OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the deaths of Liam John Wright and Charles Michael Powell**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2048/06 & 2179/06
DELIVERED ON:	20 March 2009
DELIVERED AT:	Brisbane
HEARING DATE(s):	10 – 14 November 2008 and 15 December 2008
FINDINGS OF:	Coroner John Lock
CATCHWORDS:	CORONERS: Inquest – Suicide by train over-run, Mental Health services at Logan Hospital, adequacy of care and of decision making

REPRESENTATION:

Counsel assisting the Coroner: Ms J Rosengren

The State of Queensland (as operator of the Logan Hospital): Mr P. Freeburn SC instructed by Corrs Chambers Westgarth lawyers

Registered Nurses Fitzpatrick, Kohleis, Skeffington, Wong: Mr G Rebetzke instructed by Roberts and Kane Solicitors

Dr Paul: Mr D Tait SC instructed by Blake Dawson & Waldron

Dr Leivesley: Mr Kalimnios instructed by Avant

Ms J Neill: Ms S Gallagher instructed by TressCox lawyers

CORONER'S FINDINGS AND DECISION

1. These are my findings in relation to the deaths of Liam John Wright and Charles Michael Powell. At the request of family they will be referred to as Liam and Charlie. They were not known to each other. In July 2006 they both came into contact with the mental health services based at Logan Hospital. In Liam's case he had been admitted to Ward 2B and later transferred to the secure Acute Observation Area ("AOA") of the Mental Health Unit ("MHU") based at the Hospital. However, on 14 July 2006 a decision was made to place him in a general non secure mental health unit ward, despite Mrs Wright's concerns that Liam may abscond and harm himself or others. He absconded soon after he was transferred into the open ward. About a fortnight later, on 31 July 2006, Charlie was being assessed at the Emergency Department ("ED") of Logan Hospital as to whether he should be admitted to the MHU. He was not admitted, again despite Mrs Powell's concerns for his safety and well being. Shortly after these clinical decisions were made, both of these young men took their own lives by jumping in front of a train.

2. These findings seek to explain how the deaths occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. I will be dealing with each case separately by way of findings but there will be some recommendations made which relate to the MHU at Logan Hospital which arise out of both cases. There was some overlapping of clinicians involved in each case, and there are some similar issues involved, apart from the proximity in time; the fact that Logan Hospital is involved; and the method by which they each died. In both cases Dr Joan Lawrence, a psychiatrist and an Adjunct Professor in psychiatry, has provided an expert assessment and report as to the appropriateness of the treatment and clinical decisions made. Dr Lawrence had provided a report to the Health Quality and Complaints Commission in respect to Liam which was being used for confidential mediation purposes. The Commission, Dr Lawrence and Liam's family helpfully agreed to release the report to the Coroner for use in the inquest and I thank them for this decision. Dr Lawrence then agreed to provide a report to the Coroner in respect to Charlie's case.

3. I also would like to acknowledge the valuable advice and assistance I have received from Ms Jennifer Rosengren in her role as Counsel Assisting. I also received helpful assistance from other counsel representing the various parties who were given leave to appear.

4. Section 45 of the *Coroners Act 2003* ("the Act") provides that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The scope of the Coroner's inquiry and findings

5. A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-
   - (a) whether a death in fact happened;
   - (b) the identity of the deceased;
   - (c) when, where and how the death occurred; and
   - (d) what caused the person to die.

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

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

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

The admissibility of evidence and the standard of proof

9. The coroner's court is not bound by the rules of evidence because the Act provides that the court "*may inform itself in any way it considers appropriate".*[4] That does not mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its origin or source when determining what weight should be given to the information.

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[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] Section 46
[3] Sections 45(5) and 46(3)
[4] Section 37

10. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[5]

11. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable.[6] This means that the more significant the issue to be determined; or the more serious an allegation; or the more inherently unlikely an occurrence; then in those cases the clearer and more persuasive the evidence should be in order for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

12. It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[8] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[9] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

13. If, from information obtained at an inquest or during the investigation, a coroner reasonably believes that the information may cause a disciplinary body for a person's profession or trade to inquire into or take steps in relation to the person's conduct, then the coroner may give that information to that body.[10]

The evidence relating to Liam John Wright

14. It is not necessary to repeat or summarise all of the information contained in the exhibits and from the oral evidence given, but I will refer to what I consider to be the more important parts of the evidence.

15. The issues raised at the inquest included the following:

    (a) Was Liam's mental state adequately assessed at the Hospital between 12 and 14 July 2006?
    (b) Was the decision by Dr Davies to transfer Liam to the open ward on 14 July 2006 reasonable in all the circumstances?
    (c) Did the Hospital adequately respond to the concerns raised by Liam's parents during his admission?

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[5] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[6] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[7] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[8] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[9] (1990) 65 ALJR 167 at 168
[10] Section 48

16. Liam's parents have helpfully provided the court with background information about Liam. It would have been painful for them to provide this information. I thank them for this. At the conclusion of evidence Mrs Wright made a brief statement. Liam's death has had a profound and devastating affect on the family. There is not one day they do not think of Liam. He was only 19 years old and they felt that with the right help he would have had a promising future. He was in the third year of his apprenticeship as a carpenter. He was a dearly loved son.

17. It was at the age of fourteen that Liam first started exhibiting behavioural problems. At the age of fifteen, he was diagnosed with Attention Deficit Hyperactivity Disorder and was prescribed anti-depressant medications. He was expelled from Trinity College at Beenleigh towards the end of grade 11 and completed the rest of his secondary education at Loganlea State High. He then started a carpentry apprenticeship.

18. His behaviour deteriorated after leaving school and this usually corresponded with excessive alcohol consumption. The police were called by Liam's parents on several occasions because of his threatening behaviour.

19. Mrs Wright said that Liam had experienced a number of things going wrong in the last 6 months of his life, which in retrospect Mrs Wright thinks caused him significant problems. These included the engine of his car blowing up, losing his license for speeding and his best friend, (who had been living with them at the time) leaving to join the army. He had also badly broken his arm requiring it to be in a plaster and he had been told by his doctor that he would not be able to work as a carpenter for quite a few months. Mrs Wright recalls Liam as having been greatly upset about this as he loved his job and liked being occupied.

20. In early July 2006, Liam became involved with a girl. This was complicated by the fact that she was or had been in a relationship with one of Liam's brother's friends. The young woman advised police that she had only kissed Liam on one occasion when they were both affected by drugs or alcohol at the time. She maintained that she was still in her relationship with the friend. Whatever may be the whole story, it is clear that Liam had developed some feelings towards her. He became greatly upset about the turn of events that followed. On 11 July 2006 he spent the day with her. She informed him that Liam's younger brother had told Liam's friend of the relationship with her. When Liam found out about this he drank a number of vodkas in a short period and became very emotional. He was also very angry with his younger brother. He then went to a pub and finally returned home. His parents spoke to him about his anger and he seemed to settle. However, later that night at approximately 12.30 am Liam came out of his bedroom holding a kitchen knife and was threatening to use it on himself. The police were called. Mr and Mrs Wright had persuaded Liam to relinquish the knife prior to the arrival of the police. Liam then agreed to voluntarily attend the hospital with the

police for a psychiatric assessment. He was taken by police to the hospital under an Emergency Examination Order.

21. The police indicated to Mrs Wright that she should call the MHU at Logan Hospital and express the grave concerns she held regarding Liam's deteriorating behaviour. Mrs Wright made a call and spoke to a nurse, who whilst sympathetic, told Mrs Wright that it might be difficult to admit him to hospital because of a lack of beds. Mrs Wright was adamant that Liam remain in hospital overnight and the hospital medical records confirm that she had expressed extreme concern about her son and expressed a desire for him to be admitted.

22. The records indicate that at about 2.00 am on 12 July 2006, Liam was assessed by Dr Renee Denham in the ED. She was in her first semester as a training registrar in psychiatry at the hospital. Dr Denham made a comprehensive assessment which was recorded in a very legible form in the medical records. Her excellent notes become important in the context of this case as will be seen later. She provided a statement to the court[11] and gave evidence.

23. Dr Denham recorded a detailed history and what was said by Liam during the assessment, but importantly, in the context of this case, that:

   a) Liam had frequently thought of ending his life and he had decided to end it all earlier that evening and left his bedroom to grab a knife but his parents were at home;

   b) He told police "I tried to kill myself with the knife and I still want to do it" and he was asking the police to help him;

   c) His parents told the police that he'd been suicidal for 1 month;

   d) He had been seen in the ED one month earlier for suicidal ideation;

   e) He had thoughts of killing his brother although he had said that he thought he'd be remorseful afterwards;

   f) He felt he had nothing to live for and hated life and that he would kill himself if he knew how to do it.

