QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Patient A**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Maroochydore
FILE NO(s):	2009/3027
DELIVERED ON:	5 July 2012
DELIVERED AT:	Maroochydore
HEARING DATE(s):	18 April 2012, 2-4 July 2012
FINDINGS OF:	John Lock, Brisbane Coroner
CATCHWORDS:	Coroners: inquest, Suicide, Mental Health, Treatment Approach - in community or admit to hospital, Communication with family, Adequacy of Root Cause Analysis

REPRESENTATION:

Counsel Assisting:	Mr C Minnery of Counsel, Office of State Coroner
Queensland Health and its employees:	Ms SJ Gallagher of Counsel instructed by the State of Queensland
Clinical Nurses Tuckett and Davies:	Mr G Rebetzsky of Counsel instructed by Roberts & Kane

Introduction

1. Patient A was aged 49. He had been receiving treatment for a recurrent depressive illness for some 10 years. Despite being largely symptom free for 8 years, he had recently experienced a relapse. His GP wrote a letter of referral to the Adult Mental Health Community Assessment and Treatment Team (Acute Care Team) at Maroochydore on 23 November 2009, as a result of a deterioration in Patient A's mental health and because he was expressing suicidal ideation.

2. He was reviewed by members of the Acute Care Team over the next week. His partner reported he had expressed concern to members of the Acute Care Team about Patient A's deterioration and suicidal ideation on a number of occasions, requesting he be hospitalised. This did not occur. On 6 December 2009 he was found hanging by his partner's mother at his place of residence.

3. His partner has raised a number of concerns about the care provided to Patient A by the Nambour General Hospital and the Sunshine Coast Health Service District. Given those concerns and as there was uncertainty concerning the circumstances leading up to his death, a decision was made to hold an inquest.

4. A pre-inquest hearing was held on 18 April 2012. At that hearing an order was made that the name of the deceased and of his partner, together with any details, which may identify the name of the deceased or his partner, would not be published in any form after the date of this order. That order will continue and these findings de-identify their names and identifying particulars.

5. The issues that have been identified to be explored at the inquest are:–

    a) The findings required by section 45 (2) of the *Coroners Act 2003*, namely the identity of the deceased, when, where and how he died and what caused his death;
    b) the adequacy of the care provided by the Acute Care Team to Patient A including but not limited to:-
        - a review of the decision-making process of the hospital and treating team including the treatment approach;
        - choice of medication and the issue of why he was not hospitalised;
        - communication issues within the team, with the patient and to the family of the patient; and
        - a review of a Root Cause Analysis and the implementation of any recommendations made as result of that report.

The scope of the Coroner's inquiry and findings

6. 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.

7. 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.

8. 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]

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

The Admissibility of Evidence and the Standard of Proof

10. Proceedings in a coroner's court are 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

[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s46
[3] s45(5) and 46(3)
[4] s35

regard to its origin or source when determining what weight should be given to the information.

11. 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]

12. 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, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

13. 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.

14. 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 Concerning Treatment

15. The medical history and information provided to the coronial investigation indicates Patient A had been diagnosed with a Major Depressive Disorder and a suicide attempt by overdose as far back as January 1998. He had a month long hospital admission at that time and was subsequently treated by various health districts including Royal Brisbane Hospital, Princess Alexandra Hospital and Redlands District.

16. On 20 February 2002 there was a further admission to Royal Brisbane Hospital, with a diagnosis of Bipolar Affective Disorder. He received follow-up treatment by the Valley Integrated Mental Health Service.

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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] S 48(4)

17. Patient A's partner became aware of the mental health concerns soon after they commenced a relationship in 1998. The partner has been closely involved in his treatment from that time and it is clear he has provided very close and supportive assistance to Patient A over the next 10 years.

18. His partner confirms that in 2002 Patient A was hospitalised in Royal Brisbane Hospital. He says the symptoms Patient A had on the occasion of that admission were exactly the same as the symptoms Patient A was experiencing in November 2009. Those symptoms include overwhelming thoughts of blackness, constantly crying, not shaving or having a shower and having no pride in his appearance (which was unusual because he was meticulous in his appearance) and generally withdrawing.

19. His partner states that over a period of time Patient A started to get better and they moved to the Sunshine Coast where the beach environment and other circumstances helped to improve his mental health. The improvement was such that for a good part of the next period of eight years Patient A's reliance on medication reduced to the extent he came off it altogether and he was showing few or no symptoms of mental illness at all.

20. In May 2009 the couple decided to move to Tasmania and they purchased a house property near Hobart. They moved into the house in July 2009. Over the next few months Patient A started to express concerns of feeling tired and complaining about the gloomy weather. He saw a GP who prescribed him an antidepressant, Zoloft 100mg (sertraline). His condition however deteriorated and on 9 October 2009 the GP referred him to the Royal Hobart Hospital for a crisis assessment. He was admitted and diagnosed with Bipolar Disorder and depression. He was subsequently discharged on 16 October 2009. On discharge he was prescribed Zoloft 100mg and Zyprexa 2.5mg (olanzapine an anti-psychotic.) Guidelines[11] for use of Olanzapine indicate it can be used in combination with lithium or valproate for Bipolar 1 Disorder. In Hobart, valproate had also been utilised but as he developed a rash within 24 hours it was ceased.

21. A decision was then made by Patient A and his partner that they would relocate to the Gold Coast. The move was made quickly and Patient A came back to Queensland first, whilst his partner remained in Tasmania and made arrangements to sell their property.

22. Patient A saw a GP on the Sunshine Coast on 11 November 2009 stating his recent suicidal ideation had abated and he was wishing to reduce his medication. He was advised to wait six months and then undertake any reduction under specialist supervision.

[11] Exhibit B12.3 *Australian and New Zealand clinical practice guidelines for the treatment of bipolar disorder*

23. On 23 November 2009 Patient A saw his GP again. As a result the GP wrote a letter of referral to the Adult Mental Health Community Assessment and Treatment Team (Acute Care Team) describing "a recurrence of a depressive phase of a bipolar condition, having been last depressive 10 years ago with current prescriptions of Zyprexa and Zoloft and that he was expressing suicidal ideation but no method chosen".

24. The Acute Care Team operated as a mobile, multi-disciplinary team via a hospital and community based triage and assessment service and short term intensive treatment team. It operated under comprehensive guidelines and procedures.[12] It is evident the staff involved in this case were all qualified and registered and most of them had long term experience. They had all been trained in risk assessment and management for suicidal behaviour. Since this case a District procedure for Risk Assessment has been finalised following on from the introduction in February 2010 by the Director of Mental Health of the State, of a Guideline for Suicide Risk Assessment and Management.[13]

25. Clinical Nurse Linda Duff completed a Consumer Intake form, and sent a facsimile to Hobart Hospital and the GP in Tasmania on 24 November 2009 requesting information about that admission. The GP provided a reply that day noting he had contact with the patient on three occasions, outlining a decade long history of depression and the fact he was referred to Hobart Hospital.

26. The Royal Hobart Hospital also provided a copy of a discharge summary for his recent admission, which stated Patient A had been admitted because of suicidal ideation and depressed mood which had been present for two months prior to moving to Tasmania. It was noted he was given valproate to which he developed a rash and olanzapine was commenced instead. There was a brief reference to his moving to Tasmania which had been stressful and that he appeared to improve with the decision to return to Queensland. He was discharged after seven days with a referral back to his GP and advised to consult a psychiatrist in Queensland.

27. On 26th of November 2009 Acting Clinical Nurse Consultant Joan Reid together with Clinical Nurse Tuckett conducted a home visit and CNC Reid completed a detailed Consumer Assessment. Without recalling the precise time they spent on the assessment they both said this would usually take between 1 to 1.5 hours.

28. CNC Reid noted he was teary and upset and CNC Reid conducted only the more important parts of the assessment for that reason. Nonetheless it is apparent the assessment was a comprehensive one. She noted features consistent with a Major Depressive Disorder, and there were

[12] Exhibit B14, Statement of Janelle Killick attachment JK-3 & JK-6
[13] Exhibit B14, Statement of Janelle Killick attachment JK-4 & JK-5

expressions of suicidal ideation but no plan or intent was noted. There were various protective factors identified including his son, his partner and friends. Past admissions to Royal Brisbane Hospital and Princess Alexandra Hospital and previous ECT therapy was noted.

29. CNC Reid was fairly confident hospitalisation was not discussed and Patient A did not request this. She considered he was a moderate risk of self harm. She stated if he was considered to be a high risk she would have arranged to bring him to hospital for a Mental Health Act assessment.

30. CN Tuckett stated patient A presented as distressed and depressed with suicidal ideation but denying plan or intent. She had a clear recollection Patient A did not request an admission to hospital.

31. The plan formulated by them was for Patient A to be reviewed by the medical team as soon as possible given the diagnosis; to review his medication given he gave a history that he had become manic on antidepressants in the past; for there to be close monitoring for the next two weeks; to liaise with his GP; and to review the plan on a regular basis.

32. On returning to the office CNC Reid and CN Tuckett would have attended the handover conducted at 2.30 in the afternoon with the morning and afternoon team where Patient A was discussed and the plan was agreed upon. Patient A would have been included on the acute board. CNC Reid was not certain if the Consumer Assessment form[14]had been completed or if she transferred her notes after the handover and before she completed her shift. No notes of the handover are recorded however she was confident the case plan was discussed and agreed to as the plan was in fact carried out.

