OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Robert Harris**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Cairns
FILE NO(s):	COR 1862/06(5)
DELIVERED ON:	15 December 2008
DELIVERED AT:	Cairns
HEARING DATE(s):	10,11,12 December 2007
FINDINGS OF:	Ms K McGinness, Coroner
CATCHWORDS:	**CORONERS: Inquest – Suicide, Mental Health Patient**

REPRESENTATION:

Counsel Assisting: Mr John Tate; Ms Josephine Willis

Queensland Nurses Union: Mr Michael Fellows (Counsel instructed by Robertson & Kane)

Department of Health: Ms Lisa Evans (Counsel instructed by Crown Law)

Family: Ms Lauren Harris

Introduction

[1] These are my findings in relation to the death of Robert Harris ("Robert"). These findings seek to explain how his death occurred and consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future. The *Coroners Act* 2003 provides that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organizations granted leave to appear at the inquest. These findings will be distributed in accordance with the requirements of the Act and also placed on the website of the Office of the State Coroner.

The Coroner's jurisdiction

The scope of a Coroner's inquiry and findings

[2] A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

[3] 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 but as that issue was not contentious in this case I need not seek to examine those authorities here. I will say something about the general nature of inquests however.

[4] 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]

[5] 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]

[6] A coroner must not include in the findings or any comments or recommendations or statements that a person is or may be guilty of an offence or civilly liable for something.[3] However, if, as a result of considering the information gathered during an inquest, a coroner reasonably suspects that a person may be guilty of a criminal offence; the coroner must refer the information to the appropriate prosecuting authority.[4]

The admissibility of evidence and the standard of proof

[7] Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "may inform itself in any way it considers appropriate." That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

[8] 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]

[9] 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

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1 *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

2 s46

3 s45(5) and 46(3)

4 s48

5 *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

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 trial of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

[10] 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.

The evidence

[11] I turn now to the evidence. I have considered all of the evidence given during this three day Inquest. I will not attempt to summarise the evidence in full however I will refer to the evidence which I consider is appropriate to record in these reasons and the evidence I believe is necessary to understand the findings I have made.

Social Background

[12] Robert was born on 10 June 1946 and was 60 years old at the time of his death. Robert was married to his wife Beverly Harris for 30 years. Robert and Beverly had two children during their marriage, Lauren and Gavin, both adults at the time of their father's death.

[13] Robert worked for some 19 years with Ansett Airlines and, according to his wife, he enjoyed his time with Ansett. Unfortunately, like many others, Robert lost his long term employment when the airline collapsed. He then worked for a period at Virgin airlines. Robert finally settled into working in retail hardware which is where he was working at the time of his death.

[14] Beverly, together with her adult children, participated in the Inquest. When giving her evidence Beverly described Robert as "*a very good man, very good father and*

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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 (1991) 65 ALJR 167 at 168

very good husband. He loved everybody and everybody loved him. He was very friendly. Enjoyed travelling and enjoyed his work. We enjoyed barbeques and we had a lot of friends. He really enjoyed his 19 years at Ansett. We loved where we were living. He was a quiet man – didn't talk a lot, have a lot to say. Everybody that saw him, he treated the same. He was always happy go lucky. He was a people's person. We enjoyed going out, enjoyed country music and we went out nearly every week"[10]

[15] I wish to place on record my thanks to Beverly, Lauren and Gavin Harris for having the courage to engage in the process of this Inquest. It was clear to me throughout the Inquest that Robert was much loved by his family. Scattered throughout Robert's medical records were various references by Robert to the great comfort he took from his loving wife, children and his happy home life. I am sure this has been a most painful process for the Harris family and I wish to acknowledge their assistance in providing invaluable background and assisting me with some most insightful observations and written submissions.

[16] The medical staff and professionals whose paths crossed with Robert's have unfailingly described Robert as a warm and engaging man who was always co-operative with treating staff and thankful for their assistance.

Mental Health History

[17] Robert was first diagnosed with depression in 2001, after he had left the airline industry. He was prescribed with an anti-depressant known as Fluvoxamine. He stopped taking the medication and started on it again in 2004.

First suicide attempt on 15 May 2006.

[18] On 15 May 2006 at around 2 pm Robert was found by his wife slumped on the kitchen floor, unable to be aroused, having taken an overdose of various substances. Robert was taken by ambulance to the Emergency Department Triage at Cairns Base Hospital. Robert later informed staff that he had consumed 4 x fourex gold beers, taken about 24 Panadeine tablets and Promethazine. Beverly advised that she had found a ladder and rope/noose in the garage. This was later confirmed by Robert.[11]

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10 Transcript 10/12/07 page 49

11 Ex 5 Medical Records CBH 15/5/ 06 and 16/5/06

[19] Following his admission to the medical ward the medical records note that Robert had felt well until the morning of the 15th May but after he had gone to work at 7 am he became agitated, clearing out his locker and stating he "had an appointment with an undertaker".

[20] In an interview with Dr. Underhill the following day on 16 May 2006, Robert stated that he felt he had let everyone down, said he was feeling OK and denied problems at work or home. Dr. Underhill noted his impression that this was a significant suicide attempt and requested, as part of a treatment plan, that Robert be given psychiatric input.

