OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	Inquest into the death of Graeme William Julian Eady
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR/03 2771
DELIVERED ON:	20 June 2007
DELIVERED AT:	Brisbane
HEARING DATE(s):	3 October 2006, 4 and 5 December 2006, 16 February 2007
FINDINGS OF:	CA Clements, Deputy State Coroner
CATCHWORDS:	**CORONERS: Inquest; plastic bag asphyxiation of young man receiving psychiatric care in hospital under involuntary treatment order; procedure for intermittent visual observations of patients**

REPRESENTATION:

Counsel:

Assisting: Mr S J Hamlyn-Harris

Royal Brisbane and Women's Hospital and Princess Alexandra Hospital: Ms L Evans, instructed by Crown Law

Nurses Darrel Smithstone, Robyn Ann Pacey and Julianne Stephanie Bell: Mr G Rebetzke, solicitor, instructed by Roberts & Kane Solicitors

Mr Eady's family: Mr B Wessling-Smith

CORONERS FINDINGS AND DECISION

Introduction

1. This is the inquest into the death and circumstances of death of Graeme William Julian Eady. Mr Eady died on 19 October 2003, at the Princess Alexandra Hospital.

2. Graeme Eady was born on 9 October 1978. Although he had a history of feeling depressed, he did not have formal treatment for a psychiatric condition until July 2003 when he was diagnosed with a major depressive disorder. He was then treated as an outpatient until a suicide attempt on 24 September 2003 when he was admitted as an inpatient to G Floor of the Mental Health Unit at the Royal Brisbane and Women's Hospital. His mental state appeared to stabilise initially and then worsen. On 11 October 2003, he was transferred to H Floor of the Mental Health Unit. On 13 October 2003, a decision was made to place him under an involuntary treatment order. On the afternoon of 15 October 2003 he was found unconscious, after apparently placing a plastic bag over his head, in the bathroom of his room, Room 24 of H Floor. After efforts were made to resuscitate him, he was transferred to the Emergency Department and, later that day, to the Princess Alexandra Hospital but did not recover, and died four days later after his life support was ceased.

Coroners Act 1958 applies

3. The inquest was conducted pursuant to section 26 of the *Coroners Act 1958* ("the Act") because Mr Eady's death occurred before 1 December 2003, the date on which the *Coroners Act 2003* was proclaimed. It is therefore a "pre-commencement death" within the terms of s100 of the latter Act, and the provisions of the *Coroners Act 1958* are preserved and continue to apply in relation to the inquest. I must deliver my findings pursuant to the provisions of that Act. I do so, reserving the right to revise these reasons should the need or the necessity arises.

4. The purpose of this inquest, as of any inquest under the Act, is to establish, as far as practicable –

   - the fact that a person has died:
   - the identity of the deceased person;
   - whether any person should be charged with any of those offences referred to in section 24 of the Act;
   - where, when and in what circumstances the deceased came by their death.

5. It should be kept firmly in mind that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence suitable for a criminal trial are not suitable for an inquest. In an inquest there

are no parties; there is no charge; there is no prosecution; there is no defence; there is no trial. An inquest is simply an attempt to establish facts. It is an inquisitorial process, a process of investigation – see *Annetts v McCann* (1990) 170 CLR 596 at 613-617, per Toohey J.

6. A Coroner's inquest is an investigation by inquisition in which no one has a right to be heard. It is not inclusive of adversary litigation. Nevertheless, the rules of natural justice and procedural fairness are applicable. Application of these rules will depend on the particular circumstances of the case in question.

7. In making my findings I am not permitted, under the Act, to express any opinion, on any matter which is outside the scope of this inquest, except in the form of a rider or recommendation.

8. The findings I make here are not to be framed in any way which may determine or influence any question or issue of liability in any other place or which might suggest that any person should be found guilty or otherwise in any other proceedings.

9. Graeme Eady had for some time been suffering from depression, and was 25 years old when he died. I express my sympathy and condolences, and that of the Court, to Graeme Eady's family and friends in their sad loss. His death was a tragic loss of life and it has been very hard for his family to come to terms with losing him in such circumstances.

Summary of the evidence

10. Graeme Eady's mother, Ms Celia Hale, described how Graeme became depressed and very serious when he was around 15 or 16 years old at a time when she herself was going through a divorce. She said that Graeme was a highly intelligent, creative and substantial young man who for a long time had not wanted to speak of his depression.

11. These observations are supported by Graeme Eady's own account of his history of depression in a letter he wrote to his cousin while he was a patient in the Mental Health Unit of the Royal Brisbane and Women's Hospital some time after his admission in late September 2003:

12. "I've been fighting depression since I was 15 or 16, I became a pro at hiding it and tried fighting it in my own ways, I was fearful of doctors due to the fact I had a stage of self-mutilation when I was 16, basically I figured they might try and lock me up. Unfortunately I doofed and deceived everyone up till about 3 months ago."

13. In the letter, he also told his cousin that it was "good for me to get it off my chest".

14. Ms Hale said that, after leaving school, Graeme took an electrical apprenticeship with Ergon Energy. He took a posting to Cunnamulla, but later resigned because of isolation and his depression. He moved to Kalgoorlie in Western Australia to be with his brother and his children, but according to Ms Hale, depression caught up with him again and he moved back to Brisbane in February 2003. She saw signs of depression in him after his return but felt there was little she could do as he was not facing the problem at that stage. However, in early July it became clear to her that he needed help, and she encouraged him to see a doctor.

15. On 8 July 2003, Ms Hale took Graeme to see Dr Jason Smith, a general practitioner in Brisbane. Dr Smith immediately referred him to the Community Health Clinic at Fortitude Valley. In a letter of referral to the clinic, Dr Smith noted that Graeme had presented to him suffering a major depressive episode, and had described a history of episodes of depression, with some of which he had performed self-mutilation; this was taken further at the age of 18 when he tried to commit suicide by slashing his wrists. Graeme had not, however, sought medical or other assistance at the time. Dr Smith also noted in the referral letter to Graeme's account of having suffered, since May, from depressed mood, lack of energy, no motivation, disordered sleep, a feeling of emptiness and a desire to "escape" his current situation.

16. Dr Smith commenced Graeme on an anti-depressant, Zoloft. In his referral letter, Dr Smith noted:

> "… I think there needs to be a sense of urgency in his review and treatment."

17. The Inner North Brisbane Mental Health Service responded promptly. The referral was considered by a social worker at the Mental Health Service, and an appointment made for Graeme to see Dr Tara Khoo, who at the time was a senior psychiatric registrar in the Acute Care Team, on the morning of 11 July 2003 at the Valley Community Mental Centre in Fortitude Valley.

18. Dr Khoo's diagnosis was one of chronic dysthymia (or chronic low mood) with a more recent depressive episode, on a background of borderline personality traits. She was concerned about Graeme's motivation to address these issues, but he had eventually agreed to follow-up. She increased his prescription of Zoloft from 50mg to 100mg per day. An appointment was made for him to see consultant psychiatrist, Dr Greaves.

19. Medical records show that a home visit by a member of the Acute Care Team took place on 15 July 2003. Graeme was seen again by Dr Khoo on 25 July

2003. He was seen by Dr Greaves on 31 July 2003, 23 August 2003 and again on 15 September 2003, and by psychologist Bernadette Klopp on 11, 18 and 25 August 2003 and on 1, 8 and 22 September 2003.

20. The last occasion was two days before his admission to hospital. On that occasion, Ms Klopp noted a deterioration in his mental state. He had missed his medication for a few days, and was to recommence it. Ms Klopp made an appointment for him to see a psychiatrist, Dr Wilson, who had agreed to see Graeme in Dr Greaves' absence, on 23 September 2003. Dr Khoo telephoned Graeme later in the day to advise him of the appointment; he agreed to attend and they discussed his transport arrangements. A member of the Mobile Extended Hours team followed this up by a telephone call to Graeme that evening, and he was reminded of the services that were available to him if he required them. However, Graeme did not attend the appointment with Dr Wilson. When Bernadette Klopp telephoned him, he said he had overslept, and arrangements were made for a further appointment the next day, and for other follow-up. Staff from the Mobile Extended Hours team telephoned and spoke to him that evening, but attempts to contact him by telephone the following morning, 24 September 2003, were unsuccessful, and he was not at home when a home visit was made later in the morning. When Ms Klopp contacted Graeme's brother Nick in the afternoon, he told her that he had informed police after Graeme had gone out and Nick had found "Ratsac" in the blender.

21. Late on the afternoon of 24 September 2003, Graeme was brought by ambulance to the Emergency Department of the Royal Brisbane and Women's Hospital. He had taken an overdose of Zoloft and aspirin, had swallowed "Ratsac", and made superficial cuts to his chest. He was subsequently admitted the same day to G Floor of the Mental Health Unit at the hospital for an involuntary assessment, but after assessment it was not considered necessary to make an involuntary treatment order at that stage, and he remained as an inpatient on a voluntary basis.

22. Ms Hale prepared a statement in November 2003 (Exhibit B11) setting out her account of events between 24 September 2003 when Graeme was admitted to hospital and his death on 19 October 2003. This shows that he was unhappy, angry and depressed on many of the occasions that she visited him or spoke to him whilst he was in G Floor as well as after he was transferred to H Floor. On occasions, he refused to take phone calls.

23. Whilst in hospital, Mr Eady continued to receive treated by the psychologist Bernadette Klopp from the Inner North Brisbane Mental Health Service, who had been seeing him since her initial assessment on 11 August 2002. She continued to see him for support, participated in ward rounds, and liaised with nursing staff regarding his progress and treatment.

24. Dr Greaves and Ms Klopp saw Mr Eady jointly in G Floor on 9 October 2003. He was offered increased contact with Dr Greaves and herself, as the community team, following his planned discharge. Ms Klopp also scheduled another joint interview on 16 October 2003 to facilitate his transition back into the community.

25. On Saturday, 11 October 2003, Graeme was transferred from G Floor to H Floor of the Mental Health Unit. The progress notes in Graeme Eady's hospital chart for 11 October 2003 contain an entry by a member of the nursing staff noting that Graeme was involved in a physical altercation with a co-patient, was counselled regarding inappropriate behaviour, but continued to make verbal threats towards this patient. He was counselled regarding this without success and there was said to be no change in his intentions. That appears to be the last entry in the progress notes made in G Floor.

26. The next entry was made at 1735 hours on 11 October 2003 by registered nurse Bruce Graham Collier, who accepted Graeme into H Floor, and records the fact that the transfer was due to the altercation with a co-patient. These notes also record that he was not happy about the move but accepting of it, and was advised to communicate with the nursing staff if he had any concerns. The next entry, later that evening, notes that he was in his room, reading a book and playing chess, and was polite and pleasant when approached.

27. On the following morning, Sunday 12 October 2003, Graeme was noted to have been asleep on all rounds during that night. He was recorded as keeping a low profile the next day, spending lengthy periods on his bed and with minimal interaction with staff and co-patients. That evening, he approached the nursing station requesting to go back to G Floor, was told that this was not an option at such a late hour and also that G Floor did not have a bed. Late in the evening he was given diazepam at his request, with the effect that he slept throughout the night.

28. On the following day, Monday 13 October 2003, Graeme was reviewed by Dr Williams, psychiatric registrar in H Floor. This review was documented in some detail by Dr Williams in the patient chart.

29. Dr Williams explained in evidence that because Graeme had been transferred to H Floor, his care was transferred to another psychiatric consultant who at the time was Dr Christina Hirst, the acting consultant for the ward. Dr Williams as the psychiatric registrar was responsible for Graeme Eady's treatment under the supervision of Dr Hirst while he was on H Floor. In the hospital notes for Monday 13 October 2003, Dr Williams recorded that his diagnosis at the time was of a major depressive episode; Mr Eady was noted to be clearly quite distressed about his transfer and had some significant suicidal thoughts and some plan of suicide. He indicated to Dr Williams an

intent to self harm by electrocution, which was not carried through, and indicated ongoing suicidal ideations and plans but refused to elaborate on these. Mr Eady claimed that he would attempt self harm if he was not transferred back to his previous floor where he felt he had a more supportive environment. He was quite angry about the transfer, was refusing to actively engage in his treatment on H Floor but was co-operative in taking his medication. Dr Williams considered that Graeme Eady was experiencing quite distressing emotions; a lot of his focus in the conversation with Dr Williams was around a sense of injustice about the transfer, and Graeme presented with symptoms suggestive of a depressive disorder in the context of a more long standing chronic illness that had been present for some years. He rated his own mood as depressed.

30. Dr Williams considered that Graeme remained at risk of self harm and felt that he was probably more at risk of such behaviour in the context of difficult emotions and poor frustration tolerance. His treatment plan at that time, as documented by Dr Williams, was to continue with his current management, to work on building a better therapeutic relationship with him, to maintain him on 15 minute visual observations and to monitor his access to means of self harm. He was to be reviewed by the consultant psychiatrist, Dr Hirst, later that afternoon with regard to planning further management.

31. Although Graeme was admitted to the Hospital under an involuntary assessment order on 24 September 2003, it was not considered necessary at that time to make an involuntary treatment order. He had then continued as a voluntary patient, but on 13 October, Dr Williams, who was an authorised doctor for the purposes of the *Mental Health Act 2000*, made an involuntary treatment order (in-patient category) for Mr Eady, on the basis that Dr Williams considered there was no less restrictive means of ensuring Graeme's safety in hospital. At 11 am on 15 October 2003, Dr Christina Hirst, a staff psychiatrist at the hospital, confirmed the order.

32. Dr Hirst first saw Graeme Eady on Monday 13 October 2003. She became his treating psychiatrist following his arrival in H Floor and was not involved in the making of the decision to transfer him there from G Floor on 11 October 2003. She was aware, however, of the circumstances that lead to that decision, namely that Graeme Eady had been involved in an altercation with another patient and was making continued threats to that patient in G Floor. She understood that the clinical judgment of the treating team on G Floor was that it would be more appropriate in these circumstances to move Graeme. Dr Hirst regarded H Floor as a safer environment because of his continued distressed state of mind, his anger, his slowness to respond to the medication and the changeover of medication, factors which made it a very vulnerable situation in her view.

33. In a statement signed on 8 March 2004, Dr Hirst said this:

> “In view of his major depressive illness with suicidal ideation and difficulty establishing a working therapeutic alliance with Staff at that time, he was made an involuntary patient under the Mental Health Act on 15-minute observations with no leave off the ward. His medication was reviewed, and the decision made to continue with the anti-depressant Venlafaxine XR150mg aiming to increase this dose to 225mg on 17/10/03 if necessary. Diazapam 5mg three times a day was added with further Diazapam to be used as needed to settle his agitation. The aim of this management plan was to validate his feelings of extreme distress and to ensure a high level of support.”

34. Dr Hirst explained in evidence that when she saw Graeme on Monday 13 October 2003, he was very, very angry, was saying he did not trust staff and was a bit ambivalent about taking his medication. She felt it was too risky at that stage to continue the voluntary treatment, and saw the involuntary treatment order as a safety net in case he suddenly wanted to leave the ward or did not want to take his medication. When she interviewed Graeme, he agreed that the order would make him feel safer. He was very impulsive and angry at the time. He felt that the move from G Floor to H Floor had been a personal rejection, and she explained to him that it really was in his best interests, he was not being rejected, and they wanted to place him in a safer environment. He seemed to be able to understand the logic behind the safer ward argument. Dr Hirst said the advantage of H Floor was that there were more nursing staff and a smaller number of people who were potentially aggressive. H Floor contained 10 psycho-geriatric patients, 5 suffering from anorexia nervosa and 10 general psychiatric patients, so that there was a smaller number of people who were potentially aggressive. Dr Hirst understood that the reason for moving Graeme, rather than the other patient involved in the altercation, was that Graeme was continuing to make threats to the other person, and the judgment of the clinical team was that they regarded H Floor as a safer environment in his very vulnerable situation.

35. She said that in view of his major depressive illness with suicidal ideation and difficulty establishing a working therapeutic alliance with staff at that time, Graeme was made an involuntary patient under the *Mental Health Act 2000*, and was placed on 15 minute observations with no leave from the ward. His medication was also reviewed at that time. She said that he agreed to the management plan, spent a more settled day on 14 October 2003, and reported feeling “okay” when she saw him on that date.

36. At the time of his death, Mr Eady remained under 15 minute visual observations with no leave from the ward as a result of his mental state. Dr Hirst regarded the 15 minute observations as appropriate for Graeme at that time.

37. Dr Hirst said that "one of the difficulties with treating him because he was so full of rage [was] that it was very hard … to sort of contain that rage and not be rejected back" (T59).

38. Graeme Eady's mother, Ms Hale, was critical of the care that Graeme was receiving in the Royal Brisbane and Women's Hospital. She said she believed that he should not have been transferred from G Floor to H Floor, which she considered to be unsuitable for him. She also felt that because he was on Valium, he was very confused. She also acknowledged, however, that Graeme had been very unhappy in G Floor. She also raised the question of whether Graeme had been observed within the 15 minute observation intervals he was under at the time.

39. Registered Nurse Darrel Smithstone said that he had normal interactions with Graeme on 14 October 2003, but a note Mr Smithstone made at 1 pm that day records that Graeme was very dismissive of staff and that when his mother called him he refused to speak to her, with no reason given.

40. Psychologist Bernadette Klopp last saw Graeme on Tuesday, 14 October 2003, in the company of the psychiatric registrar Dr Ian Williams. In her statement dated 6 November 2003, Ms Klopp described that visit:

> "He was withdrawn and irritable and refused to get out of bed to engage in an interview. I arranged to return on Wednesday, 15 October at 3.00pm to talk to him. Dr Williams was advised that Mr Eady was unwilling to engage in conversation and that I would return and meet with Mr Eady the next day."

41. Early on the afternoon of 15 October 2003, Mr Eady was found unconscious on the bathroom floor at the Royal Brisbane Hospital by Mr Smithstone.

42. Clinical nurse Bruce Collyer was the shift coordinator on H Floor that day. When he started his shift at 6.45 am that day, he assigned responsibility for the intermittent visual observations throughout the shift, allocating the task to different staff members at hourly intervals. This was the normal practice for the allocation of the observations.

43. Dr Williams saw Graeme on the morning of 15 October 2003, and noted in the chart that Graeme remained angry and irritable, but seemed to have a bit more reactivity in his emotions (in a positive sense). He was agreeable to remaining in hospital but said he still had some suicidal ideation but without any clear plan or intent. Dr Williams also noted in the chart that the involuntary treatment order had been ratified.

44. Assistant in Nursing, Carolyn Davies, conducted the observations on Graeme Eady from midday until 1 pm. She noted nothing different in his behaviour to what she had seen in him on previous days – namely that he seldom spoke to her and was often in bed. When she handed over the observations for the next hour, there was nothing about his behaviour that she felt necessary to tell the oncoming nurse.

45. Registered nurse Julianne Stephanie Bell was allocated to conduct observations in the ward between 1 pm and 2 pm on 15 October 2003. She could not recall anything about the observations that day, and it can be inferred that she did not notice anything about Graeme Eady that was out of the ordinary. Her contact with Graeme up until then had been limited, but when she carried out observations and gave him medications, she found him to be compliant but to be spending a lot of time in bed.

46. Ms Robyn Pacey, an enrolled nurse at H Floor of the Mental Health Unit, worked a 6.45 am to 3.15 pm shift on 15 October 2003, and was rostered to carry out the observations from 2 pm to 3 pm. Apart from noting Graeme Eady's presence during intermittent visual observation allocations, she had not had anything to do with him, but at approximately 2 pm she saw him in conversation with registered nurse Darrell Smithstone at the nurse's station. She then saw him leave the nurses station and go into the TV area.

47. When she then collected the IVO Board from the nurse's station and commenced the 2pm check, she ticked Mr Eady as being sighted as she had seen him speaking to Mr Smithstone at the nurse's station. There were 22 patients it was necessary for her to sight in order to complete her 2 pm IVO duties, and she estimated that it would have taken her about 10 minutes to do that.

48. As soon as she returned to the nurse's station after completing these duties, she was told by the receptionist that there was a telephone call for her. The call was from the Stomal therapist for the hospital. She took the call at the nurse's station. She had been waiting for this call because she needed to discuss with the therapist one of her patients who had a severe ulcer wound that required the therapist's expertise. In fact she had been trying to contact the Stomal therapist for several days. She estimates that this telephone call would have taken at least 10 minutes. While she was on the telephone, she saw Mr Smithstone around the front of the nurse's station with the IVO Board in his hand. She then knew that the IVO's were being taken care of while she was on the phone.

49. Within minutes of seeing Mr Smithstone with the IVO Board, she completed her phone call. A short time later, she was still at the nurse's station when she heard Mr Smithstone yelling for assistance. Ms Pacey's recollection was

that Mr Smithstone called for assistance before she had time to do what she had intended, namely to document the phone call she had just had.

50. Ms Pacey could not be precise as to when she saw Mr Smithstone with the IVO Board. However, if her other time estimates are reasonably accurate, it must have been some time after 2.15 pm. It can be inferred from her evidence that Registered Nurse Smithstone commenced the observations because he could see that Ms Pacey, as the person rostered to do them, was otherwise engaged on her telephone call. Ms Pacey said that it was "usual practice for IVOs to be completed by other staff members if the allocated staff member is busy and they notice that the IVOs have not been undertaken. This is why the IVO Board is placed back in the same spot after each round of observations." Mr Smithstone's evidence, however, is that it was the 2.30 pm observations he commenced, not the 2.15 pm observations.

51. Mr Smithstone said in his statement that he had had normal interactions from Mr Eady on 14 October 2003 and earlier on 15 October 2003 (although he had noted at 1 pm on 14 October that Graeme was very dismissive of staff and had refused to speak to his mother on the phone when she called).

52. On 15 October 2003, Mr Smithstone talked or attempted to talk to Graeme a number of times and each time he would say something, not listen to what had been said and would just walk off. At 1 pm, he wrote in Mr Eady's chart:

> "Very difficult to persuade to get out of bed [to] go to breakfast. Also difficult to persuade to clean up bed area which was very messy. In conversation said things like his life being completely worthless and if he had a gun he would shoot himself. Graeme terminated the conversation at that point."

53. Mr Smithstone's recollection was that this conversation had taken place at around 11 or 12 o'clock. At 2 pm, Mr Smithstone added the following note to the chart:

> "Graeme demanded to see another doctor and his psychologist before 1700 hrs. When told this might not be possible he became very angry and walked away."

54. According to Mr Smithstone, at about 1400 hours on 15 October 2003 he was doing "normal ward work" when Mr Eady came to him and demanded that he phone "GB", the psychiatric admissions area for the Mental Health Unit, and get the doctor and psychologist, Bernadette Klopp, to come to the ward and see him before 5.00pm. Mr Smithstone's recollection was that the doctor Graeme wanted to see was a doctor who worked in the admissions area, who was not his current doctor and not immediately available on the ward. Dr Hirst's evidence was that she understood it was Mr Eady's psychiatrist from

the community, Dr Cecily Greaves that he was asking to see along with Bernadette Klopp.

55. Mr Smithstone told Mr Eady that this was not possible immediately as he had to give medication to another patient and that he would come and see him as soon as he could. Mr Eady said, “You can either do it or you can’t”, and then walked away.

56. Mr Smithstone then had to attend to another patient which took 5 or 10 minutes, and at about 1410 hours, he went back to find Graeme Eady. He spoke to him in the TV room. Mr Eady again asked to see the doctor and his psychologist. Mr Smithstone again told him that he could not do this and attempted to explain why, but before he could do that, Graeme said: “this conversation is terminated” and then left the TV room and walked away.

57. Mr Smithstone says in his statement that he decided to do the observation rounds in the ward for 1430 hours. He also says that he does not remember if they had been completed for 1415 hours, but also says:

> “I remember ticking the 14.15 box for Mr Eady as I had seen him at 1410.”

58. There is no evidence that observations were carried out commencing at 2.15 pm. It appears that after Ms Pacey did the 2 pm observations, the next observations carried out were those Mr Smithstone commenced at about 2.30pm.

59. According to his statement, Mr Smithstone got to Mr Eady's room, Room 24, at about 14.35 but did not record the exact time. He saw that the room was empty and heard the shower running and checked on Mr Eady by knocking on the door and calling his name. There was no reply and he then entered the shower room and found Mr Eady lying on the floor on his back with a transparent plastic bag over his head. He noted that Mr Eady was not breathing and was very pale and his lips were cyanosed. He ran to the nurses’ desk and called an emergency, then ran back to Mr Eady, checked his carotid pulse and as there was no pulse, commenced cardio pulmonary resuscitation. Two doctors, Dr Matthew Hocking and Dr Vanda Phillips, came shortly afterwards and efforts to resuscitate Mr Eady continued.

60. A Cardiac/Respiratory Arrest Resuscitation Record shows the time that Mr Eady was found by Mr Smithstone as 1430 hours, and the time of the emergency call - the “333 Call” – as 1432 hours. The guidelines for the use of this form require it to be completed for all episodes where a cardiac or respiratory arrest call was made to “333”.

61. When enrolled nurse Robyn Pacey heard Mr Smithstone yelling for assistance, she and clinical nurse Bruce Collyer then wheeled the “crash

trolley" down to Room 24 where she saw that Mr Eady was lying on his back in the bathroom ensuite and that Mr Smithstone was performing CPR on him. She provided further assistance in the efforts to resuscitate Mr Eady.

62. Registered nurse Bruce Collyer said that he heard the sound of the emergency buzzer at 1430 hours and then assisted Ms Pacey to push the emergency trolley to Graeme Eady's room where Mr Smithstone and Dr Hocking commenced CPR at approximately 1430 hours. He says that the emergency team arrived and took over resuscitation at 1432 hours.

63. Mr Collyer said in evidence when he heard the sound of the emergency buzzer, he looked at his wristwatch and saw that it showed the time as 1430 hours. He noted that the wall clocks were battery operated and showed different times.

64. Registered nurse Julianne Bell was handing over her patients to the afternoon shift when she saw someone running with the "crash trolley" and pushing it into Room 24, Graeme Eady's room. She paged the doctors and spoke to the registrar to inform him of the situation. When she went to Graeme Eady's room she saw Darrel Smithstone and others giving Graeme CPR.

65. Ms Elaine Thora Collins, clinical nurse consultant at the Mental Health Unit, says that at about 14.35 hours she became aware that there was a medical emergency. She then went to the nurses' desk and then to Graeme Eady's room where she saw Dr Phillips and Dr Hocking treating Graeme along with numerous other nursing staff, including Darrel Smithstone.

66. Assistant in nursing, Carolyn Peggy Davies, had seen Graeme Eady talking in the dining room to Darrel Smithstone at about 2.00pm. Graeme's body language suggested that he was cranky. He stormed off in the direction of his room. At approximately 2.15pm she saw another nurse running with the ward emergency trolley towards Graeme's room and heard the alarm, but she was not sure of the exact time. She was sent to the Emergency Department to get some more equipment and later cleaned up the medical equipment and packaging.

67. Registered nurse Vanessa Jane Keen says that at about 2.00pm, as shift handover was about to start, she was behind the main nurses' desk attending to patient charts when Darrel Smithstone came running up to the nursing desk and said "We have got a medical emergency cardiac arrest".

68. Another registered nurse, Arumugan Thaivarayan, said that Darrel Smithstone, who he described as the medical emergency nurse for the day, came running over calling for help and he assisted him with Mr Eady. Mr Thaivarayan did not give any times.

69. Dr Steven Lane was the medical registrar on duty on 15 October 2003 and part of the medical emergency team for the hospital. In a statement tendered at the hearing, he said that he was paged by the emergency pager call at approximately 1540 hours and proceeded directly to the scene, Dr Lane's notes in Mr Eady's hospital chart shows the same time, but an examination of the chart suggests that the time is a simple error, and has been taken from Mr Smithstone's notes that immediately precede Dr Lane's, where Mr Smithstone recorded 1540 hours as the time he made his notes and, clearly by mistake, wrote 1535 hours as the time he found Mr Eady in the shower. It appears very likely, therefore, that Dr Lane went to provide assistance very shortly after the emergency call was made at 1432 hours.

70. Mr Smithstone's evidence was that two other doctors, Dr Matthew Hocking and Dr Vanda Phillips attended shortly after he commenced cardiopulmonary resuscitation. Dr Lane's statement records that Graeme regained spontaneous output; he then was intubated and ventilated with 100% oxygen, and received three boluses of 1mg Adrenaline, 10 ml Calcium chloride, 1 mg Atropine and one litre of normal saline; he regained spontaneous respirations after 15 minutes and ventilation was ceased, and he was allowed to breathe spontaneously. He was given Morphine and Midazolam for agitation and at 1640 hours was transferred to the Emergency Department in the presence of the medical superintendent, Dr Stephen Ayre, and intensive care registrar, Dr Cohen.

71. It is clear from the evidence that when Graeme was discovered and the alarm raised by Mr Smithstone, there was immediately an appropriate emergency response by a number of nursing and medical staff in an effort to resuscitate him. There are some discrepancies in the accounts of various witnesses to the emergency as to when relevant events occurred, but from the available evidence I have outlined I am able to conclude that the time that he was unobserved between his last conversation with Mr Smithstone and when he was found by Mr Smithstone in the shower was no longer than approximately 20 minutes.

72. Given that 15 minute observations cannot, for practical reasons, be carried out at mathematical intervals of exactly 15 minutes, this time between observations is not exceptional. The procedure then in place for ensuring that observations were carried out was in need of improvement; it appears that the 2.15 pm observations were missed. However, there is no evidence upon which it could reasonably be concluded that that contributed in any significant way to the delay between the (unknown) time that Graeme placed the plastic bag over his head and when he was found.

73. The Director of Mental Health, Dr Brett Emerson, telephoned Graeme's mother at 1630 hours to inform her of the situation. She then travelled from her home in Toowoomba to Brisbane with one of Graeme's brothers. After

they arrived at the hospital, they spoke to both Dr Emerson and to the Director of Emergency Medicine, Dr Brazil.

74. That evening at about 9 pm, after Mr Eady had been resuscitated and stabilised, he was transferred to the Intensive Care Unit at Princess Alexandra Hospital, as there were no beds available at the time in the Intensive Care Unit of the Royal Brisbane and Women's Hospital. On arrival at the Princess Alexandra Hospital, Graeme remained deeply unconscious with a Glasgow Coma Score of 3. There is no suggestion that this transfer prejudiced his treatment or welfare in any way.

75. On 18 October 2003, Graeme remained comatose with a Glasgow Coma Score of 3, with absent oculocephalic, tracheal and gag reflexes. On 19 October 2003, there was no improvement. Dr Christopher Joyce spoke with his family at some length. He told them that there was no realistic hope of any outcome other than death or a vegetative state. They agreed that ongoing life support therapies were not appropriate.

76. Graeme Eady died at the Princess Alexandra Hospital on 19 October 2003 after doctors had determined that his life support should be discontinued in view of his severe brain injury, and breathing assistance was discontinued. Life was certified extinct by Dr TJ Wilkes at 2.02 pm.

77. A post mortem examination certificate was issued by Dr G Lampe stating that the cause of death was:

    (a) hypoxic-ischaemic brain injury
    (b) plastic bag asphyxia.

78. Police were notified after Graeme Eady died at the Princess Alexandra Hospital on 19 October 2003, and then carried out an investigation into the circumstances of his death. Copies of medical records were obtained and statements were obtained from a number of witnesses. Plain Clothes Senior Constable Newton of the Fortitude Valley CIB completed a Coronial Investigation Report.

Procedure for intermittent visual observations (IVOs)

79. The evidence of enrolled nurse Robyn Pacey that it was usual practice for intermittent visual observations to be completed by other staff members if the person allocated to do them was busy and they noticed that the IVOs have not been undertaken, accords with the evidence of other witnesses as to the practice at that time.

80. The disadvantage of such a system is that there is no fail safe means of ensuring that the observations are carried out if the allocated staff member is

otherwise occupied. Rather, it relies upon another staff member noticing that the time for the next round of observations has arrived, or has passed and also that they are not being carried out. Obviously, this is not entirely satisfactory and perhaps a better system can be devised for ensuring that observations are carried out as directed.

81. Ms Pacey estimated that someone else had to step in to help out the person allocated to do visual observations, at least every shift.

82. Assistant in nursing Carolyn Davies said that during her time on H Floor, she noticed that on occasions the intermittent visual observation chart which was kept at the station would sometimes be 15 minutes to half an hour behind when it was busy in the ward, mostly at lunchtimes or when a patient was being difficult. She also said that sometimes she noticed that the board was sitting there at the station and she would grab it and do another person's observations because that person happened to have been busy. She acknowledged that if no-one noticed that the observations had not been done, then they might be missed.

83. Senior Constable Newton, who investigated Graeme's death and who had personal experience as a police officer of conducting observations of persons in police custody who were considered to be at risk, also referred to the need for a person carrying out observations to have that duty above and beyond all other duties.

84. Psychiatrist Dr Hirst commented that "observations certainly are very, very important … but the practicalities are that sometimes you cannot absolutely get it perfect all the time".

85. Ms Elaine Collins, clinical nurse consultant at the Mental Health Unit, said that because of the nature of the intermittent visual observations and the time needed for the person carrying them out to locate and visualise every patient on the round, they can not be carried out on a strictly 15 minute basis. It may take the full 15 minutes to complete the observations, during which time the staff member carrying them out cannot attend to their own patients. For these reasons, and because of the need to maintain vigilance in carrying out the observations, one hour is considered to be the appropriate length of time for a staff member to be allocated that responsibility before handing it over to another person.

86. Ms Collins said that the practice of conducting intermittent visual observations had been changed since that time. The looseness of the then practice had been addressed. Staff members conducting observations for an hourly period were now required to sign the observations form on taking over, and again at the end of the hour, to indicate completion of the observations and the handing over to the next person. A verbal handover was also required from

one staff member to the next at the end of each hour. In addition, if a person doing visual observations had another matter they were required to attend to, then they were required to hand over the observations to another person. Ms Collins said that since this incident it had been made clear that intermittent visual observations take precedence. There had been a lot of education about their importance.

87. It appears therefore that the hospital has taken steps to remedy the somewhat loose arrangements that were in place at the time for carrying out intermittent visual observations (when the allocated staff member was for some reason required to attend to other duties).

88. The evidence at this inquest suggests that there is a need for all psychiatric units to have a system of visual observations in place which ensures that the observations are carried out as closely as possible to the intervals which have been determined to apply.

Availability of means of suicide

89. As to the availability within the ward of the means of suicide, clinical nurse consultant Ms Elaine Collins said that routine audits are conducted. Efforts have been made to reduce the number of plastic bags and other plastic, but they could not be eliminated because of the very widespread use and ready availability of plastic – for example, in continence pads, medical gloves and bin liners, in the packaging of all medical supplies and for use in the disposal of human waste. Visitors to patients bring in items in plastic bags.

90. Dr Hirst considered that practically it was just not possible to eliminate plastic bags from hospital wards, and more generally, that it was just not possible to remove every possible means of suicide.

91. I am satisfied that it is not reasonably possible or practicable to eliminate plastic bags and other plastic material from psychiatric wards. Whilst it would be desirable to know where Graeme Eady obtained the plastic bag he used, that would not have affected the findings or any riders I might make in this inquest.

Preservation of the scene

92. The police were not notified before Graeme Eady's death of the incident in the Royal Brisbane and Women's Hospital on 15 October 2003, and for that reason it was not possible for them to carry out a forensic examination of the scene, because it had been cleaned and Graeme's personal effects removed before the police became involved.

93. As to the preservation of the scene after an incident such as this, clinical nurse consultant Elaine Collins said that there was no policy in place, although there was a very clear policy when a death occurred in the ward. Clinical nurse Bruce Collyer, who was the shift co-ordinator at the time, assisted in cleaning up the area with two other nurses. He said that hospital policy was that the scene was to be preserved if there was a death in the ward, but that was not the position at the time.

94. In these circumstances it is understandable that the scene was not preserved. Apart from the likelihood that the plastic bag used by Mr Eady might have been identified, I do not think that the preservation of the scene would have added to the evidence that it has been possible to assemble in this case.

Policy for transfer between wards

95. There is no policy in the Mental Health Service or throughout the Royal Brisbane and Women's Hospital with respect to a decision to transfer patients between floors. Where aggressive incidents occur between in-patients, a clinical decision has to be made to manage the safety of all persons. One outcome may be to move one patient to another floor to reduce the risk of further aggressive incidents.

96. It is clear on the evidence that Graeme Eady was unhappy about the decision to transfer him from G Floor to H Floor on 11 October 2003, and also that efforts were made to explain the reasons for the move to him. It is also clear that at times Graeme was quite angry when he was on G Floor and he continued to be angry after the transfer to H Floor.