33. Patient A was reviewed at his home by a psychiatric registrar, Dr Gordon Faulds, on 27 November. Dr Faulds was a senior psychiatric registrar. He had completed the registration requirements and was registered to practice as a psychiatrist in July 2010.

34. Dr Faulds noted ongoing symptoms of depression and a sense of frustration by Patient A at his limited response to treatment. Dr Faulds recorded the patient described some improvement over the preceding three days and denied any suicidal ideation.

35. Dr Faulds thought there was evidence to support a depressive relapse in his Bipolar Affective Disorder with some signs of improvement related to his treatment. He said various treatment options were discussed with Patient A. Hospitalisation was discussed as a standard option but he said the patient gave a preference for community management. Dr Faulds recommended the addition of lithium as an adjunct to the

[14] Exhibit E1 pp 16 -25

sertraline for depression and as a mood stabiliser. Patient A wanted to discuss this with his partner when he returned and Dr Faulds considered this was reasonable.

36. Dr Faulds increased the dose of sertraline (Zoloft) to 150mg and continued the dose of olanzapine. He stated his standard, albeit conservative approach was to increase this medication one dose step at a time. Dr Faulds was not convinced this was the time to order a larger increase or to change medication to other groups such as SNRIs or specifically venlafaxine. It is accepted there are increased risks during any changeover period. He noted that since 2009 there has been ongoing literature and debate as to whether antidepressants should be used in the treatment of Bi Polar Disorder at all. The evidence suggests the efficacy of treatment options for mental illness is subject to ongoing research and debate by mental health professionals, which is how it should be. There are no doubt varied approaches which have validity.

37. Dr Faulds recommended the addition of Cognitive Behavioural Therapy techniques (as distinct to a formal CBT program) for the associated anxiety and stress. Dr Faulds wrote out and provided a crisis management plan and telephone numbers. Telephone contact was to be made by the team the following day and a further home visit on 29 November 2009.

38. It is evident from the medical notes that no telephone contact was made on 28 November. It is unclear why not. It is noted that over 28 and 29 November the file was not available to clinical staff but Clinical Nurse Riley spoke to Patient A on the telephone on 29 November. Presumably this resulted from the plan discussed at the earlier team handover. CN Riley noted in a retrospective entry on 30 November (the file having been located) that the patient declined face-to-face contact that day but assured him he was not at risk and would contact the Acute Care Team if he required assistance.

39. Patient A's partner arrived back in Queensland on 29 November and immediately considered he was very unwell and he appeared worse than when he was in Hobart. He said Patient A was crying and sobbing and would lie in bed curled up in a fetal position. He was not washing himself and his mood was flat.

40. On 30 November his partner rang the mental health service at around 12.00 and says he requested Patient A be hospitalised as he was saying he wanted to "end it". It seems he spoke to CN Riley who reported in his statement that the partner was concerned Patient A had not improved since he was hospitalised in Hobart. CN Riley spoke to Patient A who said he was frustrated he had not responded to treatment but he would not harm himself because of his partner and children. Arrangements were made at the afternoon handover for face to face contact that day with members of the Acute Care Team.

41. Some time later that day Melissa Matthews, a psychologist in the Acute Care Team attended with CN Tuckett. Ms Matthews noted Patient A engaged in conversation but presented with low mood, his affect was restricted and anxious but there was no indication of any formal thought disorder. He was polite and engaged easily and was not dishevelled. Although she recalls he was teary at times, he was not sobbing or curled up in the chair.

42. Ms Matthews offered supportive counselling during which Patient A discussed his negative thoughts and frustration due to the perceived ineffectiveness of treatment and lack of progress. She certainly considered he was unwell but denied there was any reference to him having overwhelming black thoughts. She provided some strategies to structure his daily activities and increase behavioural activation. He was advised his concerns regarding his perceived lack of progress along with current clinical risk would be discussed with the team, including the treating psychiatric registrar, at the clinical handover meeting the following day. At the finalisation of the visit Ms Matthews stated Patient A was able to provide assurances regarding his personal safety and given he was in the company of his supportive partner.

43. Ms Matthews recalls any reference to hospitalisation was in the context of discussing various treatment options. She stated Patient A said he wanted to stay at home as he felt supported and was agreeable to community treatment. Ms Matthews said if there had been a strong preference expressed for hospital she would have contacted the on call psychiatrist and facilitated an assessment at hospital. She does not agree Patient A or his partner begged to be hospitalised.

44. CN Tuckett considered his mood was low with some anxiety and there had been no improvement. She documented the attendance in a detailed progress note. He was still unwell and she was concerned, hence the plan for him to be reviewed by a doctor the next day. She recalls there was no discussion about hospitalisation and would have documented this if it had occurred. She said he was not presenting as crying, sobbing, saying he would be better off dead or curled up in a chair. He did not say he had black and overwhelming thoughts or continually saying he was suicidal. She said she would have documented this history and presentation as it would be very significant. CN Tuckett denied either Patient A and/or his partner was begging to be admitted to hospital. If that had occurred she would have acted upon it by ringing the psychiatric registrar and arranging a review in hospital.

