announced in Queensland.

48. Inquiries into mental health issues have also been conducted by, and reports have issued from the Senate Select Committee on Mental Health,[107] the Bundaberg Hospital Commission of Inquiry, the Queensland Public Hospitals Commission of Inquiry, the COAG National Action Plan for Mental Health and the Queensland Health Systems Review of 2005 (the "Forster" inquiry).

49. A State-wide Mental Health Network has been formed to respond to the Forster Review's recommendation relating to the development of a structure, which vests greater responsibility for the outcomes of mental health services with clinicians. Sub-committees of the Network will address issues including rural remote areas, safety and quality and primary health care.

50. In July 2006, the National Action Plan on Mental Health 2006-2011 was endorsed by the Queensland Health Minister and a complementary five-year mental health strategy is being developed for Queensland to facilitate consistency with the National plan. That plan is very near completion. [108]

51. An independent external evaluation of the Queensland Government Suicide Prevention Strategy has just commenced,[109] as has a pilot, both in Queensland and nationally, investigating with the private sector, a *"perception of care"* instrument which will provide consumers of mental health services with the opportunity to feedback to the service about the level of service delivery in meeting their particular needs. Whilst a framework for the development of a policy between general practitioners and mental health services in Queensland has been

[105] Exhibit 185 at page 15.
[106] See evidence of Dr. Aaron Groves pages 620-670.
[107] Reports handed down in March and April 2006.
[108] Evidence of Dr. Aaron Groves.
[109] See evidence of Dr. Aaron Groves.

developed, again there is no policy developed in relation to implementation of the framework. [110]

This is by no means an exhaustive list of the state and national inquiries conducted into mental health issues, the reports resulting from such inquiries or the guidelines/policies formulated as a result. The reference material to the Issues Paper of the Public Advocate alone details pages and pages of references to Australia-wide reports, investigations, statistics, policies, results, academic material and clinical practice guidelines.

One can only guess at the cost in financial terms to the community of conducting such inquiries and reviews, preparing reports, formulating policy and conducting inquests.

The more concerning cost, however, is the cost to families, friends and the communities of people suffering a mental illness, who, despite the formulation of significant mental health policy over the last seventeen (17) years, are still dying by their own hands.

Indeed, approximately 2,500 people commit suicide in Australia each year, [111] and for every person who completes suicide, there are another 20 to 100 more attempts. [112] "*As long as there are systemic issues involved in a person's death, it is likely that these same issues are also impacting on a much larger number of people, albeit with non-fatal – though still potentially serious – life consequences*"[113].

The World Health Organisation, as long ago as 1996, identified that disability associated with mental illness is likely to be the leading cause of disability in the world by 2020 if more is not done about it.

Given that mental illness is eminently and effectively treatable,[114] why are deaths in these numbers occurring? More specifically, what systemic issues were involved in the deaths of Charles Barlow, Patrick Lusk and Emily Baggott; and what needs to change to ensure that the circumstances of their deaths are not repeated?

For it is clearly change that is required.

I will now comment on the circumstances of death in relation to each of Charles, Patrick and Emily.

[110] Evidence of Dr. Aaron Groves.
[111] Report of Sergeant Dodds - Exhibit 105. page 1.
[112] www.salvos.org.au - Report of Sergeant Dodds - Exhibit 105 page 1.
[113] Exhibit 154 – Issues paper of the Office of the Public Advocate.
[114] See the evidence of Dr. Groves, Dr. Kingswell and Dr. West.

PART B

THE CIRCUMSTANCES OF THE DEATH OF CHARLES EDWARD BARLOW

Charles was born on 6th August 1967 at Yarrabah and lived all of his life at Yarrabah. He suffered significant loss, chaos and trauma throughout his life, as a result of which "Charles was at risk and that this should have been evident. It is likely that his siblings were probably also at risk and the fact that he and both of his brothers died prematurely suggests shared vulnerability that probably had its origins very early."[115]

Extensive medical records indicate that he presented or was admitted to Yarrabah hospital several times per month, prior to the closure of the inpatient facility in 2000 and had admissions to Cairns Base Hospital Mental Health Unit in relation to either reported auditory hallucinations and/or suicidal ideation or the complications of alcohol use, diabetes or a combination.

He had attempted suicide on a number of occasions; was diagnosed with alcohol hallucinosis and associated mood disorder in 1998; and while the diagnosis was most consistently Alcohol Hallucinosis, a differential diagnosis of paranoid Schizophrenia was considered. Charles was also the subject of an involuntary treatment order upon one of his admissions to the Cairns Base Hospital from where he absconded on that occasion as well as others. There is no record of Mr. Barlow ever being referred to the Gordonvale detoxification before its closure in 2000, or any other program. The Cairns Base Hospital Mental Health Unit was, therefore, the only admission placement for Mr. Barlow.

Subsequent to his brother's death in early July 2001, Charles was seen on 19th July 2001 by Cairns Mental Health, the attending medical professional writing in the notes "suggested he get counselling to deal with grief and loss issues of his brother's death," and concluding that the file was to be closed[116].

On 20th November 2001, the medical file noted that Charles was still hearing voices "swearing at him" and telling him to hang himself. Charles was then rejected from rehabilitation in 2002 because of his poor appointment attendance and on another occasion his case was closed because of "DNA".[117]

Mr. Barlow was prescribed the antipsychotic medication Flupenthixol depot 40mgs by intramuscular injection fortnightly. Many unsuccessful attempts were made to follow up Mr. Barlow and his community mental health file was opened and closed at least half a dozen times between 1998 and 2003.

In the period between 2002 and his death, he received only 7 of the approximate 54 injections prescribed for him.

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[115] Report of Dr. Hunter
[116] Taken from the Report of Sergeant Dodds. Exhibit 105
[117] See report of Dr. Hunter Exhibit

On occasions Mr. Barlow was discharged into his own care or that of his sister Mona with whom he lived. The medical notes are unclear as to what precipitating factors informed the making of one decision or another.

His failure to cooperate, attend appointments and comply with treatment were, in Professor Hunter's view, treated by the mental health professionals as a choice Charles was making, rather than being seen as the result of an inability, perhaps because of his indigenous culture, to comprehend recovery, understand its requirements, commit to a process and sustain that commitment.

On 24th February 2004, Charles presented at the Yarrabah hospital at approximately 1650hrs. He was requesting to go to Cairns Base Hospital as he was feeling inclinations of self harm and hearing voices telling him to kill himself. The nurse at the hospital who first spoke to Charles subsequently telephoned the Medical Officer, Dr. Paul Davis who was at the medical practice. Dr. Davis was aware of Charles who often presented to Dr. Davis reporting hearing voices. Dr. Davis directed the nurse to give Charles his flupenthixol depot injection and 10mg valium and Dr. Davis also directed that Father Vincent Sands, the Life Prevention Officer, be contacted to *"look after"* Charles.

Father Vincent Sands arrived at approximately 1700hrs and spoke with Charles for approximately 10 minutes but Charles remained adamant that he wished to go to the Cairns Base Hospital. The attending Nurse noted in Charles' file "I advised pt to ignore voices, still talking about selfharm/hanging himself. LPS advised us that MO was happy for pt to go home, LPO will take pt home. I asked Charles if he was happy with going home, pt stated NO, insisted that he wants to go to CBYH. LPO taken pt home. I have advised pt to return if any further concerns".

Father Vincent Sands then spoke to Dr. Davis by telephone, informing him that Charles was adamant that he wanted to go to the Cairns Base Hospital. Dr. Davis repeated his previous instructions but did not attend to see Charles at any time.

Dr. Davis considered *"Charles a low risk patient and that he would be better trying to find him a suitably supervised situation to be in, where someone could keep a close eye on him than trying to find a similar supervised situation at 12 midnight after having been sent home from the base hospital."*

Charles walked away from Father Vincent Sands when his repeated requests to go to Cairns Base Hospital were denied. Father Vincent Sands was unable thereafter to locate Charles until Charles was found hanging from a tree a short distance from the Yarrabah hospital.

There was no Sentinel Event Review Report conducted into the circumstances of the death of Mr. Barlow. It is unclear why this did not occur. The hospital records indicate that an informal investigation was conducted at hospital level but no formal documentation was produced.

Dr. Davis was the only doctor in an indigenous community of 3000 people. Under those circumstances, the acceptable doctor/patient ratio should be 1 general

practitioner to every 600-700 people.[118] Dr. Davis concedes that the Mental Health Act provisions were not at the forefront of his mind that day. He did not consider an involuntary treatment order and clearly held the view that even if referred to Cairns Base Hospital, the pressure of beds there would only result in Charles being turned away. He was not aware of Mr. Barlow's past history of suicide attempts and did not have available a detailed history, mental state and risk assessment.

There is in fact considerable pressure on available mental health beds in Cairns,[119] due in part to inadequate community housing and non-clinical support options in Cairns[120].

In Dr. Kingswell's view, Mr. Barlow had; multiple diagnoses of Alcohol hallucinosis, Chronic Paranoid Schizophrenia, Tertiary Syphilis, Non insulin dependent diabetes, Cirrhosis of the liver and Alcohol dependence; and multiple special needs; *"and no health service ever met those needs"*. His view is that Charles should have been seen by a health professional with adequate training in the assessment of mental health disorder, particularly risk assessment, prior to this discharge from the Yarrabah primary care facility and that by reason of the dismissal of his request to be sent to Cairns, this opportunity was lost.

Dr. Bayley's view is that the Cairns Mental Health Service would still be unable to meet his needs, for the additional reasons that there is a lack of appropriate and culturally trained staff; vacant psychiatric positions; lack of a dual diagnosis worker in Yarrabah and no opportunities for mental health education within the community.

Dr. Kingswell agrees with Professor Hunter that Mr. Barlow's non-compliance, despite his deteriorating health, was regarded as treatment failure and resulted in less assertive involvement in relation to his care, when his needs and his lifestyle in fact indicated active, ongoing, sustained intervention, daily and indefinitely, if necessary. Dr. Hunter opines that Charles' lack of compliance, however it manifested itself, "should have been understood as a REASON for concertedly pursuing"[121] a strategy of assertive treatment "and NOT as a reason for abandoning it ("case closed")[122].

Dr. Hunter was also of the view that possible remaining directions available were to utilise "the provisions of an Involuntary Treatment Order which, *ipso facto*, indicates that he had been assessed as both at risk and incapable or unwilling to comply with interventions in his best interest; and brief admissions to Cairns Base Hospital as needed"[123]

Charles Barlow is not an isolated case. There are significant numbers of people who are non-compliant with treatment, non-cooperative in other ways and whose failures are not the result of an active choice to refuse treatment but an inability to understand or commit to recovery. Under those circumstances, it becomes crucial to involve significant family members and carers in treatment planning and follow-up. There is

[118] Report of Dr. Ernest Hunter Exhibit
[119] Evidence of Dr. Bayley.
[120] Report of Dr. Kingswell re hCharles Barlow
[121] Report of Dr. Ernest Hunter in the matter of Charles Edward Barlow.
[122] Report of Dr. Hunter.
[123] Report of Dr. Hunter Exhibit 148.

no evidence that Charles' sister Mona was so involved. There was in fact no treatment plan for Charles, apart from the regime of fluopenthixol depot injections, of which he received few.

Since Mr. Barlow's death, a permanent part-time mental health worker is available four (4) days per week, stationed at Yarrabah; a psychiatry registrar visits weekly (funded by the Commonwealth medical specialist outreach program) and a mental health indigenous worker attends in Yarrabah three (3) days a week.

Whilst Life promotion officers are employed in a number of areas, no clear/uniform job description for these positions exist and very little training or supervision in the area of mental health is provided to these positions.