97. I am satisfied that the decision to transfer Graeme Eady from G Floor to H Floor on 11 October 2003 was a clinical decision made on a sound and proper basis on the facts which presented themselves to those treating him at the time. I also accept the submission which has been made on behalf of the hospital and the Brisbane Health Service District that a decision as to transfer between wards is a clinical decision which should be made on a case by case basis having regard to the particular circumstances and relevant clinical considerations at the time.

98. The hospital records do not indicate who made the decision to transfer Graeme Eady from G Floor to H Floor. In submissions on behalf of the hospital (Royal Women's and Brisbane Health Service District), it is accepted that the identity of the person making such a decision, as well as the reasons for the transfer, should be clearly documented in the patient's chart, and I think that is correct.

Conclusion

99. Graeme Eady was a 25 year old man who had suffered from depression since he was about 16 years old, although this was not formally diagnosed until July of 2003. He then began receiving psychiatric treatment and care in the community. After an apparent suicide attempt on 24 September 2003, he was admitted as an inpatient to the Mental Health Unit of Royal Brisbane and Women's Hospital. On 11 October, he was transferred from G Floor to H Floor of the Mental Health Unit after an altercation with another patient. He was placed on 15 minute visual observations. An involuntary treatment order was made on 13 October 2003 because of concerns about his mental state. He continued to express ideas of suicide. The involuntary treatment order was confirmed by a psychiatrist on 15 October 2005.

100. In the early afternoon of 15 October 2003, Graeme Eady was found by a nurse in the bathroom area of his room on H Floor of the Mental Health Unit with a plastic bag over his head. He was unconscious and not breathing. Emergency treatment was immediately commenced and he was resuscitated. Later that day he was transferred to the Intensive Care Unit of the Princess Alexandra Hospital. He was found to have suffered severe brain damage as a result of the incident, and after his family were consulted, a decision was made to discontinue life support and he died on 19 October 2003 at the Princess Alexandra Hospital.

101. Graeme Eady's treating team were aware of his risk of suicide, and I consider that appropriate steps were taken, in the circumstances as they appeared to be, to address that risk, by regular consultation and monitoring of his condition, the use of medication, the making of an involuntary treatment order, and by placing him under 15 minute observations. Tragically, in his depressed mental state and in the short time when he was not under observation, Graeme took steps on 15 October 2003 to end his own life.

102. Subject to the observations I have made about the system then in place for the carrying out of intermittent visual observations, I consider that appropriate care was taken by those treating Graeme to assess and respond to his risk of suicide.

FINDINGS

103. I make the following findings –

(a) The identity of the deceased was Graeme William Julian Eady.

(b) His date of birth was 9 October 1978.

(c) His last known address was 74 Gerler Street, Bardon, Brisbane.

(d) At the time of death he was not employed.

(e) The date of death was 19 October 2003.

(f) The place of death was the Princess Alexandra Hospital, Brisbane.

(g) The formal cause of death was:
- hypoxic-ischaemic brain injury
- plastic bag asphyxia.

104. This court has jurisdiction in appropriate cases to commit for trial any person/s which the evidence shows may be charged with the offences mentioned in section 24 of the *Coroners Act 1958*. There is no evidence at all of the commission of such offences, and I therefore make the formal finding that the evidence is not sufficient to put any person or persons upon any trial. Therefore no person will be committed for trial.

RECOMMENDATIONS

105. The evidence highlighted defects in the system then in place for carrying out observations at the time of the incident involving Graeme Eady on H Floor of the Mental Health Unit at the Royal Brisbane and Women's Hospital on 15 October 2003. I have concluded that the intermittent visual observations scheduled for 2.15 pm on that day were not carried out, but the interval between when Graeme was last seen by registered nurse Smithstone and when Mr Smithstone found him in the shower was no more than about 20 minutes. I therefore find that the manner and timing of the observations did not materially contribute either to Graeme Eady having the opportunity to act as he did or to the time it took to find him and commence resuscitation.

106. The Mental Health Unit at the Royal Brisbane and Women's Hospital has adopted new procedures since the death of Graeme Eady with a view to ensuring that intermittent visual observations of patients are carried out at the directed intervals in respect of each patient, and are properly documented.

107. I consider that the new procedures for conducting IVOs are a significant improvement on the procedures which were in place at the time. I consider that the Queensland Director of Mental Health should investigate the suitability of similar procedures throughout Queensland, and to have them introduced if they are considered appropriate in all in-patient psychiatric facilities in Queensland.

108. Pursuant to section 43 of the Act, the following recommendation is made by way of rider to the formal findings.

109. I recommend:

That Queensland Health consider the introduction of State-wide guidelines regarding the carrying out of intermittent visual observations of patients in mental health facilities in order to establish a clear and unambiguous written procedure directing:

- the manner in which observations are to be performed;
- the nurse or nurses who are responsible for carrying out the observations; and
- how the observations are to be documented and recorded.

Such guidelines could be tailored to meet the specific requirements of individual hospitals but should aim to increase uniformity of observation practice and compliance with it. Compliance with policy and procedures should be audited regularly.

110. Finally I acknowledge the efforts of Graeme Eady's mother, Celia Hale, and other family members in assisting with the inquest process by the provision of information and by their attendance and the briefing of counsel to appear on their behalf.

111. Thank you to counsel appearing and assisting in this inquest. The inquest is now closed.

Chris Clements
Deputy State Coroner
20 June 2007