45. His partner disagrees that at any stage Patient A was able to give them a reassurance about his personal safety and he was not asked about this. He says both he and Patient A continually told them he was suicidal and he needed to be admitted to hospital.

46. On 1 December 2009 at approximately 4:15 pm a clinical review of the case was held. This is a more detailed review of the patient and

treatment plans than the twice daily handovers and accordingly is documented in the progress notes. The review involved Dr John Miles, the Senior psychiatrist, two other psychiatrists including Dr Faulds and other members of the team including Ms Matthews, CN Riley, CN Tuckett and CN Reid. The plan was for continued monitoring, review by the psychiatrist each second day and continuing with Cognitive Behaviour Therapy interventions conveyed by telephone. The agreed plan, was documented by CN Tuckett in the progress notes. There is no reference to following up the issue of whether Patient A had agreed to the commencement of lithium.

47. His partner states that both Patient A and himself spoke to someone from the team later that evening advising that he was still suicidal and was continually crying. This is documented in the progress notes as a telephone call made by Ms Matthews at 7:00 pm. She notes the couple were advised as to the treatment plan and Dr Faulds would visit the next day. Ms Matthews noted his partner's concerns there had been some deterioration since returning from Hobart but says she would have documented if there was reference to suicidal thoughts or that he was crying continually and was not looking after his hygiene. She considered Patient A was unwell but was much the same as the previous day.

48. During the morning of 2 December 2009 his partner described that Patient A was incredibly agitated and teary. When Dr Faulds came for a visit he told him Patient A's condition was much worse. Dr Faulds disagrees he was told the condition was much worse and he would have documented this.

49. Dr Faulds recorded his partner's concerns, which were confirmed by the patient with an increase in hopelessness, suicidal ideation but with no plan and a frustration at the lack of progress. His partner says he pleaded with Dr Faulds to immediately admit Patient A to hospital. There is no doubt there was some discussion about hospital. Dr Faulds says his focus was on the partner's concerns about there being no improvement and whether hospital would assist. He said the partner was not emphatic about this request but acknowledged the discussion was in the context of the partner suggesting a strong preference for hospital.

50. Dr Faulds noted in his statement that despite the reported deterioration Patient A also reported having an improved day with more positive thoughts and an increase in his energy. Dr Faulds considered there was evidence of significant carer stress.

51. Dr Faulds denied Patient A was in tears, was expressing self harm and overwhelming black thoughts or his partner pleaded with him to immediately admit him. He considered that although there were ongoing concerns there were some signs of response to treatment. He added lithium to his treatment and reinforced the plan for adjunctive Cognitive Behavioural therapy. In Dr Lawrence's Independent Expert report she

noted that although the doctor wrote he seemed to be reporting a better day, there was not much evidence of this.

52. On 3 December 2009 Patient A and his partner received an offer on the sale of their house in Hobart. The couple discussed whether his partner should go to the Gold Coast to sort out a house for them to live in and some employment. Patient A insisted his partner go and assured him he felt a bit better and that sorting out employment and the home situation would also help him. His partner went to the Gold Coast later that afternoon.

53. The belief there had been some improvement is to some extent confirmed in a telephone call made to Patient A by CN Tuckett at about 3 pm on 3 December. In that conversation it is recorded he had 2 better days and was determined to beat his illness. He reported his partner had gone away for 2 to 3 days and he expressed some hope he was starting to improve. She noted he done some grocery shopping, which although was overwhelming he had derived some satisfaction. Part of the conversation involved a discussion about future plans and it is evident she considered Patient A may have had some unrealistic and "grandiose" ideas and the plan was to discuss with the team about possible early signs of a manic switch. A home visit was planned for the following day and collateral information from Royal Brisbane Hospital and Princess Alexandra Hospital was also to be requested.

54. His partner states that he does not agree Patient A had 2 better days and it was only on the day since the sale had been finalised did he seem to be somewhat better.

55. On 4 December 2009 Clinical Nurses Eric Van Hooijdonk and Keith Riley conducted a home visit. They recorded Patient A reported a general improvement in mood and had increased his level of activity though he continued to experience a lack of enjoyment and he was frustrated regarding the slowness in his improvement. He was not crying or teary or unkempt. He was encouraged to improve activity levels by setting goals that he felt were achievable. He reported no suicidal ideas. The plan was to continue with daily contact and for this to be reviewed if his mood continued to improve with the view to reducing contact. CN Hooijdonk considers he was a low risk of suicide that day. There was no request by Patient A for a hospital admission.

56. By this time collateral information had been received from Princess Alexandra Hospital. The material from Royal Brisbane Hospital apparently arrived on 7 December.