OTHER ISSUES RELATING TO THE DEATH OF CHARLES EDWARD BARLOW

The report of Dr. Hunter referred directly to the following additional deficiencies in relation to Mental Health service delivery in remote and/or indigenous communities generally, including Yarrabah;

- *"There appear to have been service coordination problems both within Queensland Health (Cairns Base Hospital to Yarrabah; primary care to mental health; mental health to ATODS…) but also across the General Practice and the Queensland Health primary care service"*[124].
- Ensuring outreach follow-up of a patient under an Involuntary Treatment Order remains difficult in Indigenous communities. This reflects a number of issues, including cooperation across mental health services and primary care. In Indigenous communities the key mental health service provider is usually a primary care worker (because mental health specialist services are not usually based in communities).
- assessment of risk is an enormously complex issue and simply mandating 'tick box' approaches can undermine critical assessment.
- Clarity of roles and competencies is particularly complex in Indigenous communities. Indigenous Health Workers take on a wide range of responsibilities which are often not clearly defined in service protocols. Queensland is yet to address the registration of Health Workers (other than those with remote practice authorisation) who theoretically should not be undertaking clinical roles.
- Safe options for in- and out-of-community care in Yarrabah are limited. There remains a need for simple in-patient detoxification services closer than Cairns Base Hospital which is not utilised because of distance and environment.
- The nature of indigenous health is such that specific approaches and skills are necessary and best met when such services do not compete with the demands of mainstream responsibilities. Basic considerations, such as 'caseness' (reflected in "case closed") are different in Indigenous settings to mainstream practice.
- The psychiatric unit at Cairns Base Hospital has been running at over 100% occupancy for at least a year. Recent data demonstrates a significant increase in the length of stay of Indigenous patients. *"This probably results from the lack of long-term options that reflects de-institutionalisation generally, and the*

[124] Report of Dr. Hunter 148.

circumstances and distribution of remaining resources (available forensic beds in Townsville will soon be further restricted). Patients are detained in general hospitals for months as a result. Consequently, there is a pressure to consider non-hospital options before recommending admission. While it is clearly articulated that "if he/she has to be in, room will be found", as a clinician working in remote communities I can assure you that when I hear that "there are four outliers and three in the ER", it would be disingenuous to suggest that that information is not being entered into the equation informing my immediate decisions"[125].

- "There are problems with serious quality-of-service implications in small Health Service Districts (such as Cape York, and the Torres and Northern Peninsula Area) in which the District-based practitioners have professional and line accountability within a service with no senior clinical expertise"[126].
- Indigenous communities in North Queensland suffer from a lack of non-clinical care services for residents with serious mental illness. "*It is likely that Charles had no or limited access to activity or recreational programs, support for developing independent living skills, or alcohol free socialising. Charles may well have rejected these if they were available, but the point is that they are NOT available. There is much to be gained by community-based programs that provide consistent personnel, a safe space and some degree of meaningful activity in every community"*[127].
- Of the 42 deaths by suicide investigated by Dr. Hunter over a 10 year period in remote indigenous communities in Cape York, only 3 people had prior contact with mental health services, but may have been seen by local primary care centres for reasons associated with mental health.
- There is no clinical service capability framework for mental health in the Cairns Health District. [128]
- Whilst there has been increased funding and resourcing to Cairns Base Hospital Mental Health Unit, there is a difficulty in actually recruiting people to psychiatry positions. Of a total of thirteen (13) psychiatry positions, seven (7) are vacant as those positions have been filled by overseas doctors who are still being registered with the Medical Board of Queensland and obtaining Area of Need approval from the College of Psychiatrists. It is currently taking between six (6) and nine (9) months for overseas doctors to be registered.
- As stated in the Issues Paper of the Office of the Public Advocate, aboriginal suicidality is recognised as a particular problem for Australia. For example, in 1997-99,[129]there were twice as many deaths from mental disorders for Indigenous people as expected for all Australians; suicides accounted for 2.6 times more deaths than expected for Indigenous males and twice as many deaths as expected for Indigenous females; and an international literature review showed suicide rates among aboriginal youth in New South Wales for 1996-98 were among the highest recorded.

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[125] Report of Dr. Hunter
[126] See reports of Dr. Ernest Hunter.
[127] See Reports of Dr. Ernest Hunter.
[128] Evidence of Dr. Bayley.
[129] Exhibit 154 - Issues paper of the Office of the Public Advocate – Queensland at page 16 referring to Edwards, R. and R. Madden, *The health and welfare of Australia's Aboriginal and Torres Strait Islander people 2001.* Australian Bureau of Statistics and Australian Institute of Health and Welfare (pp. 73-76)

- "*Antisocial behaviour that brings Indigenous people into contact with the criminal justice system may often be the result of undiagnosed mental distress. However, it may not be recognised as such. In effect, this means that Indigenous people with a mental illness are more likely to either die, or to end up in the criminal justice system, than to receive appropriate treatment in a culturally appropriate health setting".*[130]
- Significant policy and practice differences exist between the 38 health districts within Queensland, and these can have significant impacts on the outcomes for vulnerable people with a mental illness[131].
- Funding has been provided for an increase in doctor numbers at Yarrabah to three (3) doctors, but recruits are unable to be found and so the number remains at one.

These and other issues arising out of the deaths of Patrick Douglas Lusk and Emily Baggott will be addressed by the making of recommendations at the conclusion of findings to be made in relation to all three deaths. I will now set out formal findings in relation to Charles Edward Barlow.

FINDINGS

1. The identity of the deceased was Charles Edward Barlow.
2. His date of birth was 6th August 1967.
3. His last known address was 32 Connolly, Yarrabah.
4. At the time of his death his occupation was unemployed.
5. The date of his death was 24th February 2004.
6. The place of his death was 16 Stanley Street, Yarrabah, North Queensland.
7. The formal cause of his death was asphyxia sequential to hanging, schizophrenia being another significant condition contributing to the death but not related to the underlying cause of the hanging.

[130] Exhibit 154 Issues Paper of the Office of the Public Advocate.
[131] Exhibit 154 Issues Paper of the Office of the Public Advocate.

PART C

THE CIRCUMSTANCES OF THE DEATH OF PATRICK DOUGLAS LUSK

Mr. Patrick Lusk was born on 17th September 1938 and had a history of severe depressive illness which had been treated successfully with electroconvulsive therapy (ECT) in 1988.

On 22nd March 2005 he attended upon his general practitioner, Dr. Desmond Hill, who treated him for depression, prescribing 50mg Zoloft initially and thereafter increasing the dose to 100mg a week later. Dr. Hill has extension training in mental health issues and so when Mr. Lusk did not respond to the drug treatment, Dr. Hill referred him to the Cooktown Hospital on 4th April 2005 for examination, admission, opinion and treatment. Dr. Hill provided a referral letter (advising that Mr. Lusk suffered from Acute Depression); and two (2) discharge summaries documenting Mr. Lusk's admissions to the Cairns Base Hospital Mental Health Unit for a Major Depressive Illness in July and October/November 1988; and his receipt of 6 ECT treatments during the latter admission.[132] Dr. Hill's expectation was that Mr. Lusk would be assessed and referred to Cairns for treatment. Consequently, Dr. Hill did not himself contact community mental health as he assumed that the admitting doctor at Cooktown hospital would attend to a mental health referral.

Mr. Lusk then presented to the Cooktown Hospital later that morning, although the time is not noted in the admission records.[133] Dr. Errol Van Rensburg, a senior medical officer,[134] was the admitting doctor. His notes indicate that Mr. Lusk was sent in from Dr. Hill with depression and had received ECT in 1990. Mr. Lusk's blood pressure, pulse and temperature results as taken by nursing staff some time earlier were recorded by Dr. Van Rensburg, but there was no history recorded of Mr. Lusk's presenting complaint; how long he had been depressed; what the character of his mood was, whether it was pervasive, when it started, what the particular precipitants might have been, what the symptoms were, whether there was sleep and appetite disturbance, and no notation of his current medications. Neither was any collateral information obtained by Dr. Van Rensburg from Cheryl Prigg.

An electrocardiograph (ECG) and blood tests were ordered, although there is no record that the ECG was ever performed and whilst there is evidence that blood samples were taken,[135] no test results were ever made available. The treatment plan of Dr. Van Rensburg as noted on the file was limited to "Admit to ward please. Discuss with Mental Health Social Worker." There is no written record of any referral to the mental health worker at any time during Mr. Lusk's admission or after his discharge and prior to his death. He did not, therefore, attend upon the mental health worker. The court accepts that Nurse Jola George telephoned community mental health and

[132] Exhibit 108
[133] Exhibit 4.
[134] Remuneration for a Senior Medical Officer as at 3rd March 2006 was $191 000 – See Exhibit 182.
[135] Evidence of Jola George.

was told that no-one could see Mr. Lusk that day. There is insufficient evidence to determine to whom Nurse George spoke.

In relation to medication, Dr. Van Rensburg made a note "Try with 1. Valium 10mg stat P.O. 2. Serenace 5 mg stat P.O" at approximately 14.10. He also prescribed "Haloperidol 5 mg. and Valium 10mg". The Valium was given at 14.50 hours. The Haloperidol was not recorded as having been given and was not given. Ms. Prigg, however, had provided Mr. Lusk with a 2.5mg dose of Valium at an earlier stage when there was a delay, in her opinion, in the dispensing of the prescribed medication.

Mr. Lusk was assigned to a single room, which was cleared of tubes and any cables, opposite the nurse's station, as Registered Nurse Jola George was aware that Mr. Lusk had a history of depression and was a possible suicide risk. She also knew that he was to be reviewed by community Mental Health. Nurses Bradford and Fale were on roster overnight and reported no complaints from Mr. Lusk.

That morning, the 5th April, a ward round was conducted by Dr. Van Rensburg, Dr. Margaret Purcell, also a senior medical officer, and the hospital superintendent, Dr. Natasha Coventry. After approximately 10- 15 minutes consideration of his case, it was decided by the group to discharge him. The review of Mr. Lusk's case did not involve Cheryl Prigg, consultation with Dr. Hill or reference to Dr. Hill's correspondence. None of the three doctors had, however, received extension training in mental health issues; or more particularly, the practical mental health skills in Rural Practice level 1 as conducted by the RACGP; and none were aware that Dr. Hill had received such training.

The last entry in the chart was by Registered Nurse Jola George at 10.45 am when she noted that Mr. Lusk was "feeling well, happy to go home. Had an appoint to Gp…Discharge summary faxed and sent. Collected by his wife at 10.45". Ms. Prigg was not provided with any information by the hospital staff as to Mr. Lusk's condition upon his discharge or of any plan or attempt to refer him to mental health. The discharge summary recorded a principal diagnosis of depression arising from a situational crisis and no change was made to Mr. Lusk's treatment.

Nurse George was concerned at the discharge decision made by the doctors and took the step of reminding Dr. Purcell about the mental health referral. The court accepts this evidence and Nurse George's evidence that the suggestion was dismissed by Dr. Purcell. Nurse George then telephoned community mental health, as she had done on 4th April, and was again told that no-one was available to see Mr. Lusk.

There is conflicting evidence in relation to whether or not the mental health worker Dr. Julie Sykley was at the community health centre, and therefore, able to see Mr. Lusk on 5th April. Dr. Sykley's evidence is that she was not there, yet Margie Stewart (the Director of Nursing) was adamant that she had personally visited the centre on that day and could confirm that Dr. Sykley was there. Margie Stewart's evidence, in relation to other issues was, however, inconsistent and little reliance is placed on her evidence in this respect either. The initially clear evidence of Donna Symes that Dr. Sykley was present and in fact took a call from the hospital and refused to see Mr. Lusk was somewhat reduced under cross-examination. The court is unable, having

regard to other evidence, including the diary of Dr. Sykley, to be satisfied on the issue one way or the other.

In any event, neither Dr. Sykley nor anyone else undertook a mental health assessment of Mr. Lusk at any time. There was a clear systems failure about which recommendations will be made, and as the court cannot be satisfied to the requisite standard that Dr. Sykley played any role in that systems failure, it does not intend to consider the evidence of the concerns expressed about her any further in these findings.

After discharge, Mr. Lusk went that afternoon to Dr. Michael Owen at the Medical Centre. Dr. Owen added 2 mg Diazepam to Mr. Lusk's medication. Also that afternoon, Ms. Prigg wrote a letter to Margie Stewart (the Director of Nursing at Cooktown hospital), with copies to Dr. Hill, Community Mental Health, the Minister for Health, the Minister of Communities and the Beyond Blue organisation. This correspondence was delivered by Ms. Prigg to the first three recipients that afternoon, although the Director of Nursing was not handed the letter personally. The letters complained about Mr. Lusk's early discharge, the lack of treatment he was given, the absence of the mental health professional and referred to the fact that Ms. Prigg had herself provided Mr. Lusk with some of her own medication when the medication prescribed for him was not forthcoming.

The next day, the 6th April, Ms. Prigg was concerned about Mr. Lusk and took him to see Dr. Hill who noted that Mr. Lusk remained depressed and worried but did not wish to return to hospital. Dr. Hill increased his medication[136] and it was agreed that Cheryl Prigg would stay with Mr. Lusk and monitor his medications.

At some time on the 6th April 2005 or in the early hours of 7th April 2005, Mr. Lusk took all of his medication and subsequently hanged himself. He was pronounced dead by Dr. Hill shortly after 6.55am on the 7th April 2005.

Ms. Prigg's letters were not brought to the attention of the Medical Superintendent until after Mr. Lusk's death. Consequently, no effective action was able to be taken.

Margie Stewart's evidence in relation to the letter received by her is conflicting. In her statement to police and in her oral evidence, she states that she received the letter on the afternoon of 5th April; that she tried to contact Cheryl Prigg that day and arrange a meeting and could only leave a message, but that she spoke to Cheryl Prigg the next day and Cheryl refused a meeting. In her sentinel event interview, however, she states that she did not receive the letter until the morning of the 6th April, that she telephoned Dr. Newland on the 7th April after Mr. Lusk's death and was advised to speak to Ms. Prigg after the funeral.

Whatever the true position might be in relation to those letters, one can only wonder, as I am sure Ms. Prigg has wondered, every single day since Mr. Lusk's death,

[136] His dose of Sertraline was increased to 150mg and his dose of Valium was increased to 6 mg at night.

whether things might have been different if her complaints had been advanced in a more timely fashion.

A Queensland Health Sentinel Event Review was conducted within a month of Mr. Lusk's death by Dr. Roy West, Ms. Judy Skalicky and Ms. Joanne Oosen and a report was furnished to the District Manager, Cairns Health Service District dated 25th May 2005.[137]

That report highlighted a number of concerning matters in relation to issues crucial to the admission, treatment and discharge of Mr. Lusk, and generally, including:-

- a lack of documentation on the file of developmental history and other relevant matters
- a lack of knowledge by staff of mental health issues and mental illness or the existence of a mental health policy
- a lack of current knowledge pertaining to treatment options
- a failure to conduct and document a formal mental state examination and clinical risk assessment
- a lack of skills pertaining to undertaking a clinical risk assessment
- a lack of knowledge of identification and management strategies of suicidal ideation
- that nursing staff do not have formal training or experience in mental health nursing
- the skills and experience of medical staff were varied
- education provided on mental health issues and mental illness was minimal
- staff reported limited opportunities to access training and education
- nursing staff levels, rostered on shifts, were inadequate
- no formal process existed regarding the ward rounds and the specific roles of each of the medical and nursing staff
- Communication of information regarding patients for admission and the plan for their care during hospitalisation was not clearly communicated to the nursing staff
- Apart from a faxed discharge summary to the GP, there was no other communication with the GP
- Ms. Prigg, Mr. Lusk's former wife was not contacted for collateral information about Mr. Lusk either during the admission process, during hospitalisation or at the point of discharge
- No advice was actively sought from mental health in relation to Mr. Lusk's presentation, treatment or follow-up
- The Medical Superintendent advised that it is not common practice for the nursing notes from the previous shifts to be reviewed at the ward round
- A number of clinical staff at the hospital indicated that they did not know if there was a formalised process in place regarding referral to either the Mental Health Team or Social Worker or whose responsibility it was to make the referral
- Clinical staff did not appear to have a good understanding of policies and procedures that should guide their clinical practice and there is no process in place for informing them of new/revised policy
- Staff were not aware if documents existed in relation to admission processes, risk assessment, referral to mental health, management of patients with suicidal ideation/self-harm and discharge planning

[137] Exhibit 128.

- No specific room or area exists for mental health admissions
- There is a high staff turnover of medical officers
- The process for provision of orientation is ad hoc
- The Resident medical officer orientation manual does not identify or address local issues and procedures
- No formal orientation/induction process exists for nurses.
- No team meetings are in place to discuss operational and clinical issues that arise.
- The executive of Cooktown hospital indicated that they were not aware of the QLD Health incident management policy prior to this event.
- Certain staff were not aware of a policy for debriefing or defusing following critical incidents.
- There were no protocols in place between Cooktown Mental Health and Cairns Base Hospital as to the management of Mental Health patients.

As a result, the Sentinel Event Team report[138] made the following recommendations:

- The admission process needs to be formalised and streamlined. Communication and handover of information, including a management plan, needs to be formalised. There needs to be identification of staff responsible for these processes.
- Training and Education need to be provided to clinical staff in relation to the Mental Health Act 2000, Clinical Risk Assessment and Mental Health Assessment.
- Cairns Integrated Mental Health Procedures need to be reviewed and Workplace Protocols developed for the local area in relation to Clinical Risk Assessment and Management of Patients with Suicidal Ideation
- The current ward round process needs to have the roles and responsibilities of individual clinicians more clearly defined.
- Documentation at the clinical ward round needs to be reviewed.
- The current referral processes to mental health need to be reviewed and communicated to all clinical staff. It is recommended that a flow chart be developed to provide a quick, visual reference for the clinical staff. Patient groups also need to be identified that will prompt an automatic referral to the Mental Health Team e.g. self harm, suicidal ideation, current mental health issue and past history of self harm or suicidal ideation.
- Timeframes for the receipt of discharge summaries by GPs need to be addressed. It is recommended that a meeting occur with the local GP's to address this issue and develop a procedure.
- Communication needs to be reviewed and addressed.
- Senior staff at the hospital require training and education in relation to the management of Sentinel Events and Critical Incidents. Provision of Human Error and patient safety system (HEAPS) training to clinical staff would also prove beneficial.

The existence of each of the deficiencies recognised in the Sentinel Event Report following Mr. Lusk's death was alarmingly confirmed by the evidence taken during the inquest, which also raised additional crucial issues relevant to service delivery of

[138] Exhibit 128.

mental health in the Cairns Regional Health Service District and Cooktown hospital in particular.

Dr. Van Rensburg gave evidence that he had never been provided with a copy of any policies and procedures for Cooktown Hospital; that he had received no induction or orientation or training in relation to mental health patients; his only knowledge of any kind of process was that used in Weipa where he had previously worked, whereby, after an initial provisional examination, there was referral to a mental health worker to carry out the more thorough examination; that he did not know where to locate crucial documents eg Primary Health Care Manual, acute protocols, the Cairns Base Hospital Resident Medical Officer Manual. He stated that he had never seen the suicide Risk Screening Questions[139].

"Dr. Coventry was not familiar with the State Wide document dealing with the assessment and management of suicidal behaviour or parts of the Clinical Care Manual [140]available on the Queensland Health Electronic Publishing Service accessed from any Qld Health computer"[141]

None of Drs. Van Rensburg, Purcell or Coventry looked at the referral letter and discharge summaries provided by Dr. Hill.

The nursing staff gave evidence that there have always been problems with having psychiatric patients at the hospital "*the nurses aren't trained and they don't get the proper care. We only have 2 nurses on night shift so there isn't enough staff if 1 to 1 is required. This has been raised previously at a lot of forums. They also need to look at the issue of what happens after hours. RFDS (Royal Flying Doctor Service) won't fly them in the dark so they have to stay here*"[142] and "*We have never had a policy for psychiatric patients, we are not set up for them. . . There is nowhere to keep patients safe. ..Single rooms have windows that simply open out… Nursing staff are thin on the ground… There is little supervision of at-risk patients... Only 2 night staff – they have responsibility for Accident and emergency…There is no after-hours psychiatric care. ..We can't get them out after dark. Patients are medicated so as not to leave the facility or cause themselves harm…Getting them to Cairns is dependent on a bed being available in Cairns... It is difficult to get an extra nurse on shift.*[143]

In the sentinel event report Dr. Coventry indicated that the referral to the social worker was discussed at the ward round, but did not seem to be required, and, in any event, Mr. Lusk declined the referral. Dr. Coventry stated that she was not sure that they could have done anything differently, given his presentation at the ward round. In the sentinel event report, Dr. Purcell expressed her anger that Mr. Lusk had promised them at the ward round that he would not self-harm.

[139] Exhibit 112.
[140] Exhibit 102.
[141] Report of Dr. Kingswell in the matter of Patrick Douglas Lusk.
[142] Evidence of Nurse Daphne Fenton.
[143] Evidence of Nurse Daphne Fenton

CLINICAL DECISION-MAKING

In Dr. Kingswell's[144] view, the formal diagnosis available at the time of Mr. Lusk's death, had the appropriate history been assembled, was a Major Depressive Disorder of Recurrent Type.[145] Dr. Kingswell considered that inpatient care was the only appropriate management, a plan for which should have included elements of safety, symptom relief, the establishment of a diagnosis, continuing symptom management and a recovery phase. Dr. West agreed.

As to safety, the court accepts the evidence of Dr. Kingswell that;

- an involuntary treatment order should have been considered
- a detailed examination of his mental state should have been conducted and was not
- a suitable hospital room in which clear observations were possible and access to self-harm was minimised should have been available and was not
- clear instructions to the nursing staff as to the need for a sleep chart and a record of Mr. Lusk's food and fluid intake as well as frequency and nature of observations should have been detailed in the medical record and was not.

As to symptom relief, the court accepts the evidence of Dr. Kingswell that;

- Mr. Lusk's dose should have been increased to 2mg per day and possibly higher (given that previous doses were ineffective)
- it was appropriate to prescribe a benzodiazepine such as Diazepam (Valium) to reduce Mr. Lusk's level of agitation and to assist in sleep
- there was no indication for the simultaneous prescription of two Benzodiazepines namely Temazepam (Temaze) and Diazepam (Valium)
- a prescription for Haloperidol (Serenace) up to 20 mgs per day was in the circumstances highly inappropriate. *"Haloperidol in that dose in a 66y year old man would very likely be associated with severe extrapyramidal side effects. The extrapyramidal side effects most commonly include uncomfortable muscular rigidity and tremor. As psychotic symptoms had not been identified there was no place for this preparation in the acute management of Mr. Lusk".*[146] Dr. West agreed.

As to diagnosis, the court accepts Dr. Kingswell's evidence that;

- Mr. Lusk should have been examined for illness that might cause depression or be a consequence of depression and a thorough neurological examination was indicated. There was no record of an adequate or any physical examination having occurred
- It was appropriate to do a number of blood tests as were ordered in this case. However, the results were not available, and should have been available, to inform treatment prior to the patient's discharge. Again, Dr. West agreed.

[144] Report of Dr. Kingswell in the matter of Patrick Douglas Lusk.
[145] DSM-TR:296.33
[146] Report of Dr. Kingswell in the matter of Patrick Douglas Lusk.

As to continuing symptom management, the court accepts Dr. Kingswell's evidence that;

- Mr. Lusk had not responded to Sertraline and had a history of an excellent response to ECT. Had Mr. Lusk been admitted to a mental health unit, ECT would have been an early consideration and had Mr. Lusk continued on medication treatment with failure to respond, accompanied by a refusal to eat or drink, the appearance of psychotic symptoms or the appearance of suicidal ideas, ECT would have been considered.

As to recovery phase, the court accepts the evidence of Dr. Kingswell that;

- a complete recovery with appropriate treatment was the most likely outcome for Mr. Lusk, who would then have required maintenance treatment with an antidepressant or lithium carbonate for at least a year beyond the point of recovery; and
- Mr. Lusk would have required follow up by his General Practitioner Dr. Hill and the Psychiatrist from the Remote Mental Health Outreach Team. Dr. West agreed.

More specifically, the court accepts the evidence of Dr. Kingswell as follows:

- There was an inadequate admission mental health assessment and suicide risk assessment; the discharge plan was also inadequate because it was informed by the inadequate admission assessments of Dr. Van Rensburg. "It therefore fell to Drs. Coventry and Purcell to close the gaps"[147]. Nonetheless they were all medical school graduates and should have been competent in undertaking a mental state examination and risk assessment. Dr. West's view also supports the notion that all doctors and nurses, as a basic competency should be able to undertake a mental health assessment and all nurses should be able to undertake a mental state examination and risk assessment.

OTHER ISSUES

Evidence received during the inquest also highlighted other issues relevant to the incidents surrounding Mr. Lusk's death, including the following matters:

- "The room in which Mr. Lusk was housed was unsuitable for the management of mental health patients. It was full of potential hazards such as non-breakaway curtain rails, curtains, oxygen fittings and a special post fitted to the bed to allow a patient to pull themselves up. It was an environment in which a person would very easily harm themselves or others".[148]

- "The Cooktown Hospital is funded for 3 doctors. From that compliment they are expected to cover the communities of Hopevale and Wujal Wujal. The doctors rotate through the various roles. ..The doctors work on an on-call roster of 1 in 3 if 3 doctors are available or 1 in 2 if only two are available. This means they are on call for 24 hours out of every 72 or 48. The on call roster is extremely busy. The current staffing does not allow the doctors to take fatigue leave, take part in

[147] Evidence of Dr. Kingswell.
[148] Exhibit - The report of Dr. Kingswell.

continuing professional development or take holidays unless relief is available (which rarely occurs)".[149]

- The Community Mental Health Service of Cooktown is managed by Community Health, rather than Cairns District Mental Health. Mental Health workers in Cooktown (when present) do not report clinically or operationally to the Director of Cairns District Mental Health Service. The Cooktown mental health staff are professionally responsible to the Director of Nursing at Cooktown. Dr. West expresses the view that this can create conflict for a worker between their clinical performance and administrative demands if they are reporting professionally to local authorities but otherwise taking clinical advice from outside clinicians. Service delivery can also be compromised.