[21] On 17 May 2006 Dr. da Silva a Psychiatric Registrar at Cairns Base Hospital, completed a thorough assessment interview with Robert. His notes record that Robert had said that things had just become too much to cope with. Robert cited having to do jury duty, which he found stressful, and issues to do with a work colleague as being two stressors. Robert said he did not want to kill himself, he just wanted some time off to get away from it all. During the Mental state examination Robert denied any current suicidal thought or plans and was willing to engage with Mental Health Service. Dr. da Silva noted that his impression was that Robert was a 59 year old man who had impulsively overdosed on the background of a situational crisis. He noted that Robert had a history of depression.

[22] Dr. Underhill conducted a further review on 18 May 2006. He noted the psychiatric input, noted that Robert felt well and that the psychiatric team were happy for discharge. Robert was discharged home with his wife and son with an appointment card to attend the psychiatric registrar on 25 May 2006 at 10 am.

Further contact with Cairns Base Hospital and Community Mental Health.

[23] The Cairns Base Hospital records stamped "psychiatry" and dated 25 May 2006 record the details of a mental state examination undertaken by Dr. da Silva. The thorough assessment retraced Robert's history and current presentation. The notes concluded that Robert was willing to contact the service as the need arose, that he was to continue with his anti-depressant medication and that he had an open appointment and mental health contact details.[12]

[24] On 1 June 2006 Robert was again seen by Dr. da Silva who noted that Robert reported things were going along pretty well. Dr. da Silva's impression was that

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12 Exhibit 5, Cairns Base Hospital medical records – 25/5/06

there was great improvement in Robert's situational crisis, he was coping well and looking forward to going back to work. Robert was advised to contact Lifeline concerning counselling.[13]

[25] On 5 June 2006 Robert telephoned Community Mental Health seeking assistance. Robert stated that the reason for the contact was that he had an appointment to see Mr. Crawford on 15 June and could not wait until then. Robert said he had been to work in the morning and could not cope, that he was not feeling good and that he had the following day off work. Robert said he would attend in the afternoon that day.[14]

[26] Robert attended as a "walk in" later that day and saw Mr. Dennis, clinical nurse ("CN"). Robert stated he could not cope at work. Discussion ensued regarding how to move forward from what Robert saw as a significant loss. Robert's general practitioner had changed his medication which would require some time to take effect. The file notes that Robert was to have a follow up with Dr. da Silva on 15 June 2006.[15]

[27] Robert attended the Community Mental Health Clinic on 15 June 2006 for his appointment however the psychiatric registrar was unavailable that day therefore only a brief review took place. Robert was noted as being initially somewhat tearful and experiencing work stressors with a colleague, triggering anxiety. Robert was re-booked for an appointment the following week. The plan in place was for Robert to spend time with his family. He stated he felt bright when at home, used relaxation techniques, and would have time off work if necessary.

[28] On 19 June 2006 at 3.30 pm Robert attended the Community Mental Health Clinic CATT team (since renamed the Acute Care Team "ACT") without an appointment. The comprehensive notes record that Robert had seen his general practitioner that morning as he was feeling upset about an incident that occurred at work. His mood was noted as flat, sad and blunted. The precipitating stressor was noted as a difference of opinion in Robert's work place. Robert was referred to Relationships Australia or Lifeline or Centacare to assist with coping and referred to his general practitioner regarding a further review of his anti-depressant medication if he did not improve.

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13 Exhibit 5, Cairns Base Hospital medical records – 1/6/06

14 Exhibit 6, Integrated Mental Health – 5/6/06

15 Exhibit 6 Medical Records – Integrated Mental Health notes 5/6/06

[29] Robert again attended the Cairns Base Hospital on 24 June 2006 for further follow up. The file notes that there would be discussions with the psychiatric registrar concerning whether a further review was needed.

Second suicide attempt – 27 June 2006

[30] On 27 June 2006 Robert left work after emptying his locker and told his colleagues he would not be back. Again, his work colleagues contacted Beverly. Beverly phoned Cairns Community Mental Health who told her to ring the Police. Through the efforts of Kym Lindner, who was performing her duties in the Cairns Police Communications Room as an interceptor, Robert was contacted on his mobile phone. Ms Lindner spoke to Robert for some 50 minutes trying to find out his whereabouts. Robert informed her that he had attempted suicide 5 weeks earlier by taking an overdose. Ms Lindner spoke to Robert until she could hear the police arrive.[16]

[31] The first police officers to find Robert were Senior Constable McCullough and Acting Sergeant Flynn, stationed at Gordonvale Police Station. They searched with great urgency throughout a cane farming area all around Harris Road at Wrights Creek. Searching along the line of the creek in a rainforest area with cane on one side and the creek on the other, Robert's dual cab Hilux was found. Robert was found about 15 feet up a tree with a webbing tie down strap tied around his neck, talking on his mobile phone. Robert had been drinking beer. Senior Constable McCullough spoke with Robert and was successful in encouraging Robert to come down from the tree. Robert was very emotional at this time. He was crying, apologising for his behaviour and unsteady on his feet.

[32] Officers McCullough and Flynn drove Robert towards the Cairns Base Hospital however, Robert wanted to first call at his home to see Beverly. After the stop-over at his home the police officers and Robert proceeded to the Cairns Base Hospital, while Beverly retrieved Robert's car and then travelled separately to the hospital with a friend. Police eventually handed Robert over to Mr Steven Sullivan, Clinical Nurse (CN) and Ms Colahan, psychologist. Both worked in the Mental Health ACT team.

[33] Ms Colahan spoke with Beverly to obtain a brief overview of the events of that day, also noting events which had occurred over the past couple of weeks. Whilst this was occurring, Mr Sullivan spoke with Robert. Ms Colahan and Mr Sullivan each recorded their consultations with Beