QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Adam Trent Ryan**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Charleville
FILE NO(s):	2009/1337
DELIVERED ON:	18 January 2013
DELIVERED AT:	Brisbane
HEARING DATE(s):	4-8 June & 16-17 August 2012
FINDINGS OF:	Mr O Rinaudo, Coroner
CATCHWORDS:	CORONERS: Inquest – adequacy of medical, nursing and mental health care at Charleville Hospital

REPRESENTATION:

Counsel Assisting	Mr C. Minnery
For the Family	Mr T. Ryan i/b Barry & Assoc
For the Nurses	Miss C Hartigan i/b Hall Payne Lawyers
Qld Health	Dr M Callaghan i/b Tresscox Lawyers
For QPS	Mr A Braithwaite i/b QPUE
Nurse Edith Sikwebu	Mr P Coggins i/b Gadens Lawyers

This is the inquest into the death and circumstances of death of Adam Trent Ryan.

1. I must deliver my findings pursuant to the provisions of the *Coroners Act 2003*. I do so, reserving the right to revise these reasons should the need arise.

2. The purpose of this inquest, as of any inquest, is to establish, as far as practicable:-

    - Whether or not a death happened;
    - The identity of the deceased person;
    - How the person died;
    - When the person died;
    - Where the person died; and
    - What caused the person to die. [Section 45 (1) and (2)]

3. It should be kept firmly in mind that an inquest is a fact finding exercise and not a method of apportioning guilt. A coroner must not include in the findings any statement that a person is, or may be guilty of an offence or civilly liable for something. [Section 45(5)]

4. The procedure and rules of evidence suitable for a criminal trial are not suitable for an inquest. The Coroners Court is not bound by the rules of evidence and may inform itself in any way it considers appropriate. [Section 37]

5. 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. These observations were confirmed by Justice Toohey in Annetts v McCann ALJR at 175.

6. A Coroner's inquest is an investigation by inquisition. 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. A coroner may, whenever appropriate, comment on anything connected with the death that relates to:-

    a) Public health or safety; or
    b) The administration of justice; or
    c) Ways to prevent deaths from happening in similar circumstances in the future. [Section 46 (1)]

8. If, from information obtained while investigating a death, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to:-

a) for an indictable offence – the Director of Public Prosecutions; or

b) for any other offence – the chief executive of the department in which the legislation creating the offence is administered.

9. A coroner may give information about a person's conduct in a profession or trade, obtained while investigating a death, to a disciplinary body for the person's profession or trade if the coroner reasonably believes the information might cause the body to inquire into, or take steps in relation to, the conduct.

10. All proceedings before this Court are sad proceedings. At this stage I express my sympathy and condolences, and that of the court, to the family of the deceased for their sad loss, in the tragic death of Adam Trent Ryan.

Introduction

11. Mr Adam Trent Ryan was born on 26 January 1979. He was 30 years old when he died on 12 July 2009. Mr Ryan committed suicide by hanging at his home in Charleville. He is survived by his mother and family.

12. His death was reported to the coroner by Queensland Police due to it being a reportable death and because of some issues of concern surrounding the death.

13. An inquest was convened to examine the circumstances of Mr Ryan's death. The Inquest was held in Charleville from Monday 4 June 2012 to Friday 8 June 2012 inclusive, and then two further days in Brisbane on 16 and 17 August 2012.

14. A number of concerning issues arose during the course of the Inquest about the adequacy of the medical care, nursing and mental health care received by Mr Ryan prior to and after his death.

15. These issues will be examined in some detail in these findings, with a view to determining if deficiencies in that care contributed to Mr Ryan's death, and if any recommendations should be made with a view to improving the care to avoid such issues in the future.

16. I am grateful to Counsel Assisting (I acknowledge that much of the evidence is taken from that submission) and to all counsel representing the various parties for their comprehensive written submissions which have been of great assistance to me in formulating these findings.

17. I make the following formal findings.

Findings section 45(2)

Pursuant to section 45 (2) *Coroners Act 2003*, I make the following formal findings:

(a) the deceased was Mr Adam Trent Ryan;

(b) Mr Ryan died from asphyxia, due to hanging;

(b) Mr Ryan died at his home at 64 Little Parry Street, Charleville, in the State of Queensland;

(c) Mr Ryan died between 7am and 8.30am Sunday 12 July 2009;

(d) Mr Ryan died as a result of committing suicide. There are no suspicious circumstances.

History

18. Mr Ryan was the youngest son of Ms Robyn Cuthers. He had three older siblings. His father separated from his mother, when Mr Ryan was seven or eight years old. Mr Ryan lived with his mother for a time, and then lived with his father.

19. Mr Ryan was the subject of police security following an incident involving an attack on his father by Outlaw Motor Cycle Gang (OMCG) members. He subsequently came to live with his mother in Charleville in 1995. Mr Ryan later revealed that during the period he was living with his father, his father had attempted suicide by overdose of pills, possibly due to his involvement with OMCG elements.

20. Mr Ryan had worked as a shearer, in the Charleville area and in Victoria. He had difficulties with drug use such as cannabis, methylamphetamine and LSD or mushrooms. He also drank alcohol to excess on occasion.

21. In approximately 2002 (although it may have been 2004) Mr Ryan suffered a drug-induced psychosis, when he was in Hamilton, Victoria. He received psychiatric treatment over the course of six to eight sessions.

22. In the late evening, 10 May 2004, Mr Ryan attempted suicide by cutting his throat. He was living in Victoria at the time. The hospital records from Victoria[1] indicate that Mr Ryan presented to hospital the next day, indicating he heard voices, and he felt others were out to get him so he thought he would *get in first* and cut his throat. He was medicated but not

[1] Exhibit E10.1, page 40 to 51

hospitalised. He ceased his medication after three weeks as he said he felt it was making him psychotic. He was counselled, and had sessions with a psychiatrist.

23. In mid 2008, Mr Ryan moved into his own home in Charleville, at 64 Little Parry Street. This house became known as a party house. Many people, around Mr Ryan's age, would regularly come to drink and socialise.

24. Mr Ryan had a girlfriend, Stevie Jo Bennett, but this relationship ended in the weeks before his death[2]. He then entered into a relationship with Sarah Maunder, until days prior to his death.

25. Ms Bennett gave evidence that she never saw Mr Ryan depressed or appearing down during their relationship[3], although he did drink alcohol regularly[4].

Events Leading to his Death

26. On 2 June 2009, Mr Ryan attended the Charleville Community Mental Health (CMH) Service for assistance, having been referred by his general practitioner to the Charleville CMH service.

27. The Charleville CMH service is located at 2 Eyre Street, Charleville, and is about four kilometres from the Charleville Hospital.

28. The Charleville CMH Service was an entirely separate organisation from the Charleville Hospital, and effectively a separate organisation from the Charleville Alcohol, Tobacco and Other Drugs Service (ATODS).

29. Mr Ryan was seen on 2 June 2009 by Ms Teegan Russell, a clinical nurse. Ms Russell filled out an intake form[5] based on information gained from Mr Ryan in an interview. This information allowed Ms Russel to perform a *provisional* diagnosis[6]. The assessment took about an hour, and included a risk screen of Mr Ryan, as in risk to Mr Ryan and risk to others.

30. She gave evidence that if she had been told of a *recent* suicide attempt by Mr Ryan (recent including five or ten years earlier) she would have put him in the medium to high risk category, in terms of risk of harming himself[7].

[2] See transcript of 4 June 2012, page 123, line 55 onwards
[3] See transcript of 4 June 2012, page 124, line 9
[4] See transcript of 4 June 2012, page 124, line 13
[5] This assessment form is Exhibit E10.1 at page 18 onwards.
[6] See the evidence of Ms Russell, transcript of 4 June 2012, page 61, line 15 onwards
[7] See transcript of 4 June 2012, page 65, line 47 onwards.

31. However, this appears contrary to the evidence. See *discussion* below for further discussion on this point.

32. Following her assessment of Mr Ryan, Ms Russell consulted with her team leader, Mr Wroe about how to approach Mr Ryan's treatment. It was decided that Mr Ryan be further assessed by a psychiatrist who would visit Charleville the next day, 3 June 2009. An appointment was arranged for Mr Ryan to attend the assessment with the psychiatrist[8].

33. The psychiatrist, Dr Kyaw saw Mr Ryan in person in Charleville, on 3 June 2009[9]. The purpose of the meeting was to perform a general diagnosis[10]. Ms Russell and Mr Michael Frame were both present[11]. Dr Kyaw visited Charleville monthly[12].

34. Dr Kyaw was aware Mr Ryan had attempted suicide in Victoria[13].

35. Dr Kyaw diagnosed Mr Ryan as having a generalised anxiety disorder with secondary depressive mood, rather than a major depressive disorder[14].

36. Again some inconsistencies arise in his evidence which will be discussed later.

37. Dr Kyaw prescribed Sertraline[15]. He also discussed and recommended reduction in Mr Ryan's consumption of alcohol[16].

38. Dr Kyaw advised Mr Ryan to attend the hospital if his condition worsened. Dr Kyaw sent a referral letter to the hospital, to inform of Mr Ryan's position and diagnosis[17]. The letter contained an error as it noted past suicidal thoughts, and not a past suicide attempt.

39. Mr Ryan failed to attend an appointment with Dr Kyaw on 18 June 2009, although he did contact the Charleville CMH Service and re-schedule for 2 July 2009[18].

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[8] This can be found on Exhibit E10.1, page 23
[9] Transcript of 6 June 2012, page 4, line 51
[10] Transcript of 6 June 2012, page 6, line 6 onwards
[11] See paragraph seventeen of Dr Kyaw's statement
[12] See paragraph seventeen of Dr Kyaw's statement
[13] Transcript of 6 June 2012, page 6, line 25
[14] Transcript of 6 June 2012, page 7, line 8, and also paragraph 23 of Dr Kyaw's statement
[15] See paragraph 31 of the statement of Dr Kyaw.
[16] See paragraph 30 of the statement of Dr Kyaw.
[17] See transcript of 6 June 2012, page 7, line 34 onwards
[18] See Exhibit E10.1, page 57

Mr Ryan next met with Dr Kyaw by video link, on 2 July 2009[19].

41. By then, Mr Ryan had ceased taking his anti-depressants for about two weeks, and had escalated his drinking[20] to perhaps fifteen to eighteen beers a day[21].

42. Following this consultation, Dr Kyaw sent another letter to the Charleville Hospital, to arrange detoxification for Mr Ryan with observations. He also requested administering Diazepam on an as/needs basis, but no more than 30mg per day, liver function tests, trialling Avanza and referral to ATODS[22]. The usual or accepted approach was for the hospital to do this referral[23].

There was no mention of suicide risk in this letter[24].

44. A further appointment between Mr Ryan and Dr Kyaw was made for 8 July 2009[25]. This appointment did not occur, as Mr Ryan was in hospital. The hospital did not advise Dr Kyaw or the Charleville CMH Service that Mr Ryan was in hospital[26]. See below for further discussion on this point.

Dr Kyaw did not see Mr Ryan again.

46. On 3 July 2009, Mr Ryan presented at the Charleville Hospital, seeking help with his alcohol consumption. He saw Dr Wilke, as arranged, who took a detailed history from him including his history of substance abuse. Dr Wilke asked about the issue of self harm, and Mr Ryan denied any thoughts of self harm. Mr Ryan presented as teary and upset.

47. The hospital did not have access to the Charleville CMH Service files. The only contact the hospital had with the Charleville CMH Service was Dr Kyaw's letter which it has been noted did not mention past suicide attempts. The only information Dr Wilke had about this was the answer to a general question about present suicidal thoughts, which Mr Ryan denied.

48. Dr Wilke concurred with Dr Kyaw's assessment that detoxification was appropriate. As a bed was available, Mr Ryan was admitted to the

[19] See transcript of 6 June 2012, page 10, line 15 onwards
[20] See transcript of 6 June 2012, page 10, line 30 onwards
[21] From the notes of the meeting taken by Dr Kyaw, transcribed in exhibit B22 at page 7 and 8
[22] This letter appears transcribed, in exhibit B22, at page nine
[23] See transcript of 6 June 2012, page 14
[24] See transcript of 6 June 2012, page 15, line 10 onwards
[25] See transcript of 6 June 2012, page 19, line 47
[26] See transcript of 6 June 2012, page 20

hospital immediately to commence detoxification. Mr Ryan declined. He agreed to commence alcohol withdrawal in the community, with the assistance of diazepam to combat withdrawal symptoms.

49. Mr John Maunder, brother of Sarah Maunder, recalls being called on a day, (possibly on 7 or 8 July 2009 – but it was most likely 4 July 2009) at about 3:10am. Mr Maunder is not certain of the actual date[27]. It is most likely 4 July 2009 as Ms Sarah Maunder, his sister, had told police about a suicide attempt stopped by her brother the previous Saturday, which was 4 July 2009. Mr Maunder received a call from Mr Ryan, during which Mr Ryan said he did not want to live any more, that '*they*' had taken Sarah away from him, and he abruptly ended the call by saying '*I gotta do it, I gotta go, bye*'. Mr Maunder said Mr Ryan sounded incoherent on the phone[28]

50. Mr Maunder was already concerned about Mr Ryan's mental state and wellbeing, medication use, talk of suicide particularly when drunk, although with no specific plan[29]), and his ongoing depression[30]. Mr Ryan had told Mr Maunder about two previous suicide attempts – one by hanging, and one by cutting his neck[31].

51. Mr John Maunder immediately went to Mr Ryan arriving within eight or ten minutes of the call ending, arriving about 3:40am. He found Mr Ryan at the rear of the house, kneeling on a swivel top bar stool, placing a noose made from a cord over his head. Mr Maunder ran over. As he saw Mr Maunder approach, Mr Ryan removed the noose from around his neck. The cord was tied over a roof beam.

52. Mr Ryan went inside the house, followed by Mr Maunder. Mr Maunder unsuccessfully tried to call his sister, and he saw what appeared to be a suicide note on the kitchen table.

53. Mr Maunder tried to encourage Mr Ryan to go to Emergency at the Charleville Hospital[32], however Mr Ryan was not interested. Mr Maunder asked Mr Ryan where he would feel safe, Mr Ryan said his mother's place[33].

[27] See transcript of 4 June 2012, page 114, line 10 onwards
[28] See transcript of 4 June 2012, page 114, line 24 onwards
[29] See the transcript of 4 June 2012, page 117, line 20
[30] See paragraph four of Mr Maunder's statement
[31] See transcript of 4 June 2012, page 112, line 10
[32] See transcript of 4 June 2012, page 120, line 5 onwards
[33] See transcript of 4 June 2012, page 120, line 10 onwards

54. Mr Maunder drove Mr Ryan to Mr Ryan's mother's home. Mr Ryan asked Mr Maunder not to talk to his mother about the suicide attempt[34]. Mr Maunder only told his partner and his sister about the suicide attempt.