24. Dr Denham thought Liam needed admission to mitigate against the risk of harm to himself or his brother and for further diagnosis. She discussed the issue of a voluntary or involuntary admission with Liam. Liam indicated to Dr Denham that he was agreeable to being admitted to the hospital voluntarily. At approximately 3.00 am, Dr Denham left Liam in the assessment room while she completed her notes in the room next

[11] Exhibit C22

door. Whilst this was happening Liam told the nursing staff that he was going home and left the ED.

25. Dr Denham immediately telephoned police and then Liam's parents. She told them that Liam had run off from the hospital and they were looking for him. Shortly afterwards, Mrs Wright says that Liam's girlfriend phoned to tell them that he was at the Loganlea railway station in a very distressed state. Liam then made his way to his grandmother's house and when his parents arrived he was demanding that they give him their car. He then started jumping up and down on the bonnet of the car. The police arrived and Liam tried to run away however he was apprehended and taken back to the hospital at about 4.30 am. He was taken to the MHU so that he could be secured and observed however he could not be placed in the Acute Observation Area (AOA) because there were no beds available.

26. It was Dr Denham's impression that Liam was a high risk of self harm, a high risk of aggression, particularly towards his brother and, by the time he was returned to the hospital, a high risk of absconding. She did not consider him to be psychotic but she could not exclude prodromal (premonitory) symptoms. She thought he may have some underlying major depressive symptoms and acute distress arising out of situational stressors and feeling rejected. Alcohol may have played a part, as he was intoxicated. She placed him under an Involuntary Treatment Order ("ITO") for a 24 hour period so a second assessment could be conducted by a psychiatrist.

27. Dr Denham's plan was to admit Liam under an ITO to ward 2B, for observations to be undertaken every 15 minutes and for Liam to be reviewed by the treating team under Dr Chinna Sammy, a psychiatrist and Senior Medical Officer.

28. Liam was then admitted to the Ward 2B at 5.00 am. Registered Nurse ("RN") Teece had some limited discussion with Liam as he basically went straight to his room and went to sleep.[12] She assessed him as a moderate to high risk of absconding and a moderate risk of deliberate self harm. She then conducted a handover to staff for the incoming morning shift.

29. Dr Dipti Paul, was a Principal House Officer at Logan Hospital working in the MHU. She had started at Logan Hospital in January 2006. By July 2006 she had about 12 months experience as a registrar in psychiatry at Logan and other hospitals. She was working in Ward 2B between 8.30 am and 5.00 pm on 12 July 2006. Liam's parents had arrived at the hospital at about 8.00 am and requested to speak with Dr Paul as they were concerned that Liam was in an insecure ward. The Wright's spoke with Dr Paul and they remember Dr Paul asking them a lot of questions

[12] See her statement which is exhibit C24

about their son's background and what had been happening at home. This is reflected in Dr Paul's notes.[13]

30. Mr and Mrs Wright told Dr Paul that there were mental health issues on both sides of the family and Mrs Wright's cousin had committed suicide. Dr Paul's notes record that she was told by Liam's parents that earlier that morning Liam had tried to abscond again by jumping the fence at the hospital and he had stated that he wanted to go home and kill his brother. There is some reference in the file about an incident at approximately 10.05 am that Liam was witnessed by one of the nursing staff climbing a fence, attempting to leave the hospital grounds. He was returned to the ward by security and was transferred to the AOA at approx 10.25 am. I am satisfied that this incident relates to the same event described by Dr Paul in her notes and that there was only one attempt made by Liam to abscond that morning.

31. Dr Paul understandably now considered that there was a high risk Liam would abscond and that there was also a high risk of a suicide and/or homicide attempt. She thought he was impulsive and had antisocial traits. Dr Paul did not proceed to formally psychiatrically assess Liam at this time, because she did not think he would provide useful information to assist her assessment, given that he wanted to leave the hospital. I accept that this was a reasonable decision to make.

32. Dr Paul's plan was to admit Liam to the AOA for his safety with 15 minute observations. The AOA is a locked ward and has a total of 5 beds and one seclusion room. Liam's parents were then invited to attend the ward round two days later on 14 July 2006. This satisfied Liam's parents as they finally had some hope they might be able to get on top of Liam's problems. There is no criticism of Dr Paul's assessment or plan. It was clearly appropriate.

33. Dr Paul did not have any further involvement with Liam while he was in the AOA. The reason for this is that in 2006 different medical staff dealt with specific wards. Dr Paul was treating patients in Ward 2B, there was a different set of staff for the patients in Ward 2A and different staff for the patients in the AOA. The issue of continuity of care clearly arises, and I will refer to this issue when examining the evidence of Dr Kingswell, the current Director of Mental Health Services for the district which includes Logan Hospital.

34. Liam was transferred to the AOA at about 10.15 am. According to RN Foreman, he saw Liam and noted that he was extremely agitated and angry about being detained in hospital.[14] He was voicing homicidal ideations towards his brother, but he was not expressing suicidal thoughts. He was noted to be hypervigilant and continually looking for ways to escape the AOA. He attempted to get through the office door at

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[13] Attached to her statement as exhibit C21

[14] His Statement is exhibit C25 and copy of his notes attached.

one stage and threatened to take staff proxy cards which controlled access out of the AOA. He had also threatened to smash his way out of the AOA and smash other windows. He had removed his plaster cast. Security and extra staff had to be called. Liam was placed in the seclusion room and sedated. RN Foreman finished his shift at 3.30 pm. It is his recollection that Liam had still not settled and remained agitated and angry at the conclusion of his shift. He considered that Liam remained at a very high risk of aggression.

35. Dr Bandesh Banduwardene[15] was working as Dr Davies' Registrar in the AOA on 12 July 2006. He received his medical qualifications in Russia in 2000 and had a 12 month period working in mental health in Sri Lanka. He arrived in Australia in March 2006 and commenced work at Logan Hospital. His experience in the mental health field, particularly in Australia, was therefore limited. The medical file indicates that he went to assess Liam at about 1.30 pm however Liam was agitated and restless and accordingly he was not able to be properly assessed by Dr Banduwardene. Dr Banduwardene says he had spoken to the nurses about Liam's threat to abscond and was aware of earlier attempts in a vague sense. He was not able to recall if he was aware of Liam's attempt to climb over the fence. He considered that seclusion for Liam was the best way to ensure the safety of staff, other patients, and Liam himself. Dr Banduwardene completed the seclusion approval and Liam was placed in the seclusion room at about 1.40 pm on 12 July 2006. The seclusion order in the medical file says it was made at 11.30 am however the observation chart notes seclusion commenced at 1.40 pm. Not a lot arises from the discrepancy. Of more significance to this case, is that by this stage, Liam had still not been formally assessed by any psychiatrist or psychiatric registrar since his admission, and this remained the case up to when Liam was interviewed by Dr Davies in the ward round which took place two days later on 14 July 2006.

36. RN Wong took over the nursing care. In her statement[16] she indicates that she has no independent recollection of Liam. She made an entry in the progress notes at 8.30 pm to the effect that Liam was visited by his mother and grandmother. She noted that he engaged in minimal conversation and gave short answers with poor eye contact. He denied suicidal or homicidal thoughts towards his brother but stated that he was still angry.

37. The next morning on 13 July 2006, Liam telephoned Mrs Wright to find out whether his girlfriend had been trying to contact him. A few hours later he phoned his grandmother and was crying and generally in a distressed state. His grandmother went up to visit him and he was apparently very withdrawn.

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[15] His statement is exhibit C19

[16] See exhibit C26

38. As Liam's arm was sore because he had removed his plaster cast the previous day, he was taken by security to have x-rays of his arm taken. He did not make any attempts to abscond. His arm was examined by an orthopaedic registrar at about 3.00 pm and was again placed in plaster.

39. Liam's parents visited him at the Hospital at 4.00 pm and were present when Dr Banduwardene reviewed Liam again at approximately 4.45 pm. Dr Banduwardene noted that Liam was more settled than he had been on the previous day although he was not interested in interacting to the extent that would allow a formal assessment. He recalls asking Liam some routine questions such as whether he had any plans of hurting himself or others. Liam denied such thoughts but Dr Banduwardene notes in his statement that the response was curt and dismissive, as if Liam did not want to be bothered speaking with him. For this reason Dr Banduwardene still assessed Liam to be a high risk of absconding and aggression, but not a high risk of suicide. The principal concern was that if he did abscond he would attempt to kill his brother. Mrs Wright recalls that at this time Liam was still threatening to escape.

40. On the evening of 13 July 2006 Liam's behaviour escalated. RN Wong observed that Liam he was irritable, agitated and was pacing. He was refusing to speak to nursing staff but RN Wong overheard him speaking to one of his parents over the telephone. He was hostile and was saying words to the effect of "*I want to go home. I don't need to be here. I know what I did and said was wrong but I was angry at the time.*"

41. A nursing entry made by RN Wong at 8.30 pm on 13 July 2006 indicates that Liam again attempted to leave the AOA via the front door and that whilst he had been denying any suicidal or homicidal thoughts to staff Mrs Wright had reported that he had been expressing suicidal thoughts to her over the telephone. RN Wong considered that Liam was a high risk of absconding and a moderate to high risk of harming himself and others.

42. On the morning of 14 July 2006, Mrs Wright recalls getting a telephone call from Liam. He seemed depressed and wanted her to come and see him. He was saying that he did not care about anything anymore and wanted to come home. Mrs Wright explained to him that she would be up to visit him at about 11.30 am for the ward round with the consultant psychiatrist.

43. Dr John Davies was the Director of the Mental Health Service for the Logan-Beaudesert Health Service District at the time.[17] He assessed Liam with Dr Banduwardene and RN Skeffington at approx 11.30 am. Mrs Wright was also present. Dr Davies says the ward round was unusual because that morning there were six patients in the five bed AOA. One patient was in the seclusion room and he was extremely disturbed such that he was thumping the walls and smearing faeces on

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[17] His statements are exhibits C18 and C18A

the walls. As a result Dr Davies decided to conduct the ward round in the open ward rather than the AOA where it would usually be conducted. He explained that the morning's events was one that added pressure to an already busy period as he was involved in a response to supply information to Queensland Health lawyers at short notice.

44. Dr Davies explains in his statement that he had not read Liam's medical records prior to assessing him but rather relied on the history provided by Dr Banduwardene, RN Skeffington, Liam and Mrs Wright. He said that it was his usual practice to read the records, but other consultants would rely on information provided to them by medical or nursing staff. In this case there were a number of time constraints affecting him and this contributed to him not reading the file.

45. It is difficult to be clear as to exactly what information Dr Davies was given about Liam. The first problem is that Clinical Nurse Skeffington had not been providing nursing care and had little knowledge of Liam. She was there because RN Fitzpatrick, who was responsible for Liam's nursing care, was looking after the disturbed patient in the seclusion room. RN Skeffington had not read the medical notes, did not provide a history to Dr Davies and did not talk much at the meeting. Her presence seems to be perfunctory. That is not meant to be personally critical of her. It seems the ward rounds always had a member of nursing staff present and she was landed with the job when RN Fitzpatrick became tied up. RN Skeffington said that her experience was that patients released from the AOA would usually have a gradual transition to the open ward with an escort and would be monitored for a while. This did not occur with Liam however she said this could have occurred if someone had requested this. She recalls Dr Davies and Mrs Wright having further discussions after Liam left and that Mrs Wright had expressed concerns that she did not want Liam in the open ward.

46. Dr Banduwardene was particularly vague about what had been communicated by him to Dr Davies. It is difficult to determine whether he was being vague because of memory lapses which might be understandable after this period of time, or because he did not want to acknowledge that his briefing to Dr Davies was less than perfect. He says that he read Dr Denham's notes on 12 July 2006. He said in evidence that he told Dr Davies about Liam's efforts to abscond including that Liam had absconded from the ED, that Liam went to his grandmother's house, that Liam threatened his brother and that Liam had threatened or attempted to grab a swipe card from staff. He said in one part of his evidence that he was not aware of Liam's attempt to climb over the fence and was not sure if he told Dr Davies that Liam had been observed trying to escape through the front door. He later said that he did tell Dr Davies that Liam tried to jump the fence but in other evidence he said he just told Dr Davies that Liam was trying to escape but did not give details. He gave Dr Davies "the gist of it".

47. There is no convincing evidence that Dr Banduwardene told Dr Davies much at all about the past history of Liam's suicide ideation as recorded by Dr Denham or the recent references to suicide as reported by Mrs Wright to RN Wong and noted in the medical records.

48. Dr Banduwardene explained that his role at the interview was only to take notes and Dr Davies did most of the talking. He thought that Liam was frustrated about being in the AOA and it was not the best environment that day for him to remain there. Some emphasis was made about the fact that Liam had expressed future plans and was therefore more goal orientated than previously.

49. Dr Banduwardene thought that Liam should have been on closer observations or monitoring if he was to be transferred to the open ward. He was surprised Liam was discharged by Dr Davies to the open ward immediately as usually the patient would have some transitional escorted leave before being left on the open ward. He did not express those concerns to Dr Davies.

50. Dr Banduwardene said that he had no right to question the assessment of Dr Davies as the Director of the service and he gave me a distinct impression that he would not question senior staff as his job could be at risk. He stated that Dr Davies was very particular and could make registrars anxious. From my impressions of Dr Banduwardene I cannot be confident about some of the details of his evidence. Taking into account the clear impression he gave me that he could be overborne by Dr Davies, and his vague and sometimes contradictory evidence, I do not think he gave Dr Davies anything more than some general history about Liam's absconding and little or no history about past or recently reported suicide ideation or threats.

51. That impression is supported by the evidence of Dr Davies about what he says he knew. Dr Davies was aware that Liam had absconded two days earlier but he was not aware that this occurred in circumstances where Liam had been assessed by Dr Denham and had agreed to a voluntary admission. He did not know that Liam had attempted to abscond from the open ward on 12 July 2006. He does recall any mention of information concerning other threats or attempts by Liam to abscond from the AOA. He was not aware that no psychiatrist or psychiatric registrar, other than Dr Denham in the ED, had made a formal assessment of Liam. He was not aware that Liam had reported to Dr Denham that he frequently thought about ending his own life and that he had the day before reported suicide ideation to Mrs Wright. He was not aware that Liam was reported to be still agitated the night before. He did not know that RN Skeffington had no involvement in Liam's care. It would have concerned him if he had known all of this. Dr Davies says in his statement that if he had been aware of this information he may have kept Liam in the AOA for a further short period of time. He probably would not have relied only on the briefing of Dr Banduwardene without reading the medical file. He said that it is difficult for him to be objective about how

this information would have affected his decision taking into account the eventual outcome.

52. Dr Davies says that on specific questioning, Liam denied psychotic symptoms and that Mrs Wright had not noticed bizarre behaviour suggestive of psychosis. He said he relied on Liam's presentation at the interview. Other factors Dr Davies thought relevant were: it was Liam's first Hospital admission, it was a toxic environment in the AOA on that day and there were six patients in a five bed ward with one in the seclusion room. He balanced Liam's risks of absconding with those issues. Of course, it is clear that Dr Davies did not have all of the information about Liam's risk of absconding and/or committing suicide.

53. During the ward round Liam also denied current intent to harm himself or his brother. Mrs Wright says in her statement that she expressed to Dr Davies the deep concerns she had for both of her sons and that she feared for their safety. After the meeting was over, Mrs Wright asked to speak with Dr Davies without Liam being present and again expressed her concerns. Dr Davies explained in his statement that he felt Mrs Wright appreciated and accepted the reason for his recommendation to move Liam to the open ward in circumstances where he would remain under an ITO. I doubt that Mrs Wright gave that impression at all.

54. Dr Davies says that his judgment about transferring Liam to an open ward proved incorrect and he has thought about the circumstances since. This event has made a significant impact on his clinical decision making and management of risk.

55. In looking back at the medical records now, Dr Davies said it was hard to be objective with hindsight knowing the tragic outcome. He did accept what Liam was saying during the ward round, but agrees that with the knowledge of the circumstances of his admission it was evident that Liam did not give truthful information, and the foundation for trust was compromised.

56. On the issue of junior doctors feeling intimidated by him and his position of seniority, Dr Davies agreed that he had to take responsibility for this. His current practice is now to ask everyone in the room during an assessment for their views and any objections to the proposed treatment plan.

57. Dr Davies agreed that on the information that is now known by him that Liam met the criteria of major depression and was possibly psychotic, however treatment could not simply be pharmacological. A rapport needed to be established with his treating clinicians and Liam needed to work on some of his other problems. This was not possible in the AOA.

58. On the issue of the number of beds in the AOA, Dr Davies said it was necessary for one person to be discharged that day and that although this should not have affected his decision, these are pressures doctors

face all the time and maybe it did affect his decision. In my view the evidence by Dr Davies on this issue was not persuasive and I find that it is more likely than not that the over demand for beds in the AOA did play a part in the decision to transfer Liam to the open ward.

59. After Liam went back to the open ward he was seen by Dr Samy and Dr Paul. The notes of the assessment indicate that Liam did not want to talk anymore as he had just been interviewed by Dr Davies. Dr Samy thought this was reasonable. Liam said he would remain outside the interview room while the medical staff continued their discussion with Mrs Wright. Mrs Wright again reiterated to these doctors her concern for Liam and his brother's safety.

60. When the interview concluded, Dr Samy and Dr Paul were told by nursing staff that Liam had possibly absconded. At approximately 1.05 pm information was provided by Queensland Rail regarding a fatal rail incident some 500 metres south of the Loganlea Railway Station. Later it was determined that Liam had placed himself in front of a moving train. The incident was witnessed by two school students. Liam was seen to place his head on the railway lines on two occasions, evidently to check the vibration to see if a train was coming. A train was seen to come from the direction of Bethania and he was seen to jump in front of the train. The driver of the train saw Liam and sounded his horn in warning and attempted to stop. After Liam was hit, one of the students called Queensland Ambulance on his mobile.