- Dr. West reports that there has been a varied response to in-services offered by visiting clinicians since Mr. Lusk's death. While Nursing staff can also access the weekly Cairns Base Hospital nursing in-services via videoconference (if workplace demands allow) or follow up with the videotape of these in-services at a more convenient time, the opportunity is rarely taken up.[150] Other witnesses[151] indicated that decreased staffing levels do not allow them to take up these opportunities.

- The Remote Team has been developing a Memorandum of Understanding that details the service delivery interaction between the district mental health teams and the Remote Area Mental Health Team based in Cairns in the hope that this will help formalise and strengthen lines of communication for clinical support and decision making in the community.

- There is a high turnover of mental health nursing staff at Cooktown Multipurpose Health Centre. The second nursing position often remains vacant or is filled by temporary staff. It also takes considerable time to recruit staff. These factors also lead to increased workloads at all levels and result "in a crisis orientated service delivery, leaving little time for health promotion, health prevention and training activities.[152]

- The Remote Area Nurse Package (RANIP), which offers incentives to state government employees, while available to other state government employees is not available to Department of Health nursing and allied health staff in Cooktown. Cooktown would need to be re-classified as a remote community in order to attract application of RANIP.[153]

- Police are often required to transport mentally ill patients from Cooktown to Cairns. No medically trained persons accompany them in the police vehicle and patients have, in the past, been sedated for up to 4.5 hours to enable them to travel between Cooktown and the Cairns Base Mental Health Unit. Travel by road has been the only option by reason of the inappropriateness of holding such persons in

[149] Report of Dr. Kingswell.
[150] Report of Dr. West.
[151] Nurses George, Fenton, Bradford
[152] Report of Dr. West.
[153] Exhibit 135.

the police watch-house and policies of the Queensland Police Service Air Wing and commercial airlines which do not allow the travel of persons who are considered a risk to aircraft. [154]

- General Practitioners have been on the frontline of mental health service delivery in Australia such that "by some estimates, GPs manage 75% to 90% of patients with mental illness in the community, and provide 30% of services to people with severe mental illness".[155] They are a critical link in the mental health chain, particularly at the point of entry to the mental health service, and at the point of discharge from hospital.

- No framework exists within Queensland Health in which clinicians can demonstrate competency or be assessed for competency.[156]

- There is currently no single point accountability for the competency, knowledge-base and performance-management of mental health staff.[157]

- There are no processes for clinical performance and evaluation, clinical risk management, clinical audit, ongoing professional development and full consumer and carer participation in quality improvement processes.[158]

FINDINGS

1. The identity of the deceased was Patrick Douglas Lusk.
2. His date of birth was 17th September 1938.
3. His last known address was 89 Power Street, Cooktown, North Queensland.
4. At the time of his death his occupation was as a taxi-driver.
5. The date of his death was 7th April 2005.
6. The place of his death was 89 Power Street, Cooktown, North Queensland.
7. The formal cause of his death was asphyxia sequential to hanging.

[154] Evidence of Sergeant Ian McDonald.
[155] Exhibit 154 - Issues paper of the Office of the Public Advocate – Queensland at page 11 referring to *Collaboration between general practice and community psychiatric services for people with chronic mental illness*, Medical Journal of Australia, Nicholas A Keks, B Malcolm Altson, Tobie L Sacks, Harry H Hustig and Amgad Tanaghow (1998), pp8-13
[156] Evidence of Dr. Aaron Groves.
[157] Evidence of Dr. Aaron Groves.
[158] Evidence of Dr. Aaron Groves.

THE ISSUE OF THE PROVISION OF INFORMATION TO THE QUEENSLAND MEDICAL BOARD

Pursuant to s.48 (4) of the Coroners Act 2003, a coroner may give information about a person's conduct in a profession or trade, obtained while investigating a death, to a disciplinary body for the person's profession or trade if the coroner reasonably believes the information might cause the body to inquire into, or take steps in relation to, the conduct.

In s.48 (5) a disciplinary body for a person's profession or trade means a body that–

(a) licenses, registers or otherwise approves the carrying on of the profession or trade; or
(b) can sanction, or recommend sanctions for, the person's conduct in the profession or trade.

The following matters are not disputed;

- That the Medical Board of Queensland is such a disciplinary body.
- That conduct of a medical practitioner in undertaking a mental state examination and a risk assessment and the making of clinical notes in relation to the assessment is conduct within Dr. Van Rensburg's profession as a senior medical officer.
- At the time of Mr. Lusk's death, Dr. Van Rensburg had been granted special purpose registration as a Medical Practitioner pursuant to s.135 of the Medical Practitioners Act 2001, effective from the 19th January 2005 to 16th January 2006.[159] There were no conditions imposed on his registration. Dr. Van Rensburg had, in fact, always practiced under a grant of special purpose registration since his initial registration with the Medical Board in 2002 after re-locating to Australia.
- Previous to working in Cooktown, Dr. Van Rensburg had worked at the Weipa hospital. Dr. Van Rensburg received no mental health training or induction in either Weipa or Cooktown, although he gave evidence that he worked "*very closely*"[160] with the mental health worker in Weipa and thought that the same process would operate in Cooktown.
- The Cooktown Mental Health Service Guidelines provide for referrals to the Mental Health Service, after assessment and screening by the medical officer/nurse.[161] Whilst all the experts agreed that a competent mental health worker would be able to do a mental state examination and a risk assessment, those skills were also basic competencies of medical practitioners. Not only was Dr. Van Rensburg's assessment inadequate, but no written referral to the mental health service was made or actively pursued. Dr. Van Rensburg did not speak to the mental health worker at all at any time. The planned referral was in fact abandoned during the ward round the next day and Mr. Lusk was discharged without any plan to follow-up the referral to the mental health worker.

[159] Exhibit 164. The Medical Board of Queensland file, letter ot Dr. Van Rensburg dated 1st February 2005.
[160] Evidence of Dr. Van Rensburg.
[161] Refer to Exhibit 5.

- During the Sentinel Event Review interview with Dr. West, Ms. Skalicky and Ms. Oosen less than a month after Mr. Lusk's death, Dr. Van Rensburg was unable to recall Mr. Lusk's death.[162]
- Thereafter, Dr. Van Rensburg relocated to Cairns and, on the 14th June 2005, commenced employment at the Alcohol Tobacco and Other Drugs Service (ATODS) under the supervision of Dr. Ian Audley, also a Senior Medical officer.[163]
- On the 30th June 2005, Dr. Roy West and Joanne Oosen wrote to Dr. Jill Newland, Medical Director of Cairns Base Hospital, expressing significant concerns about the clinical capacity of Dr. Errol Van Rensburg to practice competently and safely as a medical practitioner.[164]
- Dr. Van Rensburg continued to work at ATODS.
- On the 16th December 2005, Drs. Purcell and Coventry completed an "Assessment Form Special Purpose Registrants" in relation to their period of supervision of Dr. Van Rensburg between January 2005 and April 2005. Their opinion was that he required "*further development*" in areas of clinical knowledge base, clinical skills, emergency skills, personal and professional responsibility and teaching; that he required "*substantial assistance*" in clinical judgement/decision making skills and teamwork with colleagues; that his procedural skills and medical record/clinical documentation were "*consistent with his level of experience*" and that his communications to patients and family; and time management skills were *"better than expected"*.
- On the 3rd November 2005, Dr. Ian Audley furnished to the Medical Board an "Assessment Form Special Purpose Registrants" indicating that he had supervised Dr. Van Rensburg for two (2) months since June 2005, due to leave taken by Dr. Van Rensburg. Dr. Audley assessed him as "*consistent with level of experience*" in relation to knowledge, clinical skills, clinical judgement/decision making skills, procedural skills and time management skills; and "*performance better than expected"* in relation to communication, medical records, personal and professional responsibility and teamwork and colleagues.
- Subsequently, a resolution was made by the Medical Board on the 12th January 2006 granting Dr. Van Rensburg special purpose registration to fill an area of need as a senior medical officer at Cairns Base Hospital with supervision by Dr. Ian Audley from 17th January 2006 to 16th January 2007. The recommendations included that "*Dr. Cohn discuss the report of Drs. Purcell and Coventry with Dr. Streatfield. "it appeared there had been a "personality issue" with respect to practice at Cooktown and will not be rotated back there;"*[165] Dr. Streatfield does not recall the conversation.
- On 14th August 2006,[166] Dr. Audley signed an "Assessment Form Special Purpose Registrants" in which he indicated that Dr. Van Rensburg's performance was "*better than expected*" in the categories of Clinical knowledge base, Clinical skills and Clinical judgement/decision making skills, personal and profession responsibility and time management skills; that his communication and medical record/clinical documentation skills were "*consistent with his level of experience"*

[162] Exhibit 128.
[163] Exhibit 164. Medical Board of Queensland file.
[164] Exhibit 171.
[165] Exhibit 164. Medical Board file of Dr. Van Rensburg. Resolution of the Board ratified on 24th January 2006.
[166] Exhibit 164.

and that his teamwork required further development. Dr. Audley's report also indicated that Dr. Audley had not supervised Dr. Van Rensburg since the end of March 2006 and that there was "*no improving performance action plan in place*".

- This is consistent with the evidence of Dr. Streatfield that Dr. Audley had been coming and going from ATODS between March and August 2006 when he finally retired.
- Dr. Streatfield's evidence is that, while he signed a document as the person who would supervise Dr. Van Rensburg, after Dr. Audley, he cannot do it himself and will seek the advice of the Medical Board and try to find another clinician to undertake the supervision. That had not occurred as at the date of Dr. Streatfield's evidence in late August 2006.
- There is no evidence that the Medical Board has been provided with any information as to Dr. Van Rensburg's involvement as the admitting Senior Medical Officer and one of the discharging medical officers for Mr. Lusk; or Dr. Van Rensburg's responses to the Sentinel Event Review team; or the decision to hold an inquest into the death of Mr. Lusk or a copy of Dr. Van Rensburg's written statement dated 22nd March 2006; or information as to the training which Dr. Van Rensburg has undertaken since Mr. Lusk's death.
- That training has included the Royal College of General Practitioners Mental Health training; and induction and training over a period of one month prior to his commencement at ATODS in June 2005.

In making the decision as to whether to give information to the Medical Board in relation to Dr. Van Rensburg's conduct with respect to the nature and extent of his mental state examination and risk assessment of Mr. Lusk, the court has also taken into account the following:

- Dr. Kingswell, in his evidence clarified that it is this conduct which is the subject of his recommendation, rather than Dr. Van Rensburg's "knowledge, skills and attitudes" as referred to in Dr. Kingswell's written report.
- Dr. Kingswell's recommendation is informed by reference to the clinical notes of the assessment undertaken by Dr. Van Rensburg; perusal of the sentinel event report interview with Dr. Van Rensburg in April 2005; reference to Dr. Van Rensburg's written statement dated 22nd March, 2006; observation of Dr. Van Rensburg while giving oral evidence during the inquest; information as to the training that Dr. Van Rensburg has since undertaken; Dr. Streatfield's evidence referred to above and the evidence of Dr. Jill Newland that she will be reviewing Dr. Van Rensburg.
- Dr. Van Rensburg's conduct was not consistent with the Cooktown Mental Health Guidelines. Neither was it consistent with what Dr. Van Rensburg stated in evidence he presumed the position to be in Cooktown concerning the relationship between his position and the mental health worker.
- The court accepts the evidence of Dr. Kingswell that, in referring the issue of the mental health assessment to the mental health worker, Dr. Van Rensburg was abrogating his responsibilities as the admitting doctor.
- The court accepts Dr. Kingswell's evidence that Dr. Van Rensburg's statement dated 22nd March 2006 is not supported by the clinical notes and makes bald assertions without any reference to any material supporting those assertions. "*It is*

difficult to accept his recollection in the statement when he could not remember the patient during the Sentinel Event Review". [167]

- Dr. Van Rensburg's statement was written subsequent to receiving mental health training, induction and supervision from Dr. Audley. His oral evidence was given at a time subsequent to mental health training and supervision from Dr. Audley.
- It is concerning that despite mental health training and supervision, and indeed by reference to that training, Dr. Van Rensburg maintains that Mr. Lusk was a low risk of suicide.
- The court observed Dr. Van Rensburg to be disoriented, confused, evasive, obtuse, avoidant and vague during his evidence. Answers to questions of a clinical nature were inappropriate, on occasions comprising words of thanks.
- When questioned as to what action he would take on a future occasion, he stated that he "*would still contact mental health*" when there is clear evidence that he did not do that during the earlier occasion.
- His evidence about the unavailability of Mr. Lusk's medical file during the Sentinel Event Review interview is inconsistent with that of Dr. West, Joanne Oosen and Judy Skalicky. Having regard to the manner in which they gave their evidence, which was not challenged, I accept their evidence over that of Dr. Van Rensburg.
- Dr. Van Rensburg can be singled out from Drs. Coventry and Purcell. Dr.. Van Rensburg was the admitting doctor. The admission process informs the management planning and the discharge process. Dr. Purcell accepts that in discharging Mr. Lusk a serious mistake was made. Dr. Coventry impressed as a witness and is undertaking extension training in mental health.