55. On Monday 6 July 2009, Mr Ryan told Sarah Maunder[35] that he was seeking additional Valium beyond what had been prescribed, from a person named Des Coveney, who was a friend of Ms Maunder's family.

56. At 11:40pm on 6 July 2009, Constable Rebecca Jordin and Senior Constable Brent Dadds were tasked by Charleville police communications to attend Mr Ryan's home at 64 Little Parry Street, Charleville, in relation to a property dispute between Mr Ryan and Sarah Maunder.

Police recorded conversations on a digital recorder.

58. Ms Maunder, told police she had an altercation with Mr Ryan, who had kicked her out of the premises, but her belongings were still inside. Ms Maunder informed police that Mr Ryan may have been suicidal.

59. Mr Ryan denied any suicidal intent, but indicated he simply wanted to sleep, and was interested in getting some more Valium from the hospital.

60. Mr Ryan agreed to accompany the police to the Charleville Hospital, so he could ask for some more Valium and for his welfare to be checked.

61. Mr Ryan was transported to the Charleville Hospital by both officers, and there spoke with Nurse Sally Gordon.

62. Nurse Gordon spoke with both the police and Mr Ryan. She was told that Mr Ryan had attempted suicide in the recent past (the Saturday just past), and that he was depressed but denying suicidal intent.

63. Nurse Gordon confirmed with Mr Ryan that he was not presently suicidal and that he just wanted to go home and sleep. Nurse Gordon contacted the on-call doctor, Doctor Garde, and obtained a telephone order for Valium, for Mr Ryan.

64. Nurse Gordon failed to make any note of Mr Ryan's attempted suicide in the record[36] Dr Garde was not informed of it. Dr Garde feels it is *highly likely that it* [recent suicide attempt] *wasn't said* during her phone call with

[34] See transcript of 4 June 2012, page 120, line 52
[35] See paragraph 13 of the statement of Sarah Maunder
[36] At exhibit E9, page seven to ten inclusive

Nurse Gordon[37]. Dr Garde would likely have come in to the hospital and done her own assessment[38].

65. Mr Ryan presented at the Charleville CMH Service on 7 July 2009, at about 11am, appearing intoxicated (*still drunk, rambling*). He may have gone to the hospital for some extra Valium that day[39].

66. It is noted Dr Daglish opines in his report[40] that Mr Ryan might have appeared still intoxicated on the morning of 7 July 2009 because it was ill-advised to give him additional Valium, in the circumstances, on the late evening of the night before and he may have been still affected.

67. On or about 7 July 2009[41] Ms Stevie-Jo Bennett, a friend of Mr Ryan, was with Mr Ryan at Mr Ryan's home in Little Parry Street, Charleville, in the afternoon or early evening. Ms Bennett observed him to be wrapping an electrical cord around a roof beam, in a manner suggestive of a suicide attempt. She interrupted what he was doing, and when confronted, Mr Ryan said he wasn't doing anything[42]. This event was in the context of a fight with Mr Ryan's girlfriend, and Mr Ryan having consumed alcohol[43].

68. Shortly after the above event, Mr Ryan sequestered himself in the bathroom in an apparent second attempt at suicide by overdosing on various pills. Again, he was interrupted by Ms Bennett, who confirms that Mr Ryan was acting very strange, whether because of intoxication, the effects of pills or some other reason[44].

69. Ms Bennett also found what appears to have been a suicide note in Mr Ryan's house[45]. Ms Naomi Stanley and a friend, Rosaleigh drove Mr Ryan to his mother's home. Ms Cuthers recalls that on the previous Tuesday (i.e. 7 July 2009) Ms Stanley and another girl, bringing Mr Ryan over to her house[46]. Ms Stanley talked about the suicide attempt by Mr Ryan, and Ms Cuthers took pills from Mr Ryan, threw them in the garden, and calmed her son down. Ms Stanley and the other girl took Mr Ryan home, and said they would stay with him.

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[37] See transcript of 7 June 2012, page 107, line 51
[38] See transcript of 7 June 2012, page 108, line 47 – evidence of Dr Garde
[39] See Exhibit C1 (report of Dr Daglish), page two
[40] Exhibit C1, page 4 towards the bottom
[41] Note the evidence of Ms Bennett at the transcript of 4 June 2012, page 126 line 1 onwards, "*I don't know what day it was but I just remember the time.*"
[42] See paragraph nine of Ms Bennett's statement
[43] See paragraph six of Ms Bennett's statement
[44] See paragraph eleven of Ms Bennett's statement
[45] See paragraph twelve of the statement of Ms Bennett
[46] See statement of Ms Cuthers, exhibit B7, paragraph 17

70. Ms Stanley took Mr Ryan home, but Mr Ryan wanted to go out drinking and Ms Stanley wouldn't allow it, so Mr Ryan ended up spending the night at Ms Stanley's home so she could look after him. Ms Stanley drove Mr Ryan home the next morning.

71. Ms Bennett recalls that she did not tell anyone about the two attempts at suicide, or the finding of the suicide note until after Mr Ryan's death[47].

72. Mr Ryan had a scheduled appointment at the Charleville CMH Service on 8 July 2009. Ms Russell of that service tried to call Mr Ryan at 9am and 9:10am, but could not get through. Dr Kyaw was in Charleville at this point seeing patients, and could have seen Mr Ryan had Mr Ryan been present to be seen.

73. Mr Ryan attended the Charleville Hospital on 8 July 2009, by turning up unannounced to Dr Wilke's consulting room, between consultations. Mr Ryan indicated he had been abstinent from alcohol for about forty-eight hours, and had relapsed on the weekend (that is, on 4 and 5 July 2009).

74. Dr Wilke arranged for Mr Ryan's immediate admission to hospital. Mr Ryan's admission appears to have been at 10:30am[48]. The notes from the admitting nurse, Ms Nunn, indicate she told the Charleville CMH Service that Mr Ryan was in the hospital, and the entry in which she records this has a time of 10:30am. Ms Nunn does not record whom at the Charleville CMH Service she advised of Mr Ryan's admission, but simply the fact of that advice.

75. The first entry indicating positive contact with Mr Ryan for 8 July 2009 in the Charleville CMH Service records is 12:40am, when Ms Russell was able to reach Mr Ryan on his phone, and Mr Ryan indicated he was in hospital. Dr Kyaw had either left or was leaving at this point, because on 8 July 2009, Dr Kyaw left before lunch time[49]. Nothing in the Charleville CMH Service record indicates receiving a call from the hospital (or from Ms Nunn) advising that Mr Ryan had been admitted.

76. Mr Wroe opines that the responsibility for this failure to link Mr Ryan and Dr Kyaw is that of Ms Russell, as the treating clinician, although with some responsibility to Mr Wroe in his position as team leader[50]. Mr Wroe

[47] See transcript of 4 June 2012, page 128, line 46
[48] See Exhibit E9, page 111 – Admission Form, and also Exhibit E9, page 116 – Progress Notes from nurse Tonya Nunn, indicating 10:30am admission
[49] See transcript of 6 June 2012 (evidence of Dr Kyaw), page 20, line 24
[50] See transcript of 7 June 2012, page 14, line 57 onwards – the reference to "Mrs Whistle" is clearly a reference to Ms Russell, judging from line 16 on page 15 of the transcript of 7 June 2012

disagreed with the proposition that contact with the hospital fell to the team leader[51], which was the position of Ms Russell.

77. Charleville CMH Service team leader Ian Wroe attended upon Mr Ryan at the hospital at 3:50pm, following on from concerns raised in the 12:40 phone call with Ms Russell about Mr Ryan's physical state.

78. Whilst in hospital, Dr Wilke prescribed diazepam for Mr Ryan. He was careful to restrict the amount of diazepam available to Mr Ryan, as a result of Mr Ryan's substance abuse history. The restriction was to give Mr Ryan each dose individually for his use, rather than to give him a whole day's medication in one setting[52]. This was based on a concern about Mr Ryan's history of substance abuse[53].

79. Mr Ryan spent most of the afternoon of 8 July 2009 in his room. He was observed by Nurse Juliet Mattizanhau[54].

80. Mr Ryan was reviewed by Dr Wilke on 9 July 2009[55], and appeared free of withdrawal symptoms and no psychosis or reports of suicidal intent. Mr Ryan was doing well enough that he was flagged as a possibility for being discharged twenty-four hours later[56].

81. Mr Eamon Edwards recalls[57] seeing Mr Ryan at shortly after 11am on Thursday 9 July 2009. Mr Edwards attempted a sixteen-page ATODS assessment, and determined that Mr Ryan's cognitive faculties were not up to this kind of recall or reasoning, and he presented with shakes and walked in a slow shuffle when travelling outside his hospital room. Mr Ryan's state was so bad that Mr Edwards arranged a further appointment for 13 July 2009 to attempt the assessment then.

82. Mr Edwards was contacted on 10 July 2009 by Dr Wilke, when Mr Ryan's discharge was discussed. Mr Edwards recalls that he had concerns about whether Mr Ryan was ready[58], and gained the impression that Mr Ryan was going to be discharged by Dr Wilke regardless of what Mr Edwards thought. Dr Wilke recalls this conversation centred around ATODS

[51] See transcript of 7 June 2012, page 15, line 40
[52] See transcript of 7 June 2012, page 67, line 47 onwards
[53] See transcript of 7 June 2012, page 68, line 35, although it was also the approach of the hospital to dispense medication in this way, it appears
[54] See note at Exhibit E9, page 117
[55] See note at Exhibit E9, page 117 and also
[56] See statement of Dr Wilke, Exhibit B44, page 3
[57] Exhibits B13 and B13.1
[58] Dr Wilke does not recall this – see transcript of 7 June 2012, page 76, line 56

continuing to support Mr Ryan should he be discharged, and Dr Wilke receiving assurances that ATODS would continue this support.

83. Mr Wroe reviewed Mr Ryan again on 10 July 2009, and discussed community support following discharge.

84. Student Nurse, Marie Duncan-Beechey recalls that inappropriate comments were made about Mr Ryan during his treatment at the hospital by nursing staff[59], to the effect he was a drug user and an alcoholic[60]. She found these to be unprofessional. She also recalls that Mr Ryan was miserable and not feeling well on 10 July 2009[61].

85. Ms Duncan –Beechey also recalls that Nurse Christine Johnson reacted with inappropriate aggression to a reasonable request from Mr Ryan, including speaking with a raised tone and slamming down a folder in exasperation. Ms Johnson denies this suggestion[62].

86. At 10:45am on 11 July 2009, Mr Ryan was reviewed by the doctor who was now on shift – Dr Regina Garde. Dr Garde discharged Mr Ryan into his mother's care, and gave Mr Ryan a script for medication. In reviewing Mr Ryan, Dr Garde records that Mr Ryan denied any ideas of self harm or suicide[63] and reviewed his progress (now a zero, as in no problems) on the Alcohol Withdrawal Scale. The question about self harm was a standard question Dr Garde asked[64] rather than a response to a particular concern or note on the file. Mr Ryan presented as positive about his future, happy and having slept well.

87. Dr Garde did not read back through Mr Ryan's file, as she was essentially reviewing Mr Ryan to decide if he was fit for discharge[65]. Her assessment of Mr Ryan took something like ten to fifteen minutes[66].

88. Nurse Christine Johnson was present for this discussion with Mr Ryan. She recalls that during Dr Garde's discussion with Mr Ryan with a view to Mr Ryan being discharged, there was no discussion about Mr Ryan's current symptoms or how he was feeling, there was no discussion about suicidal thoughts, and Ms Johnson could not remember any discussion

[59] See transcript of 5 June 2012, page 99, line 18
[60] See transcript of 5 June 2012, page 99, line 9 and also at page 109, line 41
[61] See transcript of 5 June 2012, page 102, line 50
[62] See transcript of 6 June 2012, page 129
[63] See note in Exhibit E9, page 120
[64] See statement of Dr Garde, Exhibit B18.2, paragraph 43 and 46
[65] See transcript of 7 June 2012, page 110, line 43
[66] See transcript of 7 June 2012, page 112, line 27

about how Mr Ryan's detox was going[67]. The discussion took only a few minutes[68], and essentially involved Dr Garde telling Mr Ryan that he could go home and providing him a script for medications, and telling him he could come back at any time[69].

89. Mr Ryan's condition was consistent with it being appropriate for him to be discharged. It also appears that the length of his stay in hospital is consistent with that generally expected in his position[70].

90. Dr Garde gave Mr Ryan a script for Acomprostate (a medication to assist with alcohol cravings), Avanza (an anti-depressant), Thiamine (a vitamin) and thrice-daily 10mg doses of Diazepam. These medications were continued by Dr Garde, in the sense that she saw that Mr Ryan had been prescribed them in the past and continued to prescribe them[71].

91. Dr Garde's order as to diazepam allowed Mr Ryan to have a packet of fifty tablets, as she did not restrict the amount available to him[72].

92. Mr Ryan was released into the care of his mother, Ms Cuthers, who had come up to the hospital after getting a phone call from Mr Ryan[73]. Mr Ryan appeared fine, and said he was going to the shop to buy some cigarettes[74]. Mr Ryan did not return, and Ms Cuthers became concerned after about half an hour.

93. Ms Cuthers called Mr Ryan on his mobile phone, and when he answered he sounded incoherent. Ms Cuthers told Mr Ryan to get home immediately.

94. A short time later Mr Ryan arrived at Ms Cuther's home, driven by Mr Shawn Murphy. Mr Ryan got out of the car, went inside the house and collapsed in his room. Ms Cuthers called emergency services and also the hospital for assistance.

95. The phone call made to the hospital by Ms Cuthers was answered by Nurse Tonya Nunn. Ms Cuthers said words to the effect of *what fucking idiot let him out? He has gone straight back to where he was. What was*

[67] See transcript of 6 June 2012, page 110
[68] See transcript of 6 June 2012, page 110, line 11
[69] See transcript of 6 June 2012, page 110, line 24
[70] See transcript of 17 August 2012, page 7 and 8
[71] See transcript of 7 June 2012, page 112, line 35
[72] See transcript of 7 June 2012, page 112, line 52
[73] See transcript of 4 June 2012, page 11, line 12
[74] See paragraph twenty of Ms Cuthers' statement

the point, he wasn't ready to come out[75]*.* Ms Cuthers was told to bring Mr Ryan back to the hospital if she was worried about him. Ms Cuthers replied *of course I'm worried about him, he can't speak properly, he's just collapsed on the bedroom floor*.[76] Dr Garde was notified about this call, and said that Ms Cuthers should bring Mr Ryan back to the hospital if she had concerns[77].