61. Dr Ansford performed an external autopsy examination, and took toxicology samples. The injuries included severe mutilating injuries consistent with a train overrun and death would have been instantaneous.

62. In addition to this matter being reported to the Coroner, the Wrights also complained to the Health Quality and Complaints Commission.

63. The Health Quality and Complaints Commission provided the Coroner with a copy of a report it had commissioned by Dr Joan Lawrence.[18] Dr Lawrence came to certain conclusions which I will not repeat in full. She noted that the standard of documentation was exemplary and this facilitated a clinical review of the case. It was well documented that the staff had assessed his high risks of absconding, suicide and potential homicide, hence his admission to the AOA. She also supported the documented history by Dr Denham and her conclusion that Liam's presentation was consistent with a Major Depressive Episode possibly indicative of Bipolar Affective Disorder.

64. DR Lawrence was not concerned about Liam's treatment until the ward round assessment conducted by Dr Davies in the presence of Dr Banduwardene on 14 July 2006. It is clear that at this point Dr

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[18] Exhibit D8

Banduwardene had not formally assessed Liam himself. Dr Davies had not read the medical records and RN Skeffington was not involved in Liam's care. Dr Lawrence found that the focus of the assessment was on his past history of ADHD and aggressive behaviour usually precipitated by alcohol consumption and further developmental details as well as an exploration of his presenting symptoms, focussing on conflict with his brother. There was no history taken which was consistent with the history of significant depressive symptomatolgy as taken by Dr Denham. DR Lawrence noted that the record ended with a notation that Liam was frustrated at being in the AOA, that he agreed not to abscond and that there was longstanding sibling rivalry. The plan was to transfer Liam to the open ward.

65. Dr Lawrence concluded that there was little recognition of Liam's behaviour at the time of the admission or of subsequent behaviour over a 36 hour period which indicated clear episodes of increasing agitation and aggression requiring isolation, seclusion and medication in the clear absence of alcohol or drug use. By this time Liam had been alcohol and illicit drug free for some days, yet he was still very unsettled, so the logical conclusion to Dr Lawrence was that there were other underlying problems not associated with alcohol or drug use.

66. Dr Lawrence viewed the decision to allow Liam to leave the AOA into an open ward without any increased level of observation was an error of judgment. Dr Davies agrees. The documentation suggested a more prudent course was for Liam to have a more prolonged period of observation in the AOA. Dr Davies agrees that this may have been the more probable result if he had read the notes and knew all of the information. The alternative was to have a less rapid transition to the open ward as was apparently the practice, however Dr Lawrence said that if that had occurred the outcome may not have been different. It was her opinion that patients with a high risk of absconding and risk of harm have a heightened risk in the movement from a high secure to a less secure area. In this case Dr Lawrence was critical of the decision to transfer Liam to an open ward with 15 minute observations and the observations should have at least been increased to closer observations. Under examination in Court Dr Lawrence maintained her opinion. She was particularly concerned by the history as recorded by Dr Denham descriptive of a depressive disorder; Liam's repeated statements of a suicidal ideation; intentions to abscond and threatening to harm his brother. This was quite distinct from the opinion of Dr Davies which was that Liam suffered from personality vulnerabilities and adolescent problems particularly under the influence of alcohol.

67. Further Dr Lawrence considered that on the basis of Liam's behaviour in the AOA, (including that he had been threatening to abscond and that he was guarded in his approach to staff), it could not be said be said the crisis which Dr Davies had diagnosed had gone away. Further, Liam had been on an anti-depressant for a month, he had not settled, and in fact had got worse. Dr Lawrence thought that there needed to be consideration for

another anti-depressant and perhaps an anti-psychotic medication. Liam had been given Olanzapine and then Chlorpromazine which had settled him a bit. Dr Lawrence felt there should have been some consideration to his medication being trialled on an ongoing basis rather than on an as needs basis. She would have liked to have seen the medication changed before he was transferred to the open ward.

68. Dr Lawrence commented that there is not ample time or adequate numbers of beds and staff available in acute psychiatric services within general Hospitals in Queensland and Australia at the present time. She said there is a constant pressure on mental health services and clinical staff to assess severely ill patients quickly and to move them out of an acute Hospital setting into a community setting. Dr Lawrence said that such considerations would have been operating at the time of Liam's admission and may have been a factor which could influence a decision. This issue was raised by Dr Kingswell and I will expand on this when examining his evidence.

69. The Wright's also raised the issue as to whether the fencing around the courtyard which Ward 2A and 2B lead into should have been higher to prevent patients from absconding. Dr Davies said this is a vexed issue and there are two competing views. He said that high fences make the Hospital setting more custodial and alters the atmosphere. Dr Kingswell and Dr Lawrence agree on this issue. Dr Kingswell was quite adamant that creating more surveillance and higher security fencing arrangements was the wrong message to be giving to patients. In his view if a patient is considered a high risk of self harm or absconding then the solution is to provide greater staff observation. Dr Lawrence said that there are limits to which patients can be contained and they should not be treated as if they are in prison. She also agreed that clinical management through staff, medications, and observations was a better way of managing risks. Surveillance technology was also not the solution for Dr Kingswell and Dr Lawrence. I can well understand why Mrs Wright raised this issue and at first glance the solution is an obvious one, however I accept the opinions of Doctors Kingswell and Lawrence and do not intend to make any recommendations about the fencing.

70. In considering the specific issues identified at the commencement of the inquest I find as follows:
   (a) Was Liam's mental state adequately assessed at the Hospital between 12 and 14 July 2006? Yes, although it is arguable that there needed to be further consideration as to Liam's diagnosis and possible medication change.
   (b) Was the decision by Dr Davies to transfer Liam to the open ward on 14 July 2006 reasonable in all the circumstances? No.
   (c) Did the Hospital adequately respond to the concerns raised by Liam's parents during Liam's admission? No.

The evidence relating to Charles Michael Powell

71. Charles Michael Powell was aged 17 when he died on 31 July 2006. He is terribly missed by his mother, father and family. He had a half brother Daniel and two other siblings, a sister, Samara and brother, Richard. They wrote personal testimonials at his funeral which talk about how much they will miss him. A memorial plaque on a park bench was installed by the local community and a candle light vigil was held on 14 August 2006. His funeral was held on 28 September 2006 and many people attended. Mrs Powell released two white doves. On what would have been his 18th birthday on 9 December 2006, Mrs Powell organised a music concert in his honour. Charlie was passionate about his music. His sister sang. He finished school in grade 11 but had completed a traineeship in Graphic Art and multi-media design with Logan Central Speak Out Foundation who also provided a testimonial to Mrs Powell.

72. Charlie faced a number of problems however he had the support of a loving family. Although his parents were separated they were both involved in his welfare, however there appears to be some conflict between them with reports that Charlie's father thought Mrs Powell was minimising Charlie's drug problems.

73. After Charlie's death a coronial investigation commenced. Statements from many witnesses were taken. His medical records were examined. Dr Joan Lawrence prepared a report for the Coroner. The issues raised which became the focus of the inquiry were:

    (a) Was Charlie appropriately managed by the Beenleigh Community Youth Mental Health (CYMHS) in the weeks prior to his death?
    (b) Was the decision to discharge Charlie from the Logan Hospital on 31 July 2006 reasonable in all the circumstances?
    (c) Did the Hospital adequately respond to the concerns raised by Charlie's parents and half brother on 31 July 2006?

74. It is useful to set out in some detail the extent to which Charlie was being treated for his problems. This is important because there was quite a deal of information recorded about him but it is clear not all of this information was available or considered by the medical staff who made assessments of Charlie on 31 July 2006, when he was at the Logan Hospital.

75. On 17 April 2006, Charlie was admitted to the Logan Hospital Mental Health Unit under an Involuntary Treatment Order (ITO). He had suffered an acute psychotic episode thought to be induced by substance abuse. Charlie had reported that he had used a range of drugs from age 12. He was brought into the Hospital by police, accompanied by Mrs Powell. He had apparently smashed the house with a metal pole and knowing that it was inappropriate behaviour, had asked Mrs Powell for help.

76. Throughout the first interview with Charlie in Hospital, he was observed to be responding to auditory and visual hallucinations. He was talking between sentences, mumbling and his eyes were darting around the room. Charlie reported that earlier that day he had crawled around everywhere on all fours and walked on his head and on the previous day he was seen banging his head on the wall and jumping up and down and hitting his head. Charlie said that people were after him, that the television was telling him what to do and that people could read his thoughts.

77. Charlie was assessed by Dr Mir[19] at approximately 6 pm that evening. The information that Charlie provided was consistent with what he had earlier reported. Mrs Powell told Dr Mir that she had a gut feeling that Charlie may harm himself and that she had not been aware of his drug habit.

78. Charlie told Dr Mir that he had previously used crack, speed and ice but had stopped using drugs 3 weeks earlier. Dr Mir's diagnosis was an acute psychotic episode, substance induced, with differential diagnoses of schizophrenia, bipolar affective disorder and general medical concerns. Charlie was detained under an ITO and admitted to the MHU at Logan Hospital.

79. Over the next few weeks, Charlie's progress was slow but gradual. It was noted that his mood would become elevated from time to time with grandiose delusions and his diagnosis was subsequently changed to a bipolar affective disorder, the present episode of which was manic and precipitated by illicit drug intake. He was counselled about his drug use and was seen by an Alcohol, Tobacco and other Drug Services (ATODS) counsellor. He consistently denied suicidal thoughts during this admission. Both of Charlie's parents were actively involved in his care whilst an inpatient and would take him out on day leave prior to his ultimate discharge on 19 May 2006. On discharge Charlie's ITO was revoked. The plan devised for Charlie was for him to be followed up through the Beenleigh Community Youth Mental Health Service (CYMHS).

80. Susan Bourke was assigned to be Charlie's case manager.[20] Later Jennifer Neill took over. Ms Neill was much more experienced and had been supervising Ms Bourke. Charlie attended various appointments made for him over this next period and I do not intend to detail what occurred at all of the meetings held over this time. Charlie reported that his paranoid thoughts had gone but he was still thinking about his neighbours being able to know everything about him. He said that he had no thoughts of harm to self or others.

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[19] His statement is exhibit C10
[20] Her statement is exhibit C11

81. Charlie's treatment plan was for ongoing monitoring through weekly contact and psycho-education with Charlie and Mrs Powell, with emphasis on the importance of continuing with medication and medical reviews when required. He was rated as being at a very low risk of self harm.

82. Charlie saw Dr Mir with Susan Burke on 7 June 2006. Mrs Powell reported that Charlie had been well and stable since discharge from Hospital and was taking his medications and was not abusing illicit drugs. However, Mr Powell reported that he was anxious that Charlie may have been slipping backwards and he had telephoned the CMHS about those concerns. Mr Powell reported some continuing paranoia against the neighbour but no suicidal thoughts. He indicated that Charlie planned to get a car and start a new life in a new environment.

83. On 26 June 2006 Charlie attended the CYMHS and met with Ms Bourke and later with Ms Neill. Charlie denied illicit drug use although Mrs Powell was still worried about his past drug use and was checking his room daily. Charlie reported being tired and sleepy on his medication but was told that it was important to keep taking his medication and that he would be reviewed by a doctor on a regular basis.

84. Charlie and Mrs Powell went on a holiday to Sydney. Ms Neill saw Charlie and Mrs Powell about 9 days later on 5 July 2006. Neither Charlie nor Mrs Powell raised any concerns. Mrs Powell did not think Charlie had used illicit drugs whilst in Sydney.

85. Charlie reported that he felt frustrated at having to attend the CYMHS and that he was feeling "normal". Ms Neill considered that Charlie's judgment and insight were poor. The plan was for Charlie to see his GP for blood and urine screen to test for drug use. Charlie did not attend these appointments but he later indicated he was willing to do so and an appointment had been made for 5 September 2006.

86. On 19 July 2006 Charlie reported to Ms Neill that he wanted to go to work but Ms Neill considered that his presentation was such that he was unlikely to be able to perform in a workplace. She again thought he had limited insight. He was denying the use of illicit drugs and Mrs Powell reported that he was compliant with his medications.

87. On 30 July 2006 at about 1.30 pm, Charlie dressed himself all in white and took a number of photographs of himself and Mrs Powell. He told Mrs Powell that *"if someone comes to the door looking for me, give them some pictures of me".* Mrs Powell was worried about him and telephoned the Logan Hospital for assistance. She was advised to take Charlie to the Hospital if he exhibited any other behaviour that worried her.

88. That evening Mrs Powell observed Charlie take a knife from the kitchen to the garage. She was not worried that he would harm himself however

she believed he was hallucinating. Mrs Powell called Charlie's half brother Daniel to attend to assist her. Charlie eventually calmed down, relinquished the knife and went to sleep.

89. On the following morning, Charlie was apologetic for his behaviour on the previous night and Mrs Powell can remember him saying that he was sorry for making her worry about him.

90. At about 9.00 am, Mrs Powell telephoned Ms Neill from a public phone and told her that friends had visited on the weekend and that Charlie had used illicit drugs. She also told Ms Neill that Charlie had barricaded himself in his house with her inside and wanted photos taken of himself and his family *"to give to people who might be at the door".* Mrs Powell also said Charlie was walking around the house with a knife for protection and he was refusing to go to the Hospital. The plan made between Mrs Powell and Ms Neill was for Mrs Powell to return home and assess the situation and call Ms Neill back or call the police if she was concerned. Ms Neill said she would phone Mr Powell and arrange transport to the Emergency Department if possible and that she would otherwise see Charlie for an appointment at home at midday.

91. Mrs Powell returned home and Charlie requested she take him to the Hospital. Mrs Powell was extremely relieved that he had made this suggestion and thought he had a lot of courage to identify that he needed help. She remembers that he was very quiet on the trip and she noted cuts to his left wrist. They arrived at the Logan Hospital Emergency Department at approximately 10.30 am and he was identified as needing a mental health assessment. Whilst in the queue for triage, Charlie ran off. He was found in the carpark by a nurse and security and escorted to an evaluation room. RN Carol Kohleis, a senior clinical nurse interviewed Charlie with Mrs Powell at about 11.00 am. Mrs Powell reported that Charlie had had friends over on the Saturday night and they had stayed until 7.00 am the following morning after which Charlie locked doors, jammed up the windows and started pacing and looking outside. Mrs Powell found a small amount of marijuana in his room and she was afraid that he might hurt himself. Charlie said that he had used about 5 cones of marijuana but no other illicit drugs. Charlie had inflicted superficial scratches on his wrists which he said he had done with a pair of scissors to feel pain.

92. Mrs Powell says in her statement that during the course of the interview, Charlie interrupted RN Kohleis and asked her if there were any beds there for him to which she replied that there were not. Mrs Powell said to her "*What about the second floor"* and RN Kohleis responded that *"No, that's also full. It's not up to me anyway if he is going to stay or not, I have to discuss it with the doctor."* Mrs Powell asked RN Kohleis to telephone Ms Neill because she knew everything about Charlie's history.

93. By 12.30 pm Ms Neill had telephoned Mr Powell but he was asleep and she had then spoken to Daniel. Daniel reported to Ms Neill that Charlie

was very unwell, and that he was using drugs and not taking his medication. He reported that Charlie had apparently drawn a shape over his heart *"for where he was going to kill himself".* Charlie had said that he had been operated on and made into a female and would be sold as a sex slave.

94. Mr Powell then woke up and spoke to Ms Neill. He confirmed what Daniel had said and indicated that Charlie needed to be made an involuntary patient as he was refusing blood and urine tests. Mr Powell wanted Charlie to go to a private hospital.

95. At approximately 12.30 pm RN Kohleis had a telephone conversation with Ms Neill. Ms Neill reported her conversation with Mr Powell and Daniel. Ms Neill also explained the events as reported by Mrs Powell and faxed her notes through. RN Kohleis observed that Mrs Powell appeared to be anxious not to speak openly regarding her fears for her son and that Charlie was denying suicidal ideation, minimising any problems including drug use and was very guarded. RN Kohleis thought Charlie had limited insight and judgement.

96. RN Kohleis finished assessing Charlie shortly after lunch and discussed her assessment with Dr Dipti Paul. It would seem RN Kohleis was still completing her notes when Dr Paul went to assess Charlie so Dr Paul did not have access to the notes. RN Kohleis was unable to recall what was passed on to her by Ms Neill in conversation as opposed to the information that was faxed to her. It would seem that Charlie had initially presented requesting admission but over the period of time spent waiting and whilst being assessed he made persistent requests to RN Kohleis that he be allowed to go home. RN Kohleis told Dr Paul that Charlie had been difficult to interview and she was at a loss to understand what was happening to him. She referred Charlie to Dr Paul because she felt he needed a further assessment.

97. Dr Paul assessed Charlie in the ED at about 1.00 pm. Dr Paul was at the time a Principal House Officer, with about 12 months experience in psychiatric care. Dr Paul was aware that both parents were concerned about a relapse in psychosis and ongoing illicit substance abuse and that they wanted him admitted. Dr Paul was aware there were no beds in the adolescent ward. Charlie denied ever doing deliberate self harm and was vague and guarded. He said that he had made the cuts on his wrists secondary to sadness and anger because of his parents' divorce. It is apparent that Dr Paul was not aware of all of the information that was passed over to RN Kohleis by Ms Neill. Dr Paul was aware of his previous admissions and diagnosis of drug induced psychosis and bipolar disorder. She had seen the Risk Screening Assessment taken by RN Kohleis but had not read her assessment notes because RN Kohleis was still writing them. In evidence, Dr Paul she was able to recall some aspects of the history that was reported to have been given by the family, but not all aspects. Dr Paul's evidence on some aspects was unclear and

perhaps indicative of her inexperience at the time. It could also be as a result of the effluxion of time.