57. On 5 December 2009 Clinical Nurse Karen Davies had a telephone conversation with Patient A at 2:10 pm. She recorded Patient A now reported his mood had deteriorated over the last two days and he was "back on struggle street". CN Davies gave evidence that in exploring this comment with Patient A the struggle was in relation to financial matters.

Patient A reported suicidal ideation was always at the back of his mind "as was expected in someone with depression" but denied any plan or intent. CN Davies considered his responses did not indicate a sudden change or deterioration. A home visit was planned for the next day.

58. From the time that he left in the afternoon of 3 December 2009 to 6 December 2009, his partner kept up contact with continual telephone calls and text messages. His partner said he sounded very flat and in a very low mood. His partner's mother was living next door.

59. On the morning of 6 December 2009 his partner spoke to Patient A in a very brief conversation, the brevity in retrospect he found unusual. Patient A told his partner he wasn't feeling well and the mental health people were coming in the morning. His partner gave him a reassurance that he would be home by lunchtime and that he loved him. On his way in the motor vehicle on his way back he received a telephone call from his mother to say that Patient A had hung himself.

60. The information provided to police indicated that on 6 December 2009 the partner's mother spoke to Patient A prior to going to church. It is recorded he seemed to be in good spirits and asked her to leave the front gate open as he was expecting a visit from the Acute Care Team.

61. The medical progress notes record that at 10:30 am CN Tuckett made telephone calls to the landline and mobile without a response but no messages were left. At 11:50 am CN Tuckett and CN Mark Lennox attended for a home visit but no-one was apparently at home or responded to doorknocking or calling out. A later entry in the records indicated that they called out several times and looked around the house and checked in the shed and surrounds but nothing was found. A note was left near the door.

62. Neither CN Tuckett nor CN Lennox was concerned when Patient A was not immediately present as it is not unusual, for a multitude of valid reasons, for patients to be absent when they attend. It is evident neither of them believe they have any authority, statutory or otherwise, to enter a person's private premises without permission, unless there is clear evidence requiring an escalation. That approach is supported by the common law, which recognises a justification for what would otherwise constitute a trespass only in cases of necessity to preserve life or property.[15]

63. The mother of his partner arrived home at approximately midday and located a note stating the Acute Care Team had attended and were unable to locate him. She then noticed the door to the granny flat was open and proceeded to search for him. Upon entering the bedroom, she found Patient A hanging from the steel support frame. She immediately

[15] Kuru v State of NSW [2008] HCA 26 at paragraph 40

telephoned triple O. QAS arrived together with the police and attempted to revive him but this was unsuccessful.

Autopsy results

64. A full internal and external autopsy examination was ordered. Prof Peter Ellis confirmed the presence of a mark around the neck, which was consistent with the rope that was received with the body. There were no external signs of violence or injury, and nothing to suggest involvement of another person in his death. Toxicological examination revealed no alcohol and only drugs that had been prescribed for depression. These were not elevated to levels that could be considered fatal. The drugs found included olanzapine, sertraline and lithium indicating Patient A was compliant with taking his medication.

Expert Review by Dr Lawrence

65. Dr Joan Lawrence is an experienced consultant psychiatrist, experienced in clinical practice and with considerable forensic experience. She has been an assisting psychiatrist to the Mental Health Court since 2002. She was requested by the original investigating coroner to provide an expert opinion in relation to the care provided by the Acute Care Team.

66. Dr Lawrence reviewed the medical records and summarised the medical history. She told the court she was provided with letters written by Patient A's partner, however her report concentrated primarily on the medical file.

67. She said the Acute Care Team assiduously gathered in collateral information and the subsequent monitoring was very good and well recorded. She considered the medical notes painted a picture of a man suffering a relapse of his depressive illness for a period of at least two months with persistent suicidal ideation from his time in Hobart, which had not improved on the current pharmacological regime. This was reinforced when his partner telephoned on 30 November expressing his concerns.

68. Accordingly, in relation to the response of the Acute Care Team she opined that it would have been prudent, in the light of the detailed history of his illness available to the treating team and the expressed concerns of his long-term partner, to have considered hospitalisation or, at a minimum, to have sought more vigorously to treat the depression. She acknowledged consideration had been given and a decision was made to introduce a mood stabiliser and possible booster with lithium.

69. Dr Lawrence noted that a diagnosis was correctly made and an increase in the antidepressant was made, with a plan to continue the treatment involving close monitoring, assessment of suicidal risk, Cognitive Behavioural techniques to address his negative symptoms and general

support measures. She stated that there was no doubt this was done conscientiously by the treating team.

70. She opined however, as a Consultant Psychiatrist, that the documented severity of the symptomatology, the continuing suicidal ideation, the continuing symptomatology and expressions of frustration and failure to improve was inadequately responded to by the measures taken.