96. Whilst Ms Cuthers was on the phone, Mr Ryan got back into Mr Murphy's car. Ms Cuthers said she would call the police, and Mr Murphy drove off with Mr Ryan. Ms Cuthers called the police, and notified the ambulance that showed up a short time later.

97. Mr Murphy discouraged Mr Ryan from further drinking. Mr Murphy's recollection is not good[78].

98. Ms Stanley commenced searching for Mr Ryan. Mr Ryan was so intoxicated he could hardly sit up in his seat[79] and couldn't even put a Mars Bar in his mouth.

99. At 1:30pm Ms Stanley arrived at Ms Cuthers' house with Mr Ryan. Mr Ryan was clearly completely intoxicated. Ms Cuthers immediately took Mr Ryan to the Charleville Hospital.

100. Mr Ryan arrived at the hospital in the afternoon of 11 July 2009.

101. Mr Ryan's re-presentation at hospital drunk does not necessarily mean his detoxification was a failure – he had relapsed, as is common.[80]

102. Mr Ryan was placed in the same room he had previously had by Nurse Tonya Nunn[81]. Ms Cuthers gave Ms Nunn all of Mr Ryan's medication[82]. Ms Cuthers told Ms Nunn that she thought Mr Ryan was trying to kill himself[83]. Ms Cuthers went home, got Mr Ryan some clothes and a tooth brush, and came back and put it by Mr Ryan's bed at about 2:30pm. At this point, Ms Nunn told Ms Cuthers *to get a treatment order from the Courthouse, and that mental health don't work weekends so there's no*

[75] See transcript of 4 June 2012, page 13, line 25
[76] See transcript of 4 June 2012, page 13, line 29
[77] See transcript of 7 June 2012, page 115, line 45
[78] See, for example, the entirety of pages 164 and 165 of the transcript of 5 June 2012, and also Mr Murphy's admission to having not a great memory of these events at line 28 onwards, page 167, transcript of 5 June 2012
[79] See statement of Naomi Stanley, Exhibit B41, paragraph 26
[80] See transcript of 21 August 2012, page 9
[81] See statement of Robyn Cuthers, Exhibit B7, paragraph 26
[82] See transcript of 4 June 2012, page 16, line 44
[83] See statement of Robyn Cuthers, Exhibit B7, paragraph 26

point in calling them. Ms Cuthers left Mr Ryan at the hospital at about 3pm, thinking he was staying there and getting assistance.

103. Dr Garde was still doing rounds at this stage, and was notified by a nurse that Mr Ryan had returned to hospital. Dr Garde was told that it looked like Mr Ryan had *had a few drinks*, but wasn't told anything that gave her a concern which would mean she should stop what she was doing and see Mr Ryan immediately[84].

104. Dr Garde was told by the nurses at handover, which is between 2:30pm and 3:00pm, that Mr Ryan could not be located in the hospital[85]. Dr Garde told the nurse to ring Mr Ryan's mother. Dr Garde was informed that the number was disconnected, and Dr Garde said to keep trying. She cannot recall which nurse she spoke with[86]. Dr Garde also recalled in her oral evidence that she asked around whether anyone had any familial or community connection with Mr Ryan, to locate him that way, although she recalled this for the very first time in her oral evidence[87].

105. Nurse Sibusisiwe Dube recalls being the nurse who found Mr Ryan absent from his room at about the time of rounds, and notifying Dr Garde of this at about 5pm[88]. What she did was to tell the other nurses who were on shift with her, being Michael Frame, Dianne Dowrick and Shirley Sampson[89]. Ms Dube checked the toilets, the smoking area and other areas upstairs in the hospital for Mr Ryan, but did not look downstairs in the hospital[90]. She looked around upstairs twice[91]. Mr Ryan was Ms Dube's patient and thus her responsibility[92] and this is why she did the searching herself rather than seek assistance. Ms Dube raised the fact that Mr Ryan was missing with Dr Garde, and Dr Garde suggested she call Mr Ryan's mother.

106. Ms Dube claims to have tried calling the phone numbers listed for next-of-kin (being Ms Cuthers) on the medical file, and found they were disconnected. Her recollection is that she called both the landline and the mobile number for Ms Cuthers, and called each number twice, and each time she got the message indicating the numbers were disconnected[93].

[84] See transcript of 7 June 2012, page 116, line 10
[85] See transcript of 7 June 2012, page 116, line 30
[86] See transcript of 7 June 2012, page 117
[87] See transcript of 7 June 2012, page 118
[88] See statement in Exhibit B11
[89] See transcript of 6 June 2012, page 70, line 35
[90] See transcript of 6 June 2012, page 71, line 18
[91] See transcript of 6 June 2012, page 71, line 34
[92] See transcript of 6 June 2012, page 71, line 42
[93] See transcript of 6 June 2012, page 73 and 74

107. Ms Cuthers has had the same landline number for about ten years. During that time, her number has never been disconnected[94]. Her mobile number was working as at July 2009[95]. She never received any call from the hospital on her mobile number, although she did receive a phone call from the hospital on her landline number earlier in the day, from Nurse Tonia Nunn in relation to medication.

108. The first time the phone number for Mr Ryan's next-of-kin, Ms Cuthers, is mentioned on Mr Ryan's medical file is page 4 of Exhibit E9. This has an incorrect number, which is crossed out, and then the correct number written in with stars around it. It is not clear when this correction was made. There is no mobile phone number listed there for Ms Cuthers.

109. The next mention of a phone number for Ms Cuthers in Exhibit E9 is page 29, and again it is the wrong number (not corrected this time) and no mobile number is listed. The next mention of a phone number for Ms Cuthers in Exhibit E9 is page 95, with this number also being wrong, and no mobile phone listed. The same error occurs on page 111, page 132, page 150, and page 154. Nowhere in the medical record is there Ms Cuthers' mobile number and Ms Cuthers has never received a call from the hospital on her mobile phone.

110. If Ms Dube did try to call Ms Cuthers, then what Ms Dube must have done is looked at one of the other (incorrect) entries on the file, dialled that number, received a 'disconnected' message, hung up, dialled the same number again, received the same message again, and given up.

111. Nurse Marie Duncan-Beechey was of the view that the attitude towards Mr Ryan going missing amongst the other nurses was characterised by a lack of concern[96].

112. Ms Bennett attended Mr Ryan's home at 6:30pm on 11 July 2009, having heard that Mr Ryan was out of hospital. She saw Mr Ryan at a table in his kitchen, looking very tired and hardly able to speak. Mr Ryan was slow and could hardly walk. They got him water and put him in his bed[97]. Ms Stanley also recalls much the same[98].

[94] See transcript of 4 June 2012, page 18
[95] See transcript of 4 June 2012, page 18, line 32
[96] See page two of the report of Ms Duncan-Beechey, Exhibit B12.1, and also transcript of 5 June 2012, page 103, line 58 onwards
[97] See paragraph fifteen of the statement of Ms Bennett
[98] See paragraph thirty-two of the statement of Ms Stanley, Exhibit B41

113. Ms Stanley advised Ms Cuthers that Mr Ryan was at his home and out of hospital[99].

114. Ms Ryan appears to have spent the night of 11 July 2009 at his home.

115. At about 7:30am on the morning of Sunday 12 July 2009, Mr Ryan arrived back at the hospital and spoke with nurses at the nurses' station[100]. The nurses present were Britto Chimbunde, Irene Pennell (the senior nurse present), Thami Sikwebu, Michael Frame, Tonya Nunn and Marie Duncan-Beechey.