98. Dr Paul spoke with Ms Neill at length over the telephone and Ms Neill indicated that she was concerned about Charlie's mental state because of what she had been told by the family. Ms Neill believed that he was using marijuana and possibly other illicit drugs and that he was not taking his medication. Charlie denied any suicidal thoughts. Mrs Powell recalls telling Dr Paul that she was very concerned about Charlie even after he told her that he was not going to hurt himself. Mrs Powell remembers Dr Paul telling her that it was not up to her and she would need to discuss it with some other colleagues and come back with an answer. Dr Paul's statement was to the effect that Mrs Powell was insisting that Charlie be admitted but Charlie was refusing. Charlie said that he was willing to see a General Medical Practitioner.

99. Dr Paul thought that Charlie had poor insight regarding his illness and that his judgment was questionable. Charlie was denying suicidal thoughts and was not assessed by Dr Paul as severely depressed, however on the basis of the concerns expressed by Ms Neill and family, Dr Paul decided she would discuss the matter with the on call consultant.

100. Dr Paul discussed Charlie's presentation with the on call psychiatrist, Dr Leivesley. She did that because she was unsure and did not know what to do. It is unclear as to what information exactly was passed on to Dr Leivesley by Dr Paul. In evidence Dr Leivesley said he had to rely on what was set out in Dr Paul's notes in the medical record and he did not have a good independent recollection of their conversation. The conversation probably took 10 minutes. Dr Leivesley agrees that from what he has since heard and Charlie was psychotic and that he had a relapse. Dr Leivesley did not think he was aware that Charlie had drawn a shape over his heart for where he was going to kill himself. Dr Leivesley said that was a disturbing piece of information that with hindsight probably appears more disturbing than it would have at the time. Dr Leivesley does not think that knowing this information would have placed Charlie in the higher risk category at the time. Dr Leivesley placed some emphasis on the fact that Charlie was denying suicidal ideation. For him this is one bit of information that is useful for assessment purposes. Dr Leivesley agreed that the collateral information provided by the family and case manager was at odds with what was being reported to Dr Paul. Dr Leivesley said he probably was not aware that when Charlie went to Hospital he wanted admission. Dr Leivesley made a decision to discharge Charlie back to his parents because Charlie did not want to be admitted and there were no criteria to admit him under an ITO.

101. Dr Leivesley said he could not recall how he came to his decision however based on the notes of Dr Paul his thought process was likely that he thought Charlie was psychotic; and there were some concerning risk issues, but he was denying suicide, he would be going back with

family and there was medical follow being arranged. This would place Charlie at a moderate risk of suicide and Dr Leivesley would have balanced up the risks in making his decision. Dr Leivesley said that although Charlie had a mental illness which required treatment, his moderate risk of suicide meant that he should not have been made the subject of an ITO because of the least intrusive criteria contained in the *Mental Health Act 2000.* He said that there are known adverse effects of admission to a public health mental health unit and a significant number of patients commit suicide in the first week following discharge. Dr Leivesley was under the impression that Charlie would be reviewed by the Acute Care Team. He was not aware that Charlie would not be able to be reviewed by the Acute Care Team the next day. If he had known he would have made sure that Charlie was reviewed by a doctor the next day. He was not aware that subsequently the only plan was for Charlie to see a GP for blood and urine tests.

102. Dr Paul then telephoned Ms Neill and told her that Charlie was not to be admitted as he had no psychiatric features at this time. She asked Ms Neill to telephone Mr Powell about discrepancies with Charlie's history. The plan, according to Ms Neill was that Charlie needed to be assessed in the ED when he was psychotic and that he would be discharged back home with follow up care by the Acute Care Team. Ms Neill informed Dr Paul that because Charlie was not yet an adult and because he already had a case manager it was unlikely that the Acute Care Team would become involved. Ms Neill telephoned Mr Powell again and spoke with Daniel. Daniel reported that he had found two packets of marijuana under the table in Charlie's room. He also reported that he had seen Charlie spit out his medication and throw it in the bin.

103. Ms Neill telephoned Dr Paul back and told her what Daniel had said. Dr Paul stated to Ms Neill that the family were to contact the police immediately Charlie made a threat. The plan ultimately devised by Dr Paul was to discharge Charlie home with a letter to his GP for a urinary drug screen the following day and that Charlie would be reviewed by Ms Neill on 2 August 2006.

104. Ms Neill wanted Charlie to see Dr Daubney, who was in charge of the adolescent ward, and indicated that she would try and organize an earlier appointment with him as soon as possible.

105. Charlie left the Hospital at about 5.00 pm with Mrs Powell and they returned home. At approximately 6.45 pm, he complained of being cold and Mrs Powell gave him a blanket. They watched TV together and held hands.

106. Mrs Powell then indicated that she was going to pick up his sister and take her to enroll at college and Charlie said that he would go with her. After arriving home from picking up his sister, Charlie told Mrs Powell that he was going out to meet some of his friends at Bethania. Mrs Powell was still concerned about Charlie and insisted on driving him

there. Charlie agreed but on drive to Bethania Charlie changed his mind and said that he would catch the train. Mrs Powell indicated that she would accompany him on the train. They arrived at Eden's Landing railway station, and Charlie went to buy the tickets while Mrs Powell parked the car. After she parked the car, Mrs Powell saw Charlie on the opposite platform for their intended train travel. Mrs Powell then lost sight of Charlie so she rang the police from the public phone and told them that she could not see him. Mrs Powell learnt of Charlie's death soon after. Queensland Rail video footage showed that at approximately 7.05 pm Charlie was seated on the outbound platform. The footage then showed Charlie stand up and run to the Bethania end of the platform out of camera range.

107. The driver of a train (which was scheduled to travel all stops to Beenleigh) told investigators that after departing Bethania railway station he was travelling at approximately 80km per hour and after entering a left hand curve, he noticed Charlie wearing a white coloured beanie on the tracks in the train's path. The driver immediately went into full service braking, however the train struck Charlie and he was fatally injured. Charlie made no attempt to avoid being struck by the train. Police located Charlie approximately 200 metres north of the platform in the middle of the south bound track.

108. Dr Milne performed an autopsy examination and found numerous traumatic injuries consistent with a train over-run. Charlie would have died instantaneously. Some low levels of amphetamines and metabolites of cannabis were found.

109. Dr Lawrence reviewed the medical records and provided a report to the Coroner.[21] She noted there was no evidence of urinary drug screening or follow up and clearly Charlie had been non-compliant with requests for urine tests. Dr Lawrence was of the opinion that the follow up arrangements for Charlie were rather poorly organised and not implemented closely.

110. Dr Lawrence was of the view that it was evident that Charlie was still using drugs and the events of 31 July 2006 occurred in the context of drug use over the preceding weekend. Dr Lawrence was of the view that adequate collateral information was obtained and transmitted that day but there had been a process of filtering the information with possible summaries losing or minimising relevant details along the way. By the time it was discussed with Dr Leivesley, the decision not to admit was made based on a lack of Charlie's meeting the criteria on the information presented. That information included that Charlie did not want to be admitted, was denying suicide ideation and that Mrs Powell had no concerns at this stage as Charlie was not suicidal. The evidence heard by me would support the opinion of Dr Lawrence with regards to the filtered transfer of information.

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[21] Exhibit D6

111. Dr Lawrence reported that in her opinion clinically the picture indicates the presence of a psychotic disturbance with significant depressive overtones. Charlie had marked impulsivity and great ambivalence. In her view there was evidence of deliberate self harm and behaviours which indicated the possibility of suicidality or unpredictable, destructive behaviour to others. However none of this would have been acknowledged by Charlie to Dr Paul.

112. Dr Lawrence opined that on 31 July 2006, Ms Neill very appropriately obtained information from relevant sources, recommended Charlie be taken to the ED and passed information she had on to the Hospital. At the ED Charlie was guarded, admitting little, and denying much in terms of his thoughts, beliefs and behaviours. The end result was that Dr Paul was faced with a patient who had denied symptoms, refused help, denied evidence of suicidal ideation and paranoid psychotic beliefs and had denied or minimised drug use. On this basis, Dr Lawrence agreed that Charlie would have failed to meet the criteria for an ITO. However, it was her opinion in her report that if full consideration of all the information that was available, including collateral information had been made it may have led to an admission on an ITO on the basis that there was sufficient information to cause concerns about his safety. Again, the evidence heard by me would support the opinion of Dr Lawrence.

113. In evidence, Dr Lawrence stated that whilst she would have admitted Charlie to Hospital she was not critical of Dr Leivesley's decision not to admit Charlie under an ITO.

114. Dr Lawrence also said that Charlie's use of amphetamines and marijuana undoubtedly contributed to the development of the psychotic condition that led to his suicide and this was denied or not sufficiently recognised by anyone including his mother. There is evidence of some conflict between the parents as to whether or not Charlie was continuing to use drugs. There is also evidence of some minimisation of Charlie's drug use by Mrs Powell which supports the opinion of Dr Lawrence.