Having regard to all of the above matters, this court intends to provide information to the Medical Board of Queensland in relation to Dr. Van Rensburg's admission assessment of Mr. Lusk by way of provision of these reasons, a copy of Dr. Van Rensburg's interview with the Sentinel Event Team; a copy of Dr. Van Rensburg's statement dated 22nd March 2006; a copy of the transcript of Dr. Van Rensburg's evidence; a copy of the transcript of Dr. Kingswell's evidence as it relates to Dr. Van Rensburg and a copy of Dr. Kingswell's report.

The court does so on the basis that it reasonably believes the information might cause the Medical Board of Queensland to enquire into, or take steps in relation to, the conduct of Dr. Van Rensburg in his case. It also cannot be satisfied that the Medical Board has inquired into the conduct in the process of granting to Dr. Van Rensburg special purpose registration under the supervision of Dr. Audley.

[167] Evidence of Dr. Kingswell.

PART D

THE CIRCUMSTANCES OF THE DEATH OF EMILY JANE BAGGOTT

Emily was born on 28th December 1988. Her parents separated when she was very young and she spent a significant part of her life living with her mother Kathryn Gibson in various areas of New South Wales and the Gold Coast, with very little or no contact with her father. Her father was in fact unaware of her location for a great deal of the period during which Emily resided with her mother.

He was, as a result, unaware of the numerous difficulties which Emily had faced in her very short life. It is reported that she was variously a victim of sexual assault, a victim of predatory behaviour by adult males, a victim of self-harm and a victim of suicidal thoughts. She was also the subject of attention from the child protection authorities on many occasions, including occasions when her mother was admitted to mental health units as a result of her own mental health issues.

Emily herself had an extensive mental health history which included several admissions to both the Kempsey Mental Health Unit and the Gold Coast Mental Health Unit. She commenced using Cannabis Sativa and, prior to her death, was consuming up to 6 to 7 cones per day. She frequently expressed suicidal thoughts to various social workers with whom she had come into contact and had engaged in self-harming behaviour right up to the time of her death.

Medical Records indicate that on 11th March 2003, Emily was admitted to the Gold Coast Hospital expressing suicidal ideation. She was discharged 3 days later, although continued to be treated by Mental Health Services. She was admitted again on 5th September 2003, when she was diagnosed with Post Traumatic Stress Disorder, and discharged approximately one month later. There were other hospital admissions thereafter. The most recent hospital admission prior to her death was an admission to Kempsey Hospital on 3rd August 2005 where she remained until discharged on 20th August 2005. She was diagnosed with adjustment disorder, depressive disorder and an eating disorder, with a secondary diagnosis of possible borderline personality disorder, as a result of long-term trauma and deprivation. She was prescribed Cipramil.

Emily had by this time renewed contact with her father, Anthony Baggott who resides in Kuranda. Mr. Baggott was offering Emily assistance with a number of issues and Emily had expressed a wish to travel from Kempsey to reside with him and his partner Faye Allen. She was very much looking forward to her new life. Unfortunately, discharge planning from Kempsey had not taken into account the documented impulsivity of Emily's behaviour, her indications that she had intended to move to Kuranda and the urgency with which it appeared Emily wished to effect her re-location. Having obtained a ticket to travel to Cairns, she immediately sought and was granted discharge from the Kempsey Mental Health Unit.

Neither the child protection authorities, nor any medical or mental health professionals from either the Kempsey Mental health unit or the Gold Coast Mental Health Unit had had any previous contact with Emily's father or had provided

Emily's father with any information about Emily, including her risk of suicide. Again, upon discharge from the Kempsey Mental health unit, no-one attempted to involve a parent or the child protection authorities in her discharge planning; obtain from Emily her written consent to disclosure of information to her father and Faye, or otherwise take any steps to inform Mr. Baggott and Faye Allen of Emily's suicide risk. Her treating psychiatrist in Kempsey was of the view that information about Emily was confidential and could not be released without Emily's express consent. Dr. Blom was also unaware that Mr. Baggott did not know of Emily's mental health history.

Despite Emily's extensive mental health history, no continuation support to a mental health service in Cairns was put in place before Emily's departure or upon Emily's discharge. There was no referral to a particular general practitioner or other medical specialist. Emily was simply requested to contact a medical practitioner upon her arrival in Cairns.

On 3rd October 2005, Emily attended upon Dr. Cory of the Edge Hill Medical Centre after arrangements had been made by Emily's step-mother Faye Allan who had become concerned about self-harming behaviour by Emily. Ms. Allen attended the appointment also. Dr. Cory assessed Emily as high risk of suicide. Dr. Cory did not have access to Emily's previous medical history and concedes that she had very little collateral information.

Dr. Cory prescribed further Cipramil 40mg, the same dose that Emily had been on in Kempsey. Dr. Cory contacted the Crisis Assessment and Treatment Team (CATT) and spoke to a psychiatric nurse who indicated an appointment was available either that day or the next. It was decided that Emily would attend the next day.

On 4th October 2005, Sharn Jarvis, a Cairns Youth Mental Health psychologist reviewed Emily for approximately 1-1/2 hours. She did not undertake a comprehensive assessment, but did assess risk with a view to making a further appointment to obtain collateral history. Emily reported that she was very happy to be with her father and Faye and was very positive about the future. Faye accompanied Emily to that appointment also.

Sharn Jarvis assessed that Emily was at high chronic long term risk, as opposed to high acute risk, and upon assessment that the protective factors for Emily with her father and Faye were very high, a decision was made not to admit Emily and she was booked for a continuation appointment on 5th October 2005.

The court accepts the evidence of Faye Allen that she did not receive meaningful communication from either Dr. Cory or Sharn Jarvis that Emily was at high risk and that Faye was not briefed as to what observations she should keep of Emily or what indicators of risk she should look for.

On the 5th October 2005 Emily again attended upon Sharn Jarvis for an assessment of her mood and Sharn Jarvis conducted a basic mental state examination and assessed that her mood had improved, that she was smiling and happy and overall seemed a lot better than the previous day. Faye Allen did not attend with Emily as she was unaware of the assessment of high risk in relation to Emily. At this consultation, Emily advised Sharn Jarvis of her previous admissions to the Kempsey and Gold Coast Mental Health Units and Sharn Jarvis obtained Emily's consent to a transfer of the medical

records to Cairns and made a request of the Kempsey Mental Health Unit for those records.

A further appointment was made for Emily on 6th October, although Ms. Jarvis gave Emily the choice as to whether to attend that appointment or not. She made a definite appointment to see Emily on the 10th October 2005.

Unfortunately, the medical records from Kempsey and the Gold Coast were not available to Sharn Jarvis prior to Emily's death due to the lack of an electronic computer system to enable the collection of complete and accurate medical histories of patients treated in other hospitals/services within Queensland or from other states of Australia.

On 6th October 2006, Emily failed to attend her 9.00am appointment with Sharn Jarvis. At approximately midday that day, she was found by her father hanging from a rafter at the family home.

Emily's parents are understandably shattered by Emily's death. Anthony and Faye are particularly distressed that Emily's risk status was not communicated to them in a meaningful way. Faye has made it clear that if she had been told of the risk, she would have made other arrangements to ensure Emily's care and protection.

On the 13th October 2005, a Sentinel Event Review was conducted after Emily's death by Judy Skalicky, Professor Ernest Hunter and Adrian Shea and a report was subsequently prepared and furnished to the District Manager, Cairns Health Service District.[168]

The conclusions contained in that report were that there was "*no evidence that any task, practitioner, team, workplace or organisational factors within Queensland Health contributed to an adverse outcome for Emily; and that a review of the actual events and interviews with all parties involved; combined with collateral obtained post-suicide; provides that the care provided/steps taken were according to policy/procedure. The discharge planning from Kempsey Hospital was poor, but this needs to be investigated by another jurisdiction".*[169]

In his report dated 17th August 2006, however, Dr. Kingswell highlights a number of issues which the courts accepts are relevant to the treatment of Emily, both in Kempsey, the Gold Coast and finally in Cairns;

- Kempsey Mental Health failed in their responsibility to ensure that Emily obtained appropriate treatment in Cairns when Emily had not refused consent to the release of her medical details from Kempsey, it was known she had recently been an inpatient, had not complied with treatment and was depressed and suicidal.
- The view of the psychiatrist in Kempsey that Emily's problems were the result of enduring personality traits and chronic social stressors should not be seen as a reason not to consider that she was also at serious risk of depression.
- The documented history available in Cairns was inadequate and the symptoms of depression were not explored, such that a moderate to severe depressive disorder

[168] Exhibit 71
[169] Exhibit 71 paragraph 13.

might have been missed. There is no evidence that the disorder of depression was treated vigorously along evidence-based practice guidelines as outlined in Exhibit 174. Dr. Kingswell also expressed concern that despite the ticked boxes on the risk assessment instrument indicating that Emily was high risk, that was not the assessment.

- The clinical record from Kempsey identified a number of concerning elements which would have flagged for the Cairns mental health professionals that Emily was at risk of a serious mental disorder, such as depression, and a serious risk of suicide.
- A risk assessment should not be conducted without a consideration of diagnosis. Had it been established that she suffered an acute or chronic major depressive episode then an acute risk (1/4-1/2) would have been identified. She should have been reviewed by the child and adolescent psychiatrist at the earliest opportunity.
- The management with respect to the choice of antidepressants was inappropriate and should have been reviewed by the Consultant Psychiatrist. The use of an SSRI (Selective Serotonin Reuptake Inhibitors) of which Cipramil is one, has been associated with reports of worsened suicidal ideation, mania, seizure and clinical worsening,[170]particularly in the short period after they are started. During that period, there is a significant increase in the number of young people that feel the urge to take their lives. There are, therefore, significant published warnings about the precautions that need to taken.[171] Those warnings should have been passed on to the family so that they could increase their vigilance of, and assistance to, Emily. Dr. Kingswell's view is that different medication should have been prescribed. "*Fluoxetine is the only anti-depressant that has shown any benefit in young people. Emily should have had a trial of fluoxetine and further decisions made only had it not been effective"*[172].
- Coronial findings in 2004[173] following the death of a 15 year old girl who had been prescribed a SSRI[174] recommended that families and carers of children prescribed such medication should be alerted to observe patients for the onset of any depressive or other known symptoms. Other recommendations included that all options about voluntary care and treatment should be explained fully to families and carers; medical practitioners should recognise the emotional and practical burdens which close supervision of a child at home entails, satisfy themselves that the adults concerned are capable and willing to shoulder those burdens and ensure an adequate system is in place to support them; and the attention of all medical practitioners should be drawn to the recommendations of ADRAC on 17th June 2004 in relation to prescribing SSRI antidepressants in children and adolescents and the advice to be given to families and carers.
- Dr. Kingswell was concerned that, despite such findings and the ADRAC recommendations, SSRIs are continued to be prescribed. Furthermore, it seems that coronial findings are not published to treating/prescribing mental health professionals.
- Dr. Kingswell understandably also expressed concern about the failure of Queensland Health to implement a system to ensure that coronial findings are published to treating/prescribing clinicians. Any coronial recommendations which

[170] Exhibit 176.
[171] Exhibit 176.
[172] Evidence of Dr. Kingswell.
[173] Exhibit 177 Coronial findings in the matter of Vivian Margaret Crane.
[174] Roaccutane, also an SSRI.

have come to his attention have either been provided to him by this court in the process of its investigation or otherwise obtained by Dr. Kingswell himself from the Queensland Coroner's website.

- Communication between Cairns Youth Mental Health Service (CYMHS) and Emily's parents and Faye Allen was very poor as was the communication between Kempsey Mental Health service and Cairns CYMHS.
- *"There needs to be increased education about the issues of confidentiality and consent to ensure that persons understand that confidentiality ends when the safety of the person or the community is at risk".* The "Guidelines for the management of patients with suicidal behaviour or risk" issued by Queensland Health April 2004 state quite clearly that "…confidentiality is not absolute…may involve breaching confidence, including acting against the express wish of another person".
- While there are two child and youth psychiatric positions in Cairns neither of those positions were filled as at 17th August 2006.
- Due to the fact that there is no child/adolescent mental health unit in Cairns, children are sent to the Brisbane Mental Health child/adolescent unit as it is inappropriate to admit them to the Adult Mental Health Unit and may not always be appropriate to admit to the paediatric unit. In any event, paediatric nurses do not have child and youth mental health training.

FINDINGS

1. The identity of the deceased was Emily Jane Baggott.
2. Her date of birth was 28th December 1988.
3. Her last known address was Lot 42 Wright's Lookout, Kuranda, North Queensland.
4. At the time of her death her occupation was unemployed, because she was making applications to study at TAFE.
5. The date of her death was 6th October 2005.
6. The place of her death was Lot 42 Wright's Lookout, Kuranda.
7. The formal cause of her death was asphyxia sequential to hanging due to depression[175].

[175] Exhibit 65. Autopsy Report of Dr. S. McDonald.

Part E

CONCLUSIONS

Despite the existence of significant good mental health policy which has been formulated over the last seventeen (17) years, including critical policy in relation to risk assessment, participation of carers, access to medical records, liaison with general practitioners and discharge planning, it was insufficient to protect Charles, Patrick and Emily.

Patrick and Emily were inadequately assessed. In Patrick's case, basic clinical competencies in risk assessment were lacking, as were opportunities for training and processes to assess performance; and Patrick's general practitioner was not consulted at any time. In Emily's case, a lack of discharge planning in Kempsey left Emily vulnerable to risk; and confusion about confidentiality issues and the lack of a cross-border and state-wide electronic information system meant that mental health workers were not provided with crucial medical information.

Charles was not assessed at all, due to pressure on resources. There was also no safe place and no community supports/programs available to him. The system had in fact been unable to meet his needs for a considerable period, due also to cultural misunderstandings.

In all three cases, none of the family members/significant carers were involved in treatment issues to the extent to which longstanding formulated policy dictated.

Good policy itself is clearly not enough; and for so long as priority is not given to active implementation of policy, adequate resourcing and single point accountability, nothing will change for those people in our community who suffer mental illness.

What the situation now dictates is that everything cannot stay the same.

PART F

RECOMMENDATIONS

Implementation of mental health policy and service reform

1. That Queensland Health, as a matter of priority, actively implement the strategies for reducing suicide and deliberate self-harm in mental health services and related health service settings; as outlined in the National safety priorities in mental health: a national plan for reducing harm, October 2005.[176]
2. That Queensland Health, as a matter of priority, actively implements the National Practice Standards for the Mental Health Workforce[177] and the National Practice Standards for Mental Health Services.[178]
3. That Queensland Health, as a matter of priority, actively implements the reforms of the National and Queensland Action Plans on Mental Health 2006-2011.
4. That Queensland Health actively implements the Recommendations from the Public Advocate's Annual Reports to the Queensland Parliament 2003-04 and 2004-05 and give consideration to the involvement of the Office of the Public Advocate in relation to such implementation.
5. That Queensland Health, as a matter of priority, actively implements the Queensland Health Guidelines for the Management of patients with suicidal behaviour or risk.[179]
6. That Queensland Health accelerates the implementation of Key Recommendations 1,2,4,5 and 8 of the "Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events".[180]
7. That the Director of Mental Health and the corporate office of the Mental Health Branch, consistent with the Director's functions under the Mental Health Act 2000[181] be given both the mandate and the resources to;
    a. provide the necessary leadership and guidance to support District mental health services in implementing the National safety priorities, the National Practice Standards, the National and Queensland Action Plans and the recommendations of the Public Advocate's Annual Reports; and in accelerating implementation of Key Recommendations 1,2,4,5 and 8 of the "Achieving Balance: Report of the Queensland Review of Fatal Mental health Sentinel Events" and the recommendations from the Public Advocate's reports referred to above;

[176] Exhibit 185 at page 15.
[177] Exhibit 154. Appendix 1.
[178] Exhibit 154. Appendix 1.
[179] Exhibit 117.
[180] /exhibit 179.
[181] S. 489(1) Mental Health Act 2000.

b. develop and implement State-wide policy and frameworks in relation to the implementation of the recommendations raised in the Issues Paper of the Public Advocate in relation to assessments, access to information, carers and network support, liaison with general practitioners, discharge planning, supports in the community, indigenous mental health and broader systemic issues; and consider the involvement of the Public Advocate in relation thereto.

c. develop and implement state-wide policy and frameworks in relation to other recommendations made as a result of this inquest;

d. monitor, review and report on the Districts' implementation of each of these reforms, or create an independent mechanism for this review to occur.

8. With respect to District mental health services:

    a. That local policies be developed to implement the above-mentioned strategies, national practice standards, action plans and recommendations, taking into account local circumstances, service demand and capacity;

    b. That operational procedures and clinical guidelines be developed to enable staff to put these policies into practice;

    c. That a strategy for the active and ongoing implementation of these policies, procedures and guidelines be created, to include a training regime which will target all staff, whether new or existing, (including psychiatrists, nurses and allied health) and whether fulltime, part-time, temporary, casual or relieving staff. Area and District management should demonstrate their active support for this process.

    d. That Executive Directors of District mental health services be accountable to their Area Directors for the implementation of (a)-(c) above;

    e. That Area Directors actively monitor their Districts' implementation of (a)-(c) above;

    f. That Area General Managers be accountable for implementation of policy and service reform, as well as assessment of the knowledge of, and competency in, mental health procedures/policies of their staff in their Areas; and consideration be given to the involvement of the Director of Mental Health, with the Director-General of Health, in any process ensuring that Area General Managers deliver on their accountability.

9. With respect to implementing the reform agenda of the 2005 Queensland Health Systems Review (i.e. the "Forster" review):
    a. That consideration is given to the importance of flexibility in the progress of policy and service reform at the local level by Queensland Health Area General Managers, District Executive Directors and Clinical Directors.

b. That the impact of the current Queensland Health reform process on patient outcomes in mental health be closely scrutinised over a period of time, to ensure that an appropriate balance has been reached between central office control and regional independence in decision-making.

Mental health/suicide risk assessment

In addition to the recommendations contained within the Issues Paper of the Office of the Public Advocate;

1. That the State-wide Clinical Risk Assessment and Management Training Project Training package be made available to all mental health professionals, including life promotion officers, throughout Queensland, whether new or existing, full-time, part-time, temporary, casual or relieving; and that Queensland Health provide the necessary funding, to include funding for performance management of staff which will identify and correct gaps in competencies; and recurrent funding for ongoing training.

2. That, where there is no mental health unit attached to a health service at which patients are likely to present for mental health problems:
    a. if the health service has a mental health team/worker, that patients should be properly assessed by this team/worker at the earliest opportunity, and particularly before they are discharged; or
    b. if there is no mental health team/worker at the health service, that the health service should establish a formal protocol with the nearest mental health service/team/worker to ensure the proper assessment and treatment of such patients;

3. That, wherever possible, two (2) mental health workers complete a mental health risk assessment, and in the event of any difference of opinion, that a Consultant Psychiatrist review the assessment.

4. That Queensland Health amend its "Guidelines for the management of patients with suicidal behaviour or risk" to include a requirement that where there is a dispute between clinicians as to the likelihood, magnitude or immediacy of risk, that a Consultant Psychiatrist review the matter.

5. That Queensland Health develop and implement a guideline for use by mental health workers, of the National Institute for Health And Clinical Excellence Quick reference guide for Depression in Children and Young people; Identification and management in primary, community and secondary care.

6. That Queensland Health develops and implements guidelines in relation to the use of Selective Serotonin Reuptake Inhibitors for young people with a mental illness.

7. That the Queensland Government Suicide Prevention Strategy 2003-08 be revised to include reference to the need for frameworks/guidelines to assess suicide risk.

Access to information

In addition to the recommendations contained in the Issues Paper of the Office of the Public Advocate;

1. That the Director of Mental Health accelerate the implementation of a state-wide electronic network of patient information that allows treating health professionals, including both inpatient and community staff, to rapidly access patient data throughout the State; and that Queensland Health provide the necessary funding as a matter of priority.
2. That Queensland Health review the provisions of the Health Services Act 1991 Qld as they relate to the disclosure of confidential information [182]and implement such changes as will remove any doubt that the confidentiality of information relating to a person receiving a health service is balanced with the duty of care to that person, the rights of the public to protection against the risk of harm, the rights of carers and support networks to meet their responsibilities to the person and other members of the household.
3. That Queensland Health develops, implement and provide training in, state-wide guidelines defining the issues of confidentiality of mental health as they affect clients and their families and making clear to all mental health workers the circumstances in which it is appropriate for mental health staff to share information regarding the person.
4. That the requirement in S.62I Health Services Act to have the authority of the chief executive in writing for a disclosure to be made of confidential information that is necessary to assist in averting a serious risk to the life, health or safety of a person, including a person to whom the confidential information relates; or public safety, should be removed.

General Practitioner Liaison/Support

That in addition to the recommendations contained in the Issues Paper of the Office of the Public Advocate;

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

[182] Ss.62A – 62R of the Health Services Act 1991. Exhibit 170.

Supports in the community

In addition to the recommendations contained in the Issues Paper of the Office of the Public Advocate;

1. That the Queensland Government increase funding to a range of community-based services to assist both adults and children with mental health problems, in Yarrabah, Cooktown and the Cairns Integrated Mental Health Service Clinical Network.

- This should include both clinical and non-clinical services, and both generic and mental health-specific services, in addition to nurses, allied health workers, psychiatrists, psychiatry registrars and indigenous mental health workers and life promotion officers.
- That the Queensland Government ensure that:
    a. Priorities include both clinical and non-clinical support (given that many people with a mental illness also require support with housing, substance abuse, and employment)
    b. specific high-needs sub-groups receive equitable access to support (in particular, Indigenous people and people living in rural/remote areas).

2. That Queensland Health identify, develop and fund community-based and culturally-appropriate alternatives to acute inpatient admission in the Cairns District Health Service area, specifically for those patients for whom inpatient care is unnecessary or contraindicated, but who still require some support.

3. That Queensland Health invest in programs of intensive post-discharge support for patients in the Cairns District Health Service Area who have presented with suicide ideation or who have been assessed at risk of suicide or self harm.

Indigenous Mental Health

In addition to the recommendations contained within the Issues Paper of the Office of the Public Advocate;

1. That Queensland Health, as a matter of priority, implements the Protocols for the Delivery of Mental Health Services in Far North Queensland Indigenous Communities: Guidelines for health workers, clinicians, consumers and carers.[183]
2. That Queensland Health, in conducting ongoing research into Indigenous peoples' understanding of behaviour generally, particularly mental illness and suicide, give consideration to the involvement of Dr. Ernest Hunter in the formulation and implementation of policy guided by such research.

[183] Exhibit 199.

Recommendations specific to the Yarrabah community

1. That Queensland Health provides funding for the extension of the Dual Diagnosis Mental Health/Substance Abuse – Program in Cairns to Yarrabah to facilitate the entry of Dual Diagnosis Indigenous clients into existing Substance Rehabilitation Programs at Yarrabah and the Cairns District.

2. That Queensland Health provides funding for the provision of a detoxification program in Yarrabah to accommodate the needs of chronically dependent and relapsing heavy drinkers.

3. Alternatively, that Queensland Health restores in-patient capacity to the Yarrabah hospital to allow for brief periods of observation, management of detoxification, short-term management of patients at risk of harm to self or others, or until safe transport to Cairns hospital is available.

4. That Queensland Health provides funding the culturally specific mental health programs outlined in the Queensland Mental Health Plan. In the interim, urgent consideration should be given to funding non-clinical support and housing for Indigenous Australians with mental illness in the Cairns Mental Health District.

5. That resources be made available for the establishment within the Cairns Mental Health Network of an Indigenous Specific Community Mental Health Rehabilitation and Recovery Service (modelled on the new Cairns FIRRST – Far North Queensland Intensive Rehabilitation and Recovery Support Service).

6. That Queensland Health develops a job description for Life Promotion Officers and include Life Promotion Officers in all training and assessment provided to mental health workers throughout Queensland.

Recommendations specific to the Cooktown community

1. That Queensland Health establish a formal protocol between Cooktown mental health service and the Cairns District mental health service to ensure that any patient admitted to the Cooktown Hospital for mental health assessment and treatment, unless transferred to Cairns for ongoing treatment, should be discussed with the psychiatrist on-call for Rural and Remote Mental Health prior to discharge.