116. Mr Ryan was observed to be apparently not affected by any intoxicating substance, spoke clearly and appeared normal.

117. An attempt was made by the nurses to convince Mr Ryan to remain to see a doctor, but Mr Ryan politely refused. He was seeking his property, which included the substantial amount of medication that he had been admitted with on 11 July 2009. Ultimately he was given this medication, along with his other property, and he left the hospital.

118. The recollection of Marie Duncan-Beechey of this meeting differs from the recollection of most of the other nurses. Ms Duncan-Beechey was present at the Charleville Hospital as a student nurse, thus she did not have the same connection to the hospital the other nurses did.

119. He took his medication, his property and left.

120. Irene Pennell, in her police interview[101], does recall Mr Ryan thanking the staff for their treatment of him, and doing so several times. She also recalled Mr Ryan saying he had hurt his mother or upset her[102]. Ms Pennell suggested in Court that Ms Duncan-Beechey talked about Mr Ryan being euphoric before he died, consistent with a pending suicide, after the hospital learned he had died, and Ms Pennell was annoyed that Ms Duncan-Beechey had not mentioned this earlier[103].

121. At 8:25am on Sunday 12 July 2009, Ms Tracey Jaeger was advised by Mr Ross Phillott to call the police, because Mr Phillott's friend was hanging in his house. The police were called, and Mr Phillott cut Mr Ryan down from

[99] See paragraph thirty-three of the statement of Ms Stanley, Exhibit B41
[100] Note that photographs of the nurses' station can be found in Exhibit G4
[101] Exhibit B34, page 6, near the bottom of the page
[102] Exhibit B34, page 12, near the bottom of the page
[103] See transcript of 6 June 2012, page 146, line 38

where he was hanging and commenced CPR until the police and ambulance service attended.

122. Mr Ryan was located by police deceased; with part of the belt he had hung himself with next to him, and the other part approximately 2.21 metres off the ground, attached by nails to a rafter.

123. Medication was seized by police from inside the home. A check of the deceased's phone indicated he had tried to call Remi McKellar at 8:03am, but the call had not been answered.

124. A suicide note was located. It appears in full in exhibit G9, in photographs 53 to 55.

125. Investigating police conducted forensic and other testing, and the matter was reported to the coroner. The investigating officer obtained and executed a Coroner's search warrant to obtain medical records from the Charleville Hospital, and the Charleville Community Mental Health Service.

Events subsequent to death

126. Ms Dowrick suggested that staff ensure the presentation earlier that day was properly recorded on the file[104].

127. Ms Pennell was called back from home, having finished her shift, to go into the hospital to *write in the notes*.

128. Ms Dowrick recalls *someone* asked how we make further entries on the patient record, and Ms Dowrick indicated they should write *in retrospect*[105]. Ms Dowrick confirms that it is not common practice for nurses to be called in to write up notes.

129. Tonia Nunn recalls that *it was said* that the notes in relation to Mr Ryan's presentation were deficient, and they needed to be put in. Ms Nunn also recalls that *it* was said that *it has to be written in order of what you did so if it came to Court that they could see what was done*[106]. Clearly the notes were contemplated as being intended for judicial or investigative proceedings.

[104] See transcript of 6 June 2012, page 56, line 5 onwards
[105] See Exhibit B10, page 25
[106] See transcript of 5 June 2012, page 45, line 14

130. Ms Nunn recalls calling another nurse, Christine Johnson, to come back in to the hospital and to write notes in Mr Ryan's file[107]. Ms Nunn also recalls that Sib Dube was called in, but cannot recall who called her.[108]

131. Ms Nunn wrote her entry on a new page, without adding *in retrospect* or anything similar as she claims to have not heard of that before[109]. She claims she only wrote her bit, and then others wrote on the same page but she didn't see what happened to the page after that[110]. She did not destroy any pages of any notes, nor did she see anyone else destroying any pages of notes[111].

132. Christine Johnson recalls that around 11am on Sunday 12 July 2009, she received a phone call from Tonya Nunn indicating Mr Ryan had committed suicide[112]. Ms Nunn was upset, and Ms Johnson became upset. Ms Johnson went into the hospital, arriving at about 11:30am.

133. Ms Johnson recalls that upon her arrival at the hospital, there was only discussion about rewriting notes. Ms Nunn was likely already rewriting hers[113]. The discussion about the notes was that the notes needed to be made *clearer* or something to that effect[114]. She wrote in the notes also because she was *follow[ing] on from the others*[115] and could not assist with why her entry, consisting of only two lines, needed to be re-written at all[116].

134. Ms Johnson wrote her entry in the notes after the notes of Ms Nunn. She did not use any indication that the notes were retrospective, such as *addit* or anything similar[117]. Ms Johnson knew that putting some indication that the notes were being written retrospectively was required as she is and was a very experienced nurse, but didn't do it because she was *emotionally distraught*[118]. Sib Dube took the page Ms Johnson had written on after she had finished writing on it. Ms Johnson never looked at the page again, and left the hospital without discussing it with anyone, to drive Ms Dube home[119].

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[107] See transcript of 5 June 2012, page 46
[108] See transcript of 5 June 2012, page 46, line 42
[109] See transcript of 5 June 2012, page 47
[110] See transcript of 5 June 2012, page 47, line 47 onwards
[111] See transcript of 5 June 2012, page 48, line 15 onwards
[112] See transcript of 6 June 2012, page 115, line 49 onwards
[113] See transcript of 6 June 2012, page 116, line 52 onwards
[114] See transcript of 6 June 2012, page 117, line 8
[115] See transcript of 6 June 2012, page 118, line 12
[116] See transcript of 6 June 2012, page 131, line 40
[117] See transcript of 6 June 2012, page 117, line 41
[118] See transcript of 6 June 2012, page 117, and also at page 128, line 5
[119] See transcript of 6 June 2012, page 119

135. Ms Dube received a phone call from fellow nurse Edith Sikwebu, telling Ms Dube to attend the hospital as notes needed to be written in relation to phone calls that Ms Dube had made to Mr Ryan's mother[120]. Ms Dube was told that Ms Pennell was already at the hospital writing notes.

136. Ms Dube's evidence is that she went into the hospital. She saw that Ms Pennell, Ms Nunn and Ms Sikwebu were present. Ms Pennell wrote some notes, and Ms Pennell had written *addit* next to her notes. Ms Pennell spoke to Ms Dube about the fact that Mr Ryan had presented at hospital that morning and appeared well, and then Ms Dube wrote an entry in relation to attempts to call Mr Ryan's mother[121]. She did not speak to anyone about writing the notes, she just wrote them. She also wrote *in retrospect*[122].

137. Ms Ollis came and collected the notes, took them away and then they came back. Then someone, Ms Dube cannot recall who, suggested that the notes were a little messy, and that they should be put into chronological order. Ms Dube claims this was not her idea[123]. Irene Pennell and Tonya Nunn were present for this discussion[124]. What then followed was each of Tonya Nunn, Christine Johnson, Irene Pennell and Ms Dube writing entries into a new sheet of paper, and that was what went into the file.

138. When she wrote notes out the second time, Ms Dube did not use the words *in retrospect* because she didn't think of it[125]. She maintained that she did not think of it despite the fact she was copying, word for word, her previous entry which did include the words *in retrospect*, and she was also aware that she should put *in retrospect* in the notes as that is required[126].