115. Dr Lawrence further opined that Charlie may have been the victim of a health system where there still is a grave shortage of beds available such that admitting doctors have to prioritise admissions. Someone like Charlie may have been a person who warranted closer observation but the pressure of fitting them into the strict ITO criteria was such that some of those people are missed. Dr Lawrence's solution is the need for more beds, more resources and more opportunities for admission to MHU's for at least short periods of time.

116. In considering the specific issues identified at the commencement of the inquest I find as follows:
    (a) Was Charlie appropriately managed by the Beenleigh CYMHS in the weeks prior to his death? Dr Lawrence opined that the arrangements made post discharge were loose and fragmented

and vulnerable to breakdown. However I find that overall Charlie's management by the CYMHS, particularly when Ms Neill took over, was appropriate.

(b) Was the decision to discharge Charlie home from the Logan Hospital on 31 July 2006 reasonable in all the circumstances? No, on the basis that full consideration of all the material available may have led to another conclusion, however at the time Dr Leivesley was not aware of all that information.

(c) Did the Hospital adequately respond to the concerns raised by Charlie's parents and half brother? No. Collateral information had been gathered from Charlie's family in an appropriate fashion, however not all of this information found its way to Dr Leivesley and Dr Paul.

Evidence of Dr Kingswell

117. Dr William John Kingswell is an experienced psychiatrist, and experienced in the management of public mental health services. Since 4 May 2007 he has been the Executive Director of Mental Health Services for the Southside Health Service District, which encompasses the Logan Hospital. He was not involved in the care of either Liam or Charlie.

118. Dr Kingswell stated that the Logan Hospital was incredibly busy and has the third busiest Emergency Department in Queensland. Like Dr Lawrence, he also said that there was a resource issue involved. He said that Logan area had the poorest resourced mental health service in Queensland, and that Queensland was the poorest resourced state in Australia, making his district the poorest resourced mental health service in Australia.

119. Dr Kingswell has made some changes to service delivery in his district which may provide some improvements relevant to some of the issues that have been identified in both cases. Firstly, he identified an issue with continuity of care. In Liam's case for instance it is evident that Liam was seen by a medical officer in the ED, then a different psychiatrist on the ward, then another psychiatrist in the AOA. Liam then saw Dr Davies and when he was transferred to the open ward Liam had to see someone else again. This was clearly a system that needed to be addressed. Dr Kingswell made changes such that now a patient remains the responsibility of one treating team wherever they are, whether it be on an open ward or the AOA. In his view this encourages formulation of long term treatment and not just short term management. Patients no longer have to repeat their histories to different treating teams. This change is clearly welcome.

120. Another issue Dr Kingswell identified was to do with Emergency Department presentation. Mental health assessment staff (nurses and registrars) usually conduct assessments in the ED however there was no requirement to notify a clinical treating team if the presenting patient had

been or was being cared for by a treating team. A consultant psychiatrist has now been appointed the clinical leader of the mental health assessment team in the ED. This person is available during working hours and there is an on call arrangement. Either the mental health professional or psychiatric registrar can make a decision to admit. The mental health professional cannot make a decision to discharge a patient without discussing the matter with the registrar. If there is a disagreement between these two individuals then the consultant must be contacted. When a patient is admitted then this must be conveyed to the either the patient's treating consultant, or if the patient is new to the consultant of the service which is determined according to the patient's address. That consultant has to take responsibility that an adequate treatment plan is put in place.

121. Dr Kingswell also said that since July 2006 he has been given additional funding to provide for additional child and youth psychiatrists such that there would be no barriers to getting advice from a consultant child and adolescent psychiatrist at any time.

122. Charlie had a case manager who advised the family to bring Charlie to the Emergency Department. Dr Kingswell said that case managers are now encouraged to arrange for a patient to go direct to the ward rather than going through the ED. This was also the case for the child and youth service. It would seem that this would not be available after hours or on weekends. In Charlie's case this may have resulted in his admission at least to a general psychiatric ward as clearly Ms Neill had some real concerns based on the information she had received.

123. Dr Kingswell said that the changes he has made are not able to be made quickly and are largely the subject of evolution and development. I can only hope that his plans continue to be implemented and adequate resources are made available to do so. I note with concern the evidence of Dr Paul to the effect that she was not aware of the arrangements to consult and notify the appropriate consultant and she would only speak to a consultant if she had a difficulty, as happened in Charlie's case.

124. Dr Kingswell also spoke about the problems associated with the hierarchical culture within the medical profession and the difficulties in encouraging those more junior to speak out if they have concerns regarding the management of a patient. Dr Kingswell mentioned some of the training to encourage this however it is clear that not everyone attends such events and he said it will take a long time. Dr Banduwardene failed to speak out for just that reason. That was in July 2006. After hearing his evidence I had no confidence that two years later anything had changed for him.

125. In principle, I think that the changes Dr Kingswell has made would address some of the inadequacies that are evident as contributing factors in Liam's and Charlie's deaths. Continuity of care was notably lacking in Liam's case and that does seem to have been addressed by

the changes. I am not so clear that the changes to the admission process from the Emergency Department or through case managers have been successful as I am not confident they are universally known or understood. Dr Paul, who is still working at the Hospital was not aware of these changes and it may well be the case that other staff are unaware of these procedures. More work may need to be done to disseminate these policies to the relevant staff.

126. On the issue of resources Dr Kingswell stated that the *Mental Health Plan 2007-2011* as developed by the State Government includes funding for a significant number of additional community mental health staff for both adult and child and youth services. There is also a budget for capital works improvements including 25 acute adult mental health beds at Logan Hospital. Ten beds will cater for older persons with a psychiatric illness, ten for patients aged between 18 to 25 and five to replace the existing AOA. Dr Kingswell expressed concerns that in the current economic climate this may not be implemented or further delayed. He said the delivery date was now November 2010 but there were murmurings that it could be derailed. If these beds could be made available Dr Kingswell said he would find the staff.

127. I note that the funding for the 25 acute beds is included in the *Outline of the 2007-2008 State Budget Outcomes for Mental Health*.[22] It is now 2009, so Dr Kingswell's concerns about delay may have some foundation.

128. The *Mental Health Plan 2007-2011* has made provision for 25 acute mental health beds. It is vital to the community that Logan Hospital supports that this part of the plan is implemented as soon as possible. Dr Lawrence spoke about her concerns with the lack of resources and particularly the issue concerning finding beds for those in particular need and the pressures this inevitably brings to influence decisions made by medical staff such as Dr Davies and Dr Paul. Certainly I will be recommending that the Mental Health Plan as set out for the Logan district be implemented without delay.

Root Cause Analysis

129. In both of these cases the Logan Hospital conducted a Root Cause Analysis (RCA). In Liam's case no recommendations were made. Some recommendations in Charlie's case were made and were implemented. During the hearing it became evident that none of the important clinical decision makers in these two cases were approached to provide further information to the RCA process. The evidence also supported a concern that this was not an isolated example. That seemed to me to be a flawed approach. After hearing submissions, I took the view that rather than hearing further evidence on this issue I would take up my concerns directly with the Patient Safety Centre (PSC) through the Office of the

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[22] To be found on the Queensland Health website

State Coroner. It had become evident in my discussions with other Coroners that they held similar concerns. Since that time there have been meetings held with the PSC endeavouring to better understand the process and for our views to be considered.

130. It is not my intention to examine in any detail how the RCA process occurs. It has been evolving since 2006 and there is now added protection against incrimination for those taking part in the process. I have since the completion of evidence been provided with further information which goes a long way to satisfying my concerns on the issue identified at the inquest. In a letter addressed to the State Coroner dated 6 March 2009, the Senior Director of the PSC, Dr John Wakefield has advised that a memorandum has been sent to all Patient Safety Officers emphasising the need for the RCA teams to interview the clinical team involved in the incident under review for every RCA. The Clinical Incident Management Implementation Standard was introduced in 2006, amended in 2008 and is due for further review. Amendments will include the necessity for RCA teams to interview all clinical staff directly involved in the care of the patient.

131. In Charlie's case the RCA correctly noted a number of system issues that may have contributed to the decision not to admit Charlie. These included the process of gaining and recording of collateral information, that there was no standardised handover format from the assessing medical officer to help inform the consultant psychiatrist, and there was no formal process for community mental health staff or family members to seek a second opinion regarding a decision from more senior staff. The recommendations made by the RCA included developing and implementing a standard handover tool to use between the mental health assessment team and consultant psychiatrist on call and for a form for the assessment team to gain collateral information from the community mental health team and patient's family who are not present at an assessment in the ED. A flow chart was to be developed outlining appropriate channels to escalate clinical matters that may require a second opinion.