2. That the executive of Cooktown Hospital, together with the executive of the Cairns Health District Service;
    a. identify and reduce barriers to onsite training;
    b. support both nursing staff and medical officers to attend local training opportunities;
    c. facilitate the attendance of all mental health staff at Cairns Base Hospital medical and nursing in-services, either personally, by video link or by pre-recording;

d. implement processes to enable staff to access relevant protocols during work time;
e. Set up a system of peer supervision/support

3. That the Memorandum of Understanding being developed by the Cairns District Health Service Remote Team that details the service delivery interaction between the district mental health teams and the Remote Area Mental Health Team based in Cairns be completed and signed off by the district and remote team.

4. That position descriptions for Rural and Remote practitioners need to indicate that competency in mental health is essential and needs to be of the standard demanded by the Australian Medical Council and Australian Medical Schools. Position descriptions should indicate that extension training in mental health is desirable. Practitioners should be encouraged to complete the Royal Australian College of General Practitioners Level One Mental Health Skills Training or an equivalent qualification prior to taking up a position in a rural or remote Queensland Health Service.

5. That the Cairns District Health Service and the executive of the Cooktown hospital develop and implement a policy guideline to ensure that patients of the Cooktown inpatient unit need to be able to identify a primary nurse assigned to their care. That nurse needs to be fully appraised of his or her responsibilities towards an individual patient.

6. That the Cooktown Hospital staff review their complaints procedure to ensure complaints are advanced to the relevant parties as soon as possible and actioned in a timely manner.

7. That RANIP (Remote Area Nursing Incentive Package) conditions be available to nursing staff in Cooktown in an attempt to attract permanent staff, through providing increased remuneration, accommodation, and other education benefits.

8. Alternatively, that Queensland Health consider funding nursing positions in Cooktown on a basis which would offer nursing staff the alternative to fly in/out from Cairns so as to increase the chances of obtaining more permanent positions in Cooktown.

9. That Cairns District Mental Health Service review its partnerships with Queensland ambulance, Queensland police and the Royal flying Doctor Service to establish protocols for the safe transport of mentally ill persons from remote and rural locations such as Cooktown who need specialist services in Cairns.

10. That the Cairns District Mental Health Service reviews any real or perceived barriers to providing inpatient beds for patients from Cooktown and surrounding districts.

11. That consideration is given to increasing the number of Acute Mental Health Inpatient Beds at the Cairns Base Hospital to five (5) to meet existing and projected need.

12. That Queensland Health provides funding for adequate nursing staff numbers at the Cooktown hospital and community mental health worker positions at the Cooktown community health centre.

13. That the hospital at Cooktown be urgently refurbished or redeveloped so as to provide one room within it that is properly configured to adequately house patients at risk and contain those at risk of harming others.

14. That consideration is given to creating one or more medical positions to be managed by a large regional service (eg Cairns) and to provide a fly in, fly out service to relieve medical staff.

15. That the Queensland Medical Board and the Royal Australian and New Zealand College of Psychiatrists should consider streamlining their processes of assessments of competency and recognition of overseas trained psychiatrists to ensure that such applications can be processed in a timely manner.

16. That the Cooktown Hospital Administration review the process for the collection and dissemination to important stakeholders of Queensland Health State Wide initiatives, particularly those that relate to clinical practice and patient safety.

17. That there be formal lines of reporting responsibility between mental health district staff and psychiatrists/Team Leaders in Cairns Integrated Mental Health.

18. That the Cooktown Hospital Administration review the process for the distribution of the recommendations of Sentinel Event Reviews and other relevant Queensland Health Initiatives to those responsible for the implementation of the recommendations.

19. That the Executive of the Cooktown hospital formulate and publish to all staff, whether new or existing, full-time, part-time, casual, temporary or relieving, an orientation manual that identifies local issues and procedures; and provide formal orientation and induction training for all staff.

20. That Queensland Health and the executive of the Cooktown hospital develop and implement policies /guidelines to give immediate effect to the recommendations of the Sentinel Event Team Report dated 25th May 2005, in the matter of Patrick Douglas Lusk.

21. That Queensland Health provide funding, including recurrent funding, for the training and education referred to in that report, such training to be provided to all health staff, whether full-time, part-time, casual temporary or relieving.

Coronial Inquiries – Dissemination of Recommendations

1. That the Queensland Health Patient Safety Centre remains the point of contact for the receipt of all coronial findings and recommendations.

2. That the Queensland Health Patient Safety Centre be mandated to consistently provide all coronial findings and recommendations to Area Health Service Clinical Governance Units in each of the health districts so that relevant systemic improvements can be made.

3. That Area Health Service Clinical Governance Units in each of the health districts effectively communicate coronial findings and recommendations to all mental health professionals within the particular area; and provide information and reasons to clinical directors about what recommendations are to be actioned and what recommendations are not to be actioned.

I will direct that copies of these findings and recommendations be forwarded to;

1. The Queensland Health Minister.
2. The Director-General of Queensland Health.
3. The Director of Mental Health, Dr. Aaron Groves.
4. Dr. William Kingswell.
5. Professor Ernest Hunter.
6. The Office of the Public Advocate.
7. The Medical Board of Queensland.
8. Dr. Richard Walter Streatfield.
9. Dr. Jillian Mary Newland, Director of Clinical Support, Northern Area Health Service.
10. Dr. Janet Susan Bayley, Clinical Director, Cairns Integrated Mental Health Service.
11. Dr. Roy West, Consultant Psychiatrist.

EXHIBIT LIST

Inquest into the cause and circumstances of death of Patrick Douglas Lusk; Charles Edward Barlow and Emily Jane Baggott

PARTIES/INTERESTED PERSONS/NEXT OF KIN

Mr John TATE, Counsel – Assistant to the Coroner
Ms. Lisa EVANS, Counsel – Cairns Health Service District, Dr. Paul Davis and Nurse Manager Jane Donaldson
Mr. Dean MORZONE, Counsel – for Dr Errol Van Rensburg
Mr. G. REBETZKE, Roberts & Kane Solicitors – for Nurses Daphne Fenton, Jola George, Telesase Fale, Pamela Bradford
Mr. Mark GLEN – for Dr. Julie Sykley
Ms. Cheryl Prigg – next of kin of Patrick Douglas LUSK
Ms. Mona Barlow - next of kin of Charles Edward BARLOW
Mr. Anthony Baggott and Ms. Faye Allen – next of kin of Emily Jane BAGGOTT
Ms. Katherine Gibson – next of kin of Emily Jane BAGGOTT

Coroner	**Ms Tina PREVITERA**	
Exhibit No.	**Description**	**Tendered By**
LUSK 1	Form 1 Police Report of Death to a Coroner– Patrick Douglas LUSK dated 7th April 2005	TATE
2	Form 30 Autopsy Certificate (attaching Autopsy Report) - Dr J. M. JAGUSH in the matter of Patrick Douglas LUSK dated 12th April 2004	TATE
3	Medical Records – Cooktown Medical Centre – in the matter of Patrick Douglas LUSK	TATE
4	Medical Records – Cooktown Hospital – in the matter of Patrick Douglas LUSK	TATE
5	Sentinel Events Records – in the matter of Patrick Douglas LUSK	TATE
6	Statement – Det. Sgt. Paul Steven AUSTIN in the matter of Patrick Douglas LUSK	TATE
7	Statement – Snr. Const. Steven Arthur CROSS in the matter of Patrick Douglas LUSK	TATE
8	Statement – Dr. Desmond Roy HILL in the matter of Patrick Douglas LUSK	TATE
9	Statement – Glenn MARCHANT in the matter of Patrick Douglas LUSK	TATE
10	Statement – Jola GEORGE in the matter of Patrick Douglas LUSK	TATE
11	Addendum Statement – Jola GEORGE in the matter of Patrick Douglas LUSK	TATE

12	Statement – Dr. Julie Anne SYKLEY dated 24th February 2006 (including Review Report Cooktown Mental Health Service March 2005 to Dr.. Hunter dated 24th March 2005; email Dr. Coventry to Judy Skalicky dated 6/3/05;email Judy Skalicky to Julie-anne Sykley 6/9/05) in the matter of Patrick Douglas LUSK	TATE
13	Statement – Cheryl Ann PRIGG in the matter of Patrick Douglas LUSK	TATE
14	Addendum Statement – Cheryl Ann PRIGG	TATE
15	Statement – Dr. Natasha Lee CONVENTRY in the matter of Patrick Douglas LUSK	TATE
16	Statement – Dr. Margaret PURCELL in the matter of Patrick Douglas LUSK	TATE
17	Statement – Pamela Joy MARSH in the matter of Patrick Douglas LUSK	TATE
18	Statement – Dr. Michael J OWENS in the matter of Patrick Douglas LUSK	TATE
19	Statement – Pamela Eileen BRADFORD in the matter of Patrick Douglas LUSK	TATE
20	Statement – Telesase FALE in the matter of Patrick Douglas LUSK	TATE
21	Statement – Daphne Ann FENTON in the matter of Patrick Douglas LUSK	TATE
22	Statement – Dr. Errol Van RENSBURG in the matter of Patrick Douglas LUSK	TATE
23	Letter dated 5 April 2005 from Cheryl Ann PRIGG to Margie STEWART in the matter of Patrick Douglas LUSK	TATE
24	Letter dated 22 April 2005 from Cheryl Ann PRIGG to Gordon NUTTAL in the matter of Patrick Douglas LUSK	TATE
25	Letter dated 13 May 2005 from Cheryl Ann PRIGG to Gordon NUTTAL in the matter of Patrick Douglas LUSK	TATE
26	Letter dated 3 June 2005 from Cheryl Ann PRIGG to Michael BARNES in the matter of Patrick Douglas LUSK	TATE
27	Letter dated 20 May 2005 from Julie DAHL to Cheryl Ann PRIGG in the matter of Patrick Douglas LUSK	TATE
28	Letter dated 6 June 2005 from Gordon NUTTAL to Cheryl Ann PRIGG in the matter of Patrick Douglas LUSK	TATE
29 - 34	Photographs – various in the matter of Patrick Douglas LUSK	TATE
BARLOW 35	Form 1 – Charles Edward BARLOW	TATE

36	Autopsy Certificate - Dr M. STEWART in the matter of Charles Edward BARLOW dated 20/5/04	TATE
37	Toxicology Certificate – Charles Edward BARLOW dated 13/5/04	TATE
38	Medical Diary – Debbie JOLLEY (pages 25/02/04, 06/04/04, 08/04/05) and Report	TATE
39	Medical Records – Yarrabah General Practice in the matter of Charles Edward BARLOW	TATE
40 - 41	Medical Records – Yarrabah Hospital – in the matter of Charles Edward BARLOW	TATE
42	Medical Records – Cairns Base Hospital in the matter of Charles Edward BARLOW	TATE
43	Medical Records – Cairns Mental Health in the matter of Charles Edward BARLOW	TATE
44	Statement – Snr. Const. Daniel BRAMHAM – in the matter of Charles Edward BARLOW	TATE
45	Statement – Const. Nicole JANSEN – in the matter of Charles Edward BARLOW	TATE
46	Statement – Dr. Paul DAVIS in the matter of Charles Edward BARLOW	TATE
47	Statement – Veronica CURTIS in the matter of Charles Edward BARLOW	TATE
48	Statement – Vincent Gresham SANDS in the matter of Charles Edward BARLOW	TATE
49	Statement – Wayne Charles CONNOLLY in the matter of Charles Edward BARLOW	TATE
50	Statement – Vincent Desmond MURGHA in the matter of Charles Edward BARLOW	TATE
51	Statement – Carmel Veronica MYNGHA in the matter of Charles Edward BARLOW	TATE
52	Statement – Kirsten James MALONEY in the matter of Charles Edward BARLOW	TATE
53	Statement – Mona Francelle BARLOW in the matter of Charles Edward BARLOW	TATE
54	Statement – Charlene VOGLER in the matter of Charles Edward BARLOW	TATE
55 - 63	Photographs – various - in the matter of Charles Edward BARLOW	TATE
BAGGOTT 64	Form 1 – Emily Jane BAGGOTT	TATE
65	Autopsy Report - Dr. S. McDONALD in the matter of Emily Jane BAGGOTT	TATE
66	Toxicology Certificate in the matter of Emily Jane BAGGOTT	TATE
67	Life Extinct Certificate in the matter of Emily Jane BAGGOTT	TATE
68	Queensland Ambulance Report in the matter of Emily Jane BAGGOTT	TATE

69	Field Property Report in the matter of Emily Jane BAGGOTT	TATE
70	Station Property Report in the matter of Emily Jane BAGGOTT	TATE
71	Sentinel Event Review – BAGGOTT	TATE
72	Medical Records – Gold Coast Hospital in the matter of Emily Jane BAGGOTT	TATE
73	Medical Records – Gold Coast Mental Health Unit in the matter of Emily Jane BAGGOTT	TATE
74	Medical Records – Cairns Mental Health in the matter of Emily Jane BAGGOTT	TATE
75	Medical Records – Cairns Base Hospital in the matter of Emily Jane BAGGOTT	TATE
76	Medical Records – Kempsey Hospital in the matter of Emily Jane BAGGOTT	TATE
77	Statement – Dr. Sue CORY in the matter of Emily Jane BAGGOTT	TATE
78	Statement – Const. Mishe PASCOE	TATE
79	Statement – Det. Snr. Const. Melanie STEVENS	TATE
80	Statement – Kenneth Charles PARSONS	TATE
81	Statement – Anthony Walter BAGGOTT	TATE
82	Addendum Statement – Anthony Walter BAGGOTT	TATE
83	Statement – Faye Margaret ALLEN	TATE
84	Addendum Statement – Faye Margaret ALLEN	TATE
85	Statement – Sharn Cara JARVIS – Management of Consequences & Suicide Behaviour or Risk Procedure	TATE
86	Statement – Giuliana MOGOROVICH	TATE
87	Risk Assessment Report – Sharn JARVIS	TATE
88	Continuation Sheet – Sharn JARVIS	TATE
89	Continuation Sheet – Giuliana MOGOROVICH	TATE
90	Letter from Sharn JARVIS to Dr Sue CORY	TATE
91 - 100	Photographs – various in the matter of Emily Jane BAGGOTT	TATE
101	Cairns Health Service District Service Eligibility Intake and Referral Procedure Manual – Child Youth Mental Health Services	TATE

102	Primary Clinical Care Manual – Queensland Health/Royal Flying Doctor Service – 3rd Edition 2003 – Section 3 Mental Health	TATE
103	Cairns Community Suicide Risk Flow Chart	TATE
104	Submission by the Director of Mental Health, Dr. Aaron Groves dated 27/3/2006	TATE
105	Report – Sergeant DODDS	TATE
106	Statement – Dr. Errol VAN RENSBURG dated 22nd March 2006 in the matter of Patrick Douglas LUSK	MORZONE
107	Statement – ALDERSON	TATE
108	Referral Letter Dr. Desmond Hill, General Practitioner (enclosing 2 discharge summaries) to Medical Superintendent, Cooktown Hospital re; Patrick Douglas LUSK dated 4th April 2005	TATE
109	Psychiatric Wish List – Nurse Daphne FENTON in the matter of Patrick Douglas Lusk	TATE
110	Australia and New Zealand Clinical Practice Guidelines for the treatment of depression	TATE
111	Australia and New Zealand Clinical Practice Guidelines for the management of adult deliberate self harm	TATE
112	Risk Screening Question Sheet – issues by Queensland Health for use in the screening of mental health patients	TATE
113	Ward Rounds Book – Cooktown Hospital – in the matter of Patrick Douglas Lusk	EVANS
114	Recommendations by Nurse Fale in the matter of Patrick Douglas LUSK	TATE
115	Statement – Sgt. MacDONALD in the matter of Patrick Douglas LUSK	TATE
116	PA Hospital Procedures	EVANS
117	Guidelines for the management of patients with suicidal behaviour or risk - authorised by Dr Arnold Waugh, Acting Director of Mental Health	TATE
118	Statewide Clinical Risk Assessment and Management – Training Project – Mental Health Report – September 2003 – prepared by Sally Plever, Project Officer, Community Forensic Mental Health Service (attaching the article “A fine-grained Study of Inpatients Who Commit Suicide- Katie A. Busch, MD; and Jan Fawcett,MD)	TATE
119	Career Training Planner – Dr. VAN RENSBURG	MORZONE
120	Memo – Jo OOSEN, Nurse Manager to Phil Cammish, District Manager - dated 16 May 2005	TATE

121	Email – Jo OOSEN	TATE
122	Facsimile Letter – Medical Office Roster & Medical Forms	EVANS
123	2nd Addendum Statement – Cheryl Ann PRIGG	TATE
124	Autopsy Report – dated 20 April 2005	TATE
125	Toxicology	TATE
126	Memo – Joyce LEE to Officer in Charge attaching outpatient register	TATE
127	Article – Changability, Confidence, Common sense & corroboration: Comprehensive suicide risk assessment, Australasian Psychiatry, Volume 12, No. 4, December 2004	TATE
128	Complete Sentinel event report in the matter of Patrick Douglas Lusk dated 25th May 2005	EVANS
129	Organisational environment (describes line management not professional & strategic management). Cooktown Multi-Purpose Health Service as at 11/4/2005.	EVANS
130	Flow chart "A model of Sharing Mental Health Care in FNQ"	EVANS
131	Statement – Ms. Margie STEWART in the matter of Patrick Douglas LUSK	TATE
132	Industrial Relations Policy Manual – QLD Health	EVANS
133	Addendum statement – Veronica Curtis	TATE
134	Inpatient Medication Chart – in the matter of Charles Edward BARLOW	TATE
135	Historical Medication Records – in the matter of Charles Edward BARLOW	TATE
136	Map of Yarrabah in the matter of Charles Edward BARLOW	TATE
137	Letter of Referral – Dr Sue CORY To CYMHS in the matter of Emily Jane BAGGOTT	TATE
138	Letter from Public Advocate to Coroner	TATE
139	Statement of Kathryn GIBSON in the matter of Emily Jane BAGGOTT	TATE
140	Recommendations of Kathryn GIBSON in the matter of Emily Jane BAGGOTT	TATE
141	Recommendations Ms. Faye ALLEN in the matter of Emily Jane BAGGOTT	TATE
142	Statement George Samuel BAGGOTT in the matter of Emily Jane BAGGOTT	TATE
143	Cairns District Health Service – Adult Mental Health Referral form	EVANS

144	Feedback Consent form 5/10/05 - CBH	EVANS
145	Cairns Child safety service centre material n the matter of Emily Jane BAGGOTT	EVANS
146	Suicide risk assessment form – CYMHS in the matter of Emily Jane BAGGOTT	EVANS
147	Statistics – Jan 05 – Dec 05 CBH	TATE
148	Report of Dr. Ernest Hunter dated 20/07/06 – in the matter of Charles Edward BARLOW	EVANS
149	An Analysis of Suicide in Indigenous Communities of North QLD – The Historical Cultural and Symbolic Landscape – Ernest Hunter, Joseph Reser, Mercy Baird, Paul Reser May 1999	EVANS
150	Australian Institute Aboriginal and Torres Strait Islander Studies, Research Discussion Paper – "Back to Redfern – Autonomy and the 'Middle E' in relation to Aboriginal Health, Dr. Ernest Hunter, No. 18 July 2006	EVANS
151	Report of Court-Appointed Expert, Dr. William John Kingswell, Psychiatrist, in the matter of Charles Edward BARLOW	TATE
152	Yarrabah Health Strategic Plan- Deed of Commitment - in the matter of Charles Edward BARLOW	EVANS
153	Queensland Health Report on Retention of Mature-aged Nurses (50 years and over) in the Northern Zone	EVANS
154	Issues Paper – "Suicide deaths of mental health patients in Queensland", Michelle Howard, Public Advocate, August 2006	PUBLIC ADVOCATE
155	Email 18/3/05 Dr Sykley to Jane Donaldson in the matter of Patrick Douglas LUSK	GLEN
156	Email 24/3/05 Jane Donaldson to Mr Brownlie in the matter of Patrick Douglas LUSK	GLEN
157	Email 29/3/05 Jane Donaldson to Ms Stewart in the matter of Patrick Douglas LUSK	GLEN
158	Email Dr Sykley to Jane Donaldson in the matter of Patrick Douglas LUSK	GLEN
159	Industrial Relations Policy Manual (Remote Area Incentive Package – Registered Nurses) January 2002	TATE
160	Integrated Mental Health Forms (Referral forms)	TATE
161	Report prepared by Margie Stewart	REBETZKE
162	Dr VAN RENSBURG'S Staff File	TATE

163	Report of Court-Appointed Expert, Dr. William John Kingswell, Psychiatrist, in the matter of Patrick Douglas LUSK, dated 8th August 2006	TATE
164	Queensland Medical Board Certificate of Registration for Special Purpose Activity for Dr. Van Rensburg for period 17th January 2006-16th January 2007 and Assessment Form Special Purpose Registrants completed by Assessors Drs. Purcell and Coventry dated 16th December 2005 in the matter of Patrick Douglas LUSK	TATE
165	Assessment Form for Special Purpose Registrants, Medical Board of Queensland, in relation to Dr. Van Rensburg,	MORZONE
166	Statement of Donna SYMES	TATE
167	Copies of pages of Dr Sykley's diary – 4th, 5th, 6th, 7th, 29th April 2005	TATE
168	Report Dr Audley to Dr Hunter	GLEN
169	Addendum statement of Jola George in the matter of Patrick Douglas LUSK	TATE
170	Health Services Act - sections 61 – 63C	TATE
171	Letter Dr Roy West & Joanne Oosen to Dr Newland in the matter of Patrick Douglas LUSK	TATE
172	Report of Court-Appointed Expert, Dr. William John Kingswell, Psychiatrist, in the matter of Emily Jane BAGGOTT	TATE
173	Reference Guide 2005 - Depression in Children and Young People, developed by the National Collaborating Centre for Mental Health, September 2005; in the matter of Emily Jane BAGGOTT	TATE
174	Depression in Young People – A Guide for Mental Health Professionals, National Health and Medical Research Council, 1997 and rescinded 9/12/04, in the matter of Emily Jane BAGGOTT	TATE
175	Paper, "Clinical Guidance on the use of anti-depressant Medications in Children and Adolescents March 2005" - The Royal Australian and New Zealand College of Psychiatrists, The Royal Australian College of General Practitioners and the Royal Australasian College of Physicians, as attached to the report of Dr. William John Kingswell in the matter of Emily Jane BAGGOTT	TATE
176	"Prescribing Information – Cypramil" – MIMS Abbreviated prescribing information 14/8/06, as attached to the report of Dr. William John Kingswell in the matter of Emily Jane BAGGOTT	TATE
177	Coronial Inquest Findings Vivian Margaret Crane 28/10/2004 – Deputy Magistrate PINCH	TATE

178	Findings of Magistrate Hennessy in the matter of Perry	TATE
179	Summary Report of QLD Review of Fatal Mental Health Sentinel Events – Achieving Balance	TATE
180	Achieving Balance – Implementation of the Report of the Queensland Review of Fatal Mental Health Sentinel Events Update No.1 – October 2005 Update No.2 – March 2006 Update No.3 – July 2006	TATE
181	GP Mental Health Standards Collaboration Courses	MORZONE
182	Senior Medical Officer Remuneration Schedule in the matter of Patrick Douglas LUSK	TATE
183	Wage Rates for Nurses	REBETZKE
184	Chapter 55 – Alcohol Hallucinosis in the matter of Charles Edward BARLOW	TATE
185*	National Safety Priorities in Mental Health	TATE
186*	Recommendations of the Public Advocate	TATE
187	National Mental Health Report – page 3	REBETZKE
188	National Mental Health Report – pages 70, 71	REBETZKE
189	Letter to Dr Van Rensburg	TATE
190	Recommendations of Dr West	EVANS
191	Recommendations of Judy Skalicky and supporting material	EVANS
192	Recommendations – Sgt DODDS	TATE
193	Recommendations – Dr Jillian NEWLAND	EVANS
194	Recommendations – Dr BAILEY	EVANS
195	Submission of Dr Simon BRIDGE, General Practitioner, Cairns – Suicide Prevention in Mental Health, 30th April 2006	TATE
196	Report of Dr. Philip Morris, Gold Coast Institute of Mental Health dated 15th August 2006	TATE
197	Submission and Recommendations of White Wreath Association Ltd dated 14th August 2006	TATE
198	Supplementary Report – Professor Ernest Hunter to the Coroner dated 1st September 2006 in the matter of Charles Edward BARLOW	

199	Protocols for the Delivery of Mental Health Services in Far North Queensland Indigenous Communities: Guidelines for Health Workers, Clinicians, Consumers and Carers in the matter of Charles Edward BARLOW	
200	Privacy Guidelines – For Queensland Health Staff and General Practitioners to Support Continuity of Care in Qld	
201	Memorandum Senior Director Patient Safety Centre to Director of Medical Services, District Managers, General Managers, Directors AHS Clinical Governance Units re QLD Health Point of Contact for Coronial Matters 24/8/2006	