139. At this stage the husband of a patient presented at the nurses' station, and Ms Dube went away to attend to his needs. She did not see where the notes she had written went, and did not see what happened to the medical file after that. She did not destroy any pages of the medical file, nor did she see any pages of the medical file being destroyed[127]. Ms Dube did nothing at all when she learned that the page she had originally written (with retrospect on it) was not on the medical file – she did not go and ask

[120] See transcript of 6 June 2012, page 76, line 42
[121] See transcript of 6 June 2012, page 79 and 80
[122] See transcript of 6 June 2012, page 80, line 10
[123] See transcript of 6 June 2012, page 81, line 58
[124] See transcript of 6 June 2012, page 82, line 20 onwards
[125] See transcript of 6 June 2012, page 83, line 50
[126] See transcript of 6 June 2012, page 84
[127] *See transcript of 6 June 2012, page 86, line 15*

Ms Pennell or Ms Nunn what had happened to it[128] despite being *shocked* that it wasn't there.

140. Ms Pennell recalls that when she arrived at the nurses' station, Ms Katrina Ollis was present and told all staff not to talk to the police[129]. Ms Dowrick also told Ms Pennell upon Ms Pennell's arrival at the hospital that the medical notes were needed for the police[130]. There was general discussion about what had happened, and what could have been done to prevent it. The conclusion was that there was nothing that could have been done.

141. Ms Nunn then wrote a *retrospective* entry after Ms Pennell's, with more detail. Ms Dube wrote a retrospective note under Ms Nunn's as well[131]. Katrina Ollis entered the room at some stage, and was asked what the word you use to indicate a later entry in a medical file is, and said *retrospective*[132].

142. According to Ms Pennell, a discussion occurred between the nurses present. Ms Pennell indicated she thought it was ridiculous that the information they had would never be known to the police or the coroner[133]. She also felt it was likely that Ms Cuthers might sue Queensland Health, and that seeing *retrospective* next to entries would be *like a red rag to a bull*[134]. Ms Pennell also recalls that Ms Dowrick asked that she not have to speak to Ms Cuthers if Ms Cuthers attended the ward, as Ms Cuthers had been abusive in the past[135].

143. Ms Pennell claims that at some point *someone* said *let's just rewrite them*[136]. This may have been said twice. Following this anonymous suggestion, Ms Pennell said *let's just rewrite it, we'll just make it clear chronological*.[137]

144. Ms Pennell's evidence is that there was no discussion about leaving off the words *retrospective* in the second set of notes – each person arrived at this decision independently[138].

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[128] *See transcript of 6 June 2012, page 101, line 30*
[129] *See transcript of 6 June 2012, page 147, line 2*
[130] *See transcript of 6 June 2012, page 154, line 50*
[131] *See transcript of 6 June 2012, page 155*
[132] *See transcript of 6 June 2012, page 151, line 55 onwards*
[133] *See transcript of 6 June 2012, page 158*
[134] *See transcript of 6 June 2012, page 159, line 14*
[135] *See transcript of 6 June 2012, page 159, line 30*
[136] *See transcript of 6 June 2012, page 159, line 24*
[137] *See transcript of 6 June 2012, page 160, line 17*
[138] See transcript of 6 June 2012, page 163, line 37

145. The two sets of notes remained on the table. Mr Wroe attended the office and read through them, and then left. Ms Pennell thought there wasn't any need for the first set of notes and that they would simply create problems with Ms Cuthers, and so she took the first set of notes, ripped them into small pieces and threw the pieces in the bin[139]. Ms Pennell knew that destroying notes is *absolutely forbidden* but did it anyway[140].

146. The medical file, including the rewritten notes, was seized by police on 13 July 2009, pursuant to a Coroners search warrant.

147. Ms Duncan-Beechey raised the fact she had seen the notes being rewritten with staff. After some attempts at having her particularise the allegation and ensuring she understood the seriousness of it, staff at the hospital pursued the matter with a notification of the Queensland Health Ethical Standards Unit, and through interviewing staff.

148. Later, ethical standards investigators became involved, as did the police, and further interviews were conducted and recorded.

149. The conclusion of the Ethical Standards Unit investigation was that the rewriting of the notes was ill advised but not an attempt at concealment or falsification. There was essentially no malice in what had been done. The hospital then acted upon this finding by reducing the pay of each employee a minimal amount for a few months, to the extent that none of the employees involved could recall the amount or the length of time that it went on. There was barely any requirement for re-training for the individual staff involved. A seminar on proper note taking was conducted for all staff.

Submissions:

150. Counsel Assisting has made a number of recommendations which I will discuss shortly. In addition Counsel for the mother of the deceased, Ms Cuthers made the following recommendations

> *It is submitted that the following recommendations are capable, if implemented, of minimising the risk of a repeat of these failures. It is acknowledged that some of those matters have been already the subject of recommendation by the Department; however it*

[139] See transcript of 6 June 2012, page 161
[140] See transcript of 6 June 2012, page 162, line 36

should be observed that it is the implementation of recommendations that is critical.

Recommendation 1:

- *That the Community Mental Health Service in every District provide a full copy of their records and files to the treating hospital whenever a Community Mental Health Service patient is admitted preventing a repetition of the information vacuum which occurred in the present case.*

Recommendation 2:

- *That a requirement be made that the Community Mental Health Service advise any treating specialist consultants of the admission of a Community Mental Health Service patient as an in-patient of any hospital.*

Recommendation 3:

- *That nursing staff be specifically instructed to record any reference to any active suicidal behaviour by or depression of a patient from any credible source, in particular, police officers.*

Recommendation 4:

- *That the handover of patients by one medical officer to another be recorded in writing, including a specific written record of daily medication dose limitations for such patients.*

Recommendation 5:

- *That a protocol be established in order to ensure that the family member of a person admitted to hospital who then absconds is contacted by the hospital immediately and if necessary, the hospital enlists the assistance of the police service to do so.*

Recommendation 6:

- *That a protocol be established that nursing staff not return prescription medication to patients in circumstances where the patient's circumstances have changed since the previous prescription by a medical officer and where the patient is unwilling to be reviewed by the medical officer. In other words, where there is any doubt at all about the efficacy of returning medication to a*

patient, such medication should not be returned without the patient being first reviewed by a doctor.

Recommendation 7:

- *That upon the death of a patient who has been treated recently at a hospital in Queensland, the patient's hospital records are to be immediately sealed and secured in order to prevent tampering or interference before the records are provided to the Coroner.*

Recommendation 8:

- *That Queensland Health ensures that Dr Garde and Dr Wilke undergo the clinical supervision recommended by Drs Daglish and Kingswell.*

151. Counsel Assisting makes a submission at paragraph 240(e) of his submissions that Mr Ryan's death may have been contributed to by errors made in his care. It is respectfully submitted that these submissions cannot be supported by the evidence heard during the course of the Inquest. The submissions fail to address any causal link between the alleged errors identified and Mr Ryan's death.

152. Having regard to the terms of reference of the Inquest, there was no evidence during the course of the Inquest which would support a finding that Mr Ryan's death may have been contributed to by deficiencies made in his medical care, specifically his nursing care.

153. A number of measures have been put in place across Queensland Health including at the Charleville Base Hospital with a view to improving the prospects of a better outcome in a similar case. This inquest has not involved consideration of any additional measures that might be put in place in Queensland hospitals to assist in that respect.