71. In her view it would have been desirable to admit Patient A to hospital for closer observation and monitoring of his condition as well as the implementation of more vigorous treatment of his Depressive Illness, including, if necessary, the consideration of ECT, with the possibility of the addition of a mood stabiliser. She noted the fact that his next of kin had expressed the possibility of an admission to hospital should have alerted the team to the concerns of a person who knew him best.

72. In essence, she concluded the Acute Care Team assessed and monitored conscientiously, considered possibilities but no action occurred and no resolution of any considerations was achieved.

73. Dr Lawrence opined that whilst an increase in the antidepressant, Sertraline was certainly warranted, the dose of 150 mg was merely an average dose. She said in her evidence she would have increased the dose to 250 or 300 mg but agreed, given the published guidelines for treatment, that in adopting a more conservative approach of increasing to 150 mg and monitoring, this was not unreasonable.

74. In her opinion, from the records, Patient A's condition was serious, was not improving and more vigorous treatment, including the change of antidepressant would be warranted. She noted the known history indicated the response to Sertraline had been limited and had been in place for several months. This was an adequate time for assessment of efficacy of the medication. Dr Lawrence would in her clinical judgment have considered the introduction of one of the SNRI group of drugs such as venlafaxine or one of the older group of drugs such as the triccylic antidepressants.

75. Dr Lawrence considered the dose of the antipsychotic, olanzapine was a small dose and which was appropriate as a starting dose but there could be an argument for increasing the dose in the circumstances. She considered it was prudent to consider the use of a mood stabiliser. She acknowledged in her evidence Dr Faulds had recommended the addition of lithium and patient A was entitled to speak to his partner first. Given lithium can take weeks to have any clinical effect, any delay of a few days would not have changed the outcome in this case.

76. Dr Lawrence considered the use of ECT should have been considered given it had worked for him in the past. She acknowledged that clinically and legislatively there had been a change in the frequency of its use by psychiatrists, but still considered it works for severe depression.

77. Dr Lawrence accepted the medical records over 3 to 5 December noted what could be considered an improvement but there were other equivocal references and she would have wanted more than that to conclude he was improving.

78. Nonetheless, Dr Lawrence considered the decisions made indicated the care and treatment was delivered with care, dedication and appeared to be appropriate according to good clinical practice, albeit delivered cautiously. She impressed that the difference of opinion she expressed should be seen as one of clinical judgement and it must be recognised also that hindsight is invariably informative.

79. By way of comment she was of the view that the delivery of psychiatric services generally was hampered by a lack of ready access to acute psychiatric beds in hospital. There is no evidence in this case that any lack of access to a bed impacted. She further commented that in her view community-based treatment services are provided in an attempt to avert the need for hospitalisation as far as possible and this can lead inevitably to successive and unrealistic demands on Acute Care Teams in the community. Acute Care Teams were established in an effort to keep patients treated in the community and sometimes those efforts are unsuccessful with tragic outcomes as occurred in this case.

Open Disclosure and Support to the Family

80. It is evident that Patient A's partner and other family members have not felt the support provided by Queensland Health subsequent to the death has at all been appropriate.

81. A meeting took place some time in the afternoon of 7 December 2009 between family members and Dr Miles and Melissa Matthews. It is evident this was a difficult meeting for all those present and the family expressed clear and angry concerns about the mental health service that had been provided and in particular that he should have been hospitalised.

82. From the family's perspective they felt they had received no answers of any kind and were met by people who had no knowledge of the case. It was acknowledged by Dr Miles he had not reviewed the medical record. The meeting was requested urgently and they left quickly and before he could consider the medical records. There is a suggestion that In accordance with protocol the records had been quarantined and he could not bring them with him.

83. Patient A's partner stated Ms Matthews nodded repeatedly in confirming he (the partner) had repeatedly begged for Patient A to be hospitalised. Both Ms Matthews and Dr Miles stated her nodding was a mannerism

and Ms Matthews said this would be indicating she was listening and not necessarily confirming.

84. Dr Miles noted it was a difficult meeting and he explained to the family that Patient A had not met the criteria for a hospital admission, as a major indicator was whether there was an imminent risk to life. Here the patient had not stated any specific intent to harm himself or that any specific intent had increased thereby requiring admission.

85. Subsequently his partner and mother attended a meeting attended by the then Minister for Health, local Member of Parliament The Honourable Mr Wellington and others. Patient A's partner again considered this meeting was a waste of time. There was reference to a transparent root cause analysis process taking place to look into the situation. It is evident at some stage a Root Cause Analysis report was provided to the family, which is dated 19 March 2010.[16]

86. More will be said about the RCA report but it is fair to say the only recommendation made related to a conclusion the documentation was in some way lacking. Understandably this further escalated the family's concerns as they regarded the recommendation as farcical.

87. On 16 April 2010 the partner and his mother attended an open disclosure meeting to discuss the RCA. Present where representatives from Queensland Health being Dr Miles, Dr Ayres, Dr Matira Taikato the Clinical Director for the District and Janelle Killick, the Service Director as well as Mr Wellington MP.

88. From the partner's perspective this meeting was most unsuccessful. Patient A's partner stated that at one stage Dr Taikato said the meeting was to be ended as the participants were obviously at loggerheads and there were no records anywhere the patient had asked to be hospitalised. Dr Taikato denies aspects of what is alleged to have been said but does acknowledge the meeting closed when it was evident the assertion of the partner that he repeatedly asked for an admission was not going to be resolved at the meeting given what was recorded in the clinical record.

89. It is not intended to make any further comment or resolve one way or the other concerning what was or was not said at this meeting or the others. What is clear is all of the meetings were difficult and by no means therapeutic for the family.

90. Subsequently on 29 April 2010, the Service Director, Janelle Killick wrote to the partner acknowledging that contact by senior management and clinical staff was not timely or effective and proffered an apology for the further distress this had caused.

[16] Exhibit E3

91. The letter noted that processes for contact with family members subsequent to a tragic incident had been reviewed and a more timely and appropriate response has been implemented. The letter acknowledged that a request for Patient A to be admitted to hospital was documented in the health record, however it was the clinical opinion of the treating doctor and team that treatment and support could continue to be appropriately managed in the community. The letter also noted that one outcome from the Root Cause Analysis highlights that clear documentation of these considerations and the rationale for the clinical decision-making in the health record could be substantially improved. Also, as was discussed at the meeting the communication with the family and carers regarding this should be more specific and collaborative.

92. Ms Killick acknowledged, in response to a comment I made during submissions, that lessons have been learnt on how future open disclosure processes should be conducted. I would expect those lessons include ensuring those who attend have sufficient knowledge of the treatment to be able to provide answers and is conducted by someone who has had training in open disclosure processes. Open disclosure is a policy, which in my experience is highly valuable for families' right for information and which allows some closure.

93. Ms Killick provided the Court with a number of policy and guidelines some of which have been introduced since 2009. In June 2011 the Director of Mental Health for the State introduced the Consumer, Carer and family Participation Framework, the premise for which is an approach centred on the patient and the meaningful engagement of carers and families. Although the clinical staff in this case acknowledged the importance of the information received by Patient A's partner the framework urges the use of clinical judgement to look for all opportunities to share information.

Root Cause Analysis

94. A Root Cause Analysis was commissioned on 8 February 2010 and completed on 19 March 2010. The Root Cause Analysis Report documented the events based largely on the clinical record. Only one issue was identified as a lesson learnt and this related to the standard of clinical documentation.

95. The one recommendation made was that the mental health service was to develop a workplace protocol of minimum dataset requirements for inclusion in clinical documentation/progress notes. Monthly documentation orders were to be conducted over the next six months with the outcome being that the documentation met the ACHS Equip 4 Standards.

96. The report stated that the issue was important on the basis that timely and accurate clinical documentation optimises safe patient care and clinical management in accordance with legal requirements and

standards. Documentation must support clinical decision making processes and clearly articulate content of review is undertaken. Reports must also reflect that consideration has been given to the following:

a) mental state and risk assessment;
b) outcomes following any clinical review;
c) management and treatment plans; and
d) inclusion and consideration of family and significant others when developing a care plan and providing outcomes to patients being treated in the community and further, the level of support available from the family, the family is level of understanding of the needs of the person being cared for and early warning signs in relation to the condition being treated.

97. Dr John Wakefield, Executive Director of the Patient Safety and Quality Improvement Service was requested by my office to review the Root Cause Analysis. His capacity to review the process was limited by the statutory restrictions and privileges attached to RCA processes. It is accepted there are good policy reasons for those statutory privileges.

98. Dr Wakefield did say he would have certain expectations concerning the expertise of members of the team. He would expect generally the RCA team would review the medical record, interview people who were directly involved in the event and review relevant policies, procedures and/or standards.

99. The evidence of all clinical staff involved in Patient A's care is that none of them were approached to participate in the RCA. Given that evidence the RCA seems to have been a document review only. I consider this to be most unsatisfactory.

100. Dr Wakefield was reluctant to appear to be critical of the RCA members, given he did not have sufficient information as to the process adopted in this case but he would have expected the RCA team to have been able to identify some contributing factors and recommendations for possible improvements to policies, procedures or practices. He said that given the only lesson learnt outlined in the RCA report is regarding clinical documentation, a question was raised in his mind as to whether the RCA team was successful in sufficiently "drilling down" to identify root causes of the incident. Dr Wakefield questioned whether there were in fact contributing factors in this case from which recommendations might have been developed**.**

101. It might also be said, given none of the staff involved in the care assisted the RCA team, this very limitation perhaps offers an explanation why no other Root Causes were identified. It is impossible to now say what otherwise would have resulted but the methodology approached here was by no mean optimal.

102. This is by no means the first case where I or other Coroners have been critical of perceived deficient RCA reports. This is also not the first case before me where the evidence suggests virtually no-one on the treating team was interviewed in relation to the events. In fact this has been a common theme in a number of inquests conducted by me. Coroners have expressed a common message in relation to the value of RCAs. They need to be rigorous, identify root causes and provide recommendations, which relate to the root causes. When conducted properly they can often obviate the need for the holding of inquests or to narrow the issues to be examined if an inquest is held.

103. It would also be my expectation that in most, if not all RCAs, the key players in the treating team were interviewed or given an opportunity to be interviewed. This simply did not occur in this case.

104. Dr Wakefield is concerned that even isolated incidences of poor quality RCAs have the potential to undermine confidence in the process. It has been my experience the quality and frequency of RCAs has diminished in recent years. The quality is variable and some Hospitals and districts conduct high quality RCAs and others do not. This RCA is one example of the latter.

105. Dr Wakefield has agreed to meet very shortly with the State Coroner and other full time Coroners to understand our concerns with a view to taking further action necessary to ensure RCAs across Queensland Health are as good as they can be. Given from 1 July 2012 there are substantial changes to the responsibility of new Heath Districts it is uncertain as to where this is taken. For the moment I will leave the issue with that development but I offer the comment that wherever possible RCAs are conducted such that relevant members of a treating team, if they wish to participate, are provided an opportunity to be interviewed and are provided with feedback as to the outcome of the RCA.

Conclusions

106. There is evidence to support a finding the Acute Care Team provided a good level of monitoring and contact with patient A in accordance with the treatment plan that was adopted by the team. The initial response was conducted expeditiously, information gathering was conducted efficiently and a face-to-face assessment took place within two days. Monitoring thereafter took place and was certainly adequate.

107. The quality of documentation was adequate but could have been better. I accept it is impractical to document the twice-daily handover process given the number of patients, and accept as reasonable the assertion that if the handover resulted in any change of plan, then the process was for this to be documented. The note taking in the progress notes was at times comprehensive. Only one clinical review is documented and it appears to be limited in its scope. The evidence suggests there should have been at least another clinical review, which was not recorded. I

suspect it is to the clinical review/s, which the RCA findings, at least in part addresses.

108. The plan was for continued treatment in the community rather than hospitalisation. It is difficult to reconcile the evidence of the partner as to his assertions he and Patient A "repeatedly" asked for or "begged" for hospitalisation, with the evidence of all of those who were part of the treating team and who consistently denied this was the case.

109. I accept the issue of a hospital admission was raised by Patient A's partner on at least two occasions and probably more, after his return from Tasmania on 29 November. It was certainly raised with CN Riley over the telephone on 30 November and with Dr Faulds on a home assessment on 2 December. Dr Faulds' description of the partner's approach as indicating a "strong preference" for a hospital admission is in my view telling. The evidence does not support that Patient A was proffering the same preference to the treating team.

110. Dr Lawrence's expert opinion is that even absent any communication about a request, strong, persistent or otherwise for a hospital admission, the clinical picture warranted more aggressive action including an admission. Her reasons for advancing this proposition have been discussed and I accept them. Equally, Dr Lawrence was careful to suggest her view was one of her clinical judgement where other reasonable minds may differ and the approach of the Acute Care Team was within broad clinical standards and treatment guidelines.

111. A hospital admission was arguably required in thjs case and may have prevented the tragic outcome although even in Hospital not all suicides can be prevented. It is accepted the approach to continue to treat Patient A in the community was in keeping with a least restrictive approach and also had arguable clinical support. Sometimes deterioration in mood or presentation is sudden or some other psychosocial stressor intervenes, which is not predicted. It is uncertain as to what occurred during the morning of 6 December, which caused Patient A to decide to take his life but these sad events have continued to cause loss and grief to his partner and other family, for which they have my condolences.

Findings required by s45

Identity of the deceased – Patient A

How he died – Patient A was suffering from a two-month relapse of a mental illness. His partner had expressed concerns about a perceived deterioration in his presentation at home and indicated a strong preference for an admission to hospital. A clinical decision was made that he should remain to be treated in the community. Unfortunately and despite the support provided to him by his partner and family and the community-based support of the treating team he hung himself at his home.

Place of death – YANDINA QLD 4561 AUSTRALIA

Date of death– 06 December 2009

Cause of death – 1(a) Hanging

Comments and recommendations

112. I comment that wherever possible, Root Cause Analysis processes should be conducted such that relevant members of a treating team, if they wish to participate, are provided an opportunity to be interviewed and are provided with feedback as to the outcome of the RCA.

I close the inquest.

John Lock
Brisbane Coroner
BRISBANE
5 July 2012