132. It is difficult to say whether or not these solutions would minimise the risk of what occurred here to Charlie happening again but the process did identify the issues. Dr Lawrence was sceptical of the overall value of the risk assessment tools and of a standardised handover document. In both instances Dr Lawrence was of the view that verbal contact and discussion are the best methods available for conveying information. However I do consider that the solutions may be helpful in the future if they are used correctly as tools for the compiling of information to be passed on and not substitutes for appropriate verbal contact.

133. The handover of information was flawed in both of these cases. The handover of information contained in a patient's medical file is important and fraught with much difficulty. It is a complex matter and not easily solved by simple recommendations. I am aware that it is being

considered as a serious issue at a national level. In a recent inquest[23] I heard evidence from Dr Child who is a member of the Safety and Quality in Health Care Commission with the Commonwealth Department of Health. He said that the issue and importance of handovers generally in the medical field is being given a lot of attention by the Commission and elsewhere. Dr Child forwarded to my office details of a workshop being run by the Safety and Quality in Health Care Commission at the end of March 2009 titled *"Using Tools to Make Clinical Handover Safe."* I mention this information on the basis that nationally this remains a concern and whilst it is being addressed it remains the responsibility of clinicians, nurses and their Hospitals to make sure the information that is handed over is accurate and comprehensive enough for the purpose it is being given. That did not occur for either Liam or Charlie.

Findings required by section 45 of the Act

134. I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with the last of these issues, being the circumstances of Liam's and Charlie's death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of their deaths.

Liam John Wright

(a) The identity of the deceased was Liam John Wright
(b) The place of death was Beenleigh/Ferny Grove railway line at Meadowbrook, Queensland.
(c) The date of death was 14 July 2006
(d) The formal cause of death was:
1(a) Multiple Injuries, due to, or as a consequence of
1(b) Train over-run.

Charles Michael Powell

(a) The identity of the deceased was Charles Michael Powell
(b) The place of death was Edens Landing Railway Station, Edens Landing, Queensland..
(c) The date of death was 31 July 2006.
(d) The formal cause of death was:
1(a) Multiple Injuries, due to, or as a consequence of
1(b) Train over-run.

135. Liam and Charlie were young men who were experiencing troubled times. They had the support of loving family members but they needed help from Logan Hospital mental health services. When that help was

[23] Inquest into the death of Benjamin Glasgow, decision handed down on 20 March 2009

most needed various failures occurred in the delivery of those services which contributed to their tragic deaths.

136. In Liam's case the evidence supports a finding that it was an error of judgment to remove him from the Acute Observation Area to the general mental health ward. Dr Davies made the decision after having interviewed Liam over a 40 minute period. He was unaware of a number of crucial issues. He did not know that Dr Banduwardene had not formally assessed him, and that no psychiatrist had assessed him up to that point. Dr Davies did not know the full extent of Liam's history of trying to abscond or of his continued restlessness and agitation. He was not aware that Liam had reported to Dr Denham that he frequently thought about ending his own life and that he had only the day before reported suicidal ideation to Mrs Wright. Dr Davies was given a less than comprehensive history by Dr Banduwardene. Dr Davies had not read the medical file which included a comprehensive history and differential diagnoses of Dr Denham. That occurred in the context of various time pressures and other events. He was not aware that Nurse Skeffington had not provided any care to Liam and therefore could not provide any useful information. There was a failure in communication of this important information between Dr Davies and other staff. As a result, although he heard the concerns being expressed by Mrs Wright, he did not give them sufficient weight and he relied on his assessment of Liam.

137. Dr Davies says his practice is to always read the medical file but the pressures were such that on that day he relied on information passed on to him. Dr Davies accepts that had he been aware of these matters he would not have relied on what Dr Banduwardene had said and his own assessment but would have looked further at the records.

138. It is my view, that if Dr Davies had known the complete picture of Liam's presentation he was unlikely to have come to the same decision to release Liam to the open ward however there can be no absolute in that finding. The benefit of hindsight has to be taken into account. Based on the interview he had and which is recorded in the notes taken at the time, Dr Davies considered that Liam had behavioural problems possibly precipitated by alcohol abuse based on a longstanding sibling rivalry. Dr Lawrence was of the opinion that the earlier history taken by Dr Denham consistent with a Major Depressive Disorder with clinical signs of a possible Bipolar Affective Disorder which should have been considered.

139. I am also not convinced that the need to remove someone from the AOA because of a lack of beds did not play a part in Dr Davies' decision. At the very least, any transfer to the general ward should have commenced with much more constant observations but it is not clear there would have been staff available on that day to do this. These are resource issues which Dr Lawrence and Dr Kingswell both say play a part in how mental health services are delivered in Queensland. When an under resourced service is placed under pressure adverse outcomes are more likely to occur.

140. Submissions were made by Mr and Mrs Wright that I should refer Dr Davies and Dr Banduwardene to the Medical Board of Queensland (‘the Board”) for consideration by the Board of disciplinary action. I have heard from all interested parties on that issue. I fully understand and respect the reasons why Mr and Mrs Wright made that submission. Their submission was thoughtfully and logically presented. It should be understood that if a referral is made that cannot be taken as a conclusion by this court that there has been unsatisfactory professional conduct. That decision is for the Board, not this Court. It should also be understood that the threshold test provided for in section 48(4) of the Act is low. I need only reasonably believe that any information I have, could lead the Board to inquire in to, and take steps in relation to particular conduct.

141. In relation to Dr Davies he was faced with making an assessment in the context of various pressures possibly influencing him. Some of the pressures were of his own doing, particularly in not reading the medical file and instead relied on a briefing from a junior clinician. Dr Davies said in evidence that this was not his usual practice and he would not do that in the future. However there were other contributing factors that were somewhat out of his control, such as the communication breakdown with other staff which was partly as a result of other staff not providing Dr Davies with all of the information nor advising him that they disagreed with his decision. That was partly due to a hierarchical culture which compromised open lines of communication. Dr Davies was not aware of a number of crucial issues relating to Liam which may have changed his thinking. I consider that there were also resource issues in that Logan Hospital was a very busy mental health service which had a limited number of staff and beds then available. In those circumstances I do not consider that I should refer Dr Davies to the Medical Board.

142. I also take the same view with respect to Dr Banduwardene. The main allegation brought against him was his failure to disagree when Dr Davies made his decision to transfer Liam to the open ward. However he was a junior doctor involved in a consultation with a much more senior consultant, and it was reasonable for him to take a view that the Dr Davies’ decision should prevail. Contributing factors as to why Dr Banduwardene did not express his views include the unfortunate hierarchical culture already referred to and the nature of the relationship of Dr Davies and this junior doctor which would suggest Dr Banduwardene was likely to be overborne by him.

143. In relation to Charlie, he also was let down by important information being filtered through the system such that when it came to Dr Leivesley not all of the information was known to him. Charlie had a known and documented history with the Logan Hospital Mental Health Services. He had been treated in Hospital under an ITO. He was subsequently discharged with follow up in the community. Charlie’s follow up plans were not particularly well formulated but he was being treated and any

perceived deficiencies are not strongly contributory to what ultimately occurred. Appropriate advice was given to his family that he should present to the Emergency Department on 31 July 2006. Collateral information was obtained by his Ms Neill from family and passed on to the assessing nurse and then Dr Paul. I find that not all of this information was passed on to Dr Leivesley who made a decision that Charlie did not meet the ITO criteria for admission. Charlie was sent home with an inadequate follow up plan and which was not the plan as understood was to be in place by Dr Leivesley. With the benefit of hindsight, the decision to discharge Charlie with only a follow up with his GP and an appointment with Ms Neill on 2 August 2006 was wrong.

Concerns, comments and recommendations

144. Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

145. The limited continuity of care issues that were plainly evident in Liam's case have been addressed by changes to staffing arrangements made by Dr Kingswell.

146. Some of the other changes made by Dr Kingswell also seem appropriate but there is a concern they are not fully understood by staff and this should be communicated again. Certainly the capacity for a case manager to directly refer a patient to the MHU without needing an admission from the Emergency Department should be made very clear, as I suspect that is what Ms Neill may have done for Charlie.

147. In Charlie's case, various recommendations were made in the Root Cause Analysis which may partly address the clear deficiencies in ensuring all important information is passed up the chain to the eventual decision maker. It is important that the tools developed are not used as a substitute for proper verbal briefings and handover of information.

148. On the issue of what I considered to be flaws in the RCA process, I note this has now been addressed by the Patient Safety Centre and needs no formal recommendation.

149. There are resource issues which may have played a part in both these sad cases. Specifically in relation to Logan Hospital, there already is a commitment by the State of Queensland, as set out and developed in the *Mental Health Plan 2007-2011,* for funding for extra mental health clinicians and more particularly a plan to introduce a 25 acute bed ward.

150. **I recommend** that the proposal to introduce a fully staffed 25 acute bed mental heath ward at Logan Hospital as set out in the *Mental Health Plan 2007-2011* be implemented with priority.

I close this inquest. My condolences are expressed to the family and friends of Liam and Charlie who will be forever missed by them.

John Lock
Brisbane Coroner
20 March 2009