154. Each of the nurses, RN Gordon, RN Russell, RN Dube, EEN Nunn, RN Johnson and RN Pennell have continued to provide their services to the Charleville Hospital and community. If there is any tension in relation to the nurses' knowledge and practice of document management then that is not a basis for criticising the nurses but an opportunity for recommendations to be made in relation to document management training provided by Queensland Health.

Counsel for Queensland Health made the followings recommendations:

Queensland Health has already pro-actively investigated and adopted and implemented the recommendations of the HEAPS report and the ESU investigation.

156. Further training of Drs Wilke and Garde has not taken place due to both leaving the district and pursuing careers in the specialities of anaesthetics and obstetrics, not mental health or general practice. It is also submitted that the evidence of both doctors indicated a high level of insight and pro-active examination of and change in their professional practices.

157. Significant steps have been taken to improve communication and information flow across ATODS, CMHS and the public hospital.

158. ln my view, key issues arising from Mr Ryan's death have been addressed by measures such as full medical rounds and patient alerts/risks flagged on HBCIS lower the risk of a patient such as Mr Ryan being given a standard prescription for diazepam.

159. Whilst I received a submission from the solicitors for the police officers, I agree with the recommendations of Counsel Assisting that the police acted appropriately.

Discussion and recommendations

160. I am grateful to Counsel Assisting for providing the comprehensive summary of events as set out largely directly above. It is extremely important to set out the events as they highlight the many issues of concern in the death. Whilst I accept there will not be agreement that all of the evidence summarised is a true reflection of the evidence given, I am satisfied it does as to the important issues. A number of the differences are highlighted in the submissions of the various parties' representatives. However, I do not intend to go through all of them now. Suffice to say that I am satisfied the evidence properly highlights the concerns I will raise about Mr Ryan's treatment both before his death and subsequent to it.

161. It is of course impossible to say if these concerning events had not occurred whether Mr Ryan's death could have been prevented. What is clear is that systemic failings occurred which may have contributed to his death.

162. I will deal with them in order of chronological order as best as possible.

Charleville CMH Service and Dr Kyaw.

The standard of service provided by the CMH service to Mr Ryan was substandard. There were failures in assessment of Mr Ryan, a failure to read and comprehend material from Victoria, they failed to properly

communicate, indeed did not communicate at all with the Charleville Hospital about Mr Ryan's mental health. Privacy issues should not have been an issue. Important material was missed by employees who failed to read or properly read Mr Ryan's file. They failed to know that Mr Ryan was in the Charleville Hospital such that he missed what was an important meeting with Dr Kyaw.

Dr Kyaw

Dr Kyaw made some errors, one in particular, in failing to advise the hospital of Mr Ryan's past suicide attempt. It was significant in the context of Mr Ryan's treatment. Dr Kyaw was travelling out from Toowoomba to see patients. He was also interviewing patients by video. He missed an important meeting with Mr Ryan when he was in hospital but Dr Kyaw was not made aware of it. He could have communicated with ATODS directly and may have spent more time enquiring into Mr Ryan's background by speaking to his mother.

Nurse Sally Gordon

I am satisfied that Nurse Gordon failed to record information about Mr Ryan's suicide attempt. This failure reduced the chances of doctors being able to properly treat Mr Ryan or at least fully appreciate the extent of his mental health concerns.

Dr Garde

Dr Garde has in my view failed to restrict Mr Ryan's Valium use. She did not appear to take the time to properly review Mr Ryan's file or spend sufficient time with him particularly on discharge when it may well have been better to have spent some time with Ms Cuthers as his primary carer.[141].

The Nurses and staff of Charleville Hospital

They seemed to take a less than professional attitude to his leaving the hospital on 11 July 2009. Much more could have been done if they were concerned, as they should have been for his welfare. It seems clear on the evidence that Ms Dube did not make the calls to Ms Cuthers she claimed she did. It is possible she rang the wrong number.

It was completely unprofessional for the nurses Pennell, Dube, Johnson and Nunn to rewrite hospital notes and for the old notes to have been destroyed.

It was unfortunate that Mr Ryan was given back his medication in the way that it was. It may have been better to have entrusted it to Ms Cuthers if possible.

[141] See exhibit C1, page 7, second full paragraph

163. Prior to his death hospital staff made a number of errors in Mr Ryan's treatment, in particular, they should have been more aware of his mental health issues. This was brought about both by the lack of communication from CMH service and a failure by the hospital to seek further information. It seems inconceivable that the hospital would not be provided with all the information to properly diagnose and treat Mr Ryan.

Recommendations

164. There is much to be critical about both from the point of view of the Charleville CMH Service and the Charleville Hospital however, most of the matters referred to have been addressed by Queensland Health and the Charleville Hospital. This point has been made by a number of the representatives in their submissions as set out above.

165. Systemic issues identified in the Ethical Standards Report have been dealt with.

166. it is most unlikely that the nurses will be rewriting notes or destroying notes having regard to the counselling and penalty some of them have had imposed.

167. Communication with police in respect of coronial investigations has been improved and is unlikely to be impeded in the future.

168. Whilst I have been critical of Dr Garde and Dr Wilke it seems to me that both will now be well aware of the short comings in respect of their involvement in this death and that nothing is likely to be gained by further training or referral of them.

169. I am satisfied that steps have been taken to ensure open and honest discussions with family after a death of a loved one.

170. The relationship between the Charleville Hospital CMH Service and ATODS has been improved and strengthened. This is an essential and significant move forward in the treatment of mentally ill patients in the district. It seems clear that hospital staff were not equipped to handle someone with the concerns of Mr Ryan. Of course Charleville is a small hospital but no one should be expected to receive substandard treatment wherever they may choose to live.

171. The District now has an out-of-hours fax referral form, and in addition a generic email address to facilitate referrals. Daily intake meetings occur in the morning, and additional informal meetings are held.

172. Steps have been taken to improve the assessment and intake process in the mental health teams, and to educate the community, particularly GPs and other allied health professionals in relation to contact details for the

mental health team. Improvements in the intake process have meant that the hospital receives notification if the mental health service has an intake. Improvements in the process of referrals to mental health from the Charleville Hospital emergency department have also occurred.

173. Whilst things have improved markedly there is always room for further improvements. It can only be hoped that by exposing the shortcomings in the treatment of this patient that lessons will be learned and improvements made.

174. Improvements have also occurred in the process of recording contact details for family members and patients. An audit of this process showed highly encouraging results. There were also improvements in the process of reviewing patient information and the patient record when assessing and reviewing patients, to ensure that information such as the limitation of Valium availability is known to all.

175. I have considered the recommendations of Counsel for Ms Cuthers and see that there is substantial merit in a number of his proposed recommendations all set out above.

176. In particular, Recommendation 2, 3, 4, 5 and 6. All of these proposals make sense to me. **I would refer the Department of Health to those recommendations for their active consideration and implementation as necessary.**

177. I am satisfied that Recommendation 1 has already been implemented however to the extent that it has not been, it also should be actively considered. Whilst I think Recommendation 7 has some merit I would hope that as a general course, hospitals would collect and secure records in circumstances of reportable deaths for transfer as required to the police and ultimately the coroner. I have dealt with Recommendation 8.

178. Other than that I make no further formal recommendation.

179. I express my sincerest sympathy to Ms Cuthers and other family members. I am sorry for the length of time taken to deliver these findings and particularly the adjournment prior to Christmas which was unavoidable.

I close the inquest.

Orazio (Ray) Rinaudo
Coroner
18 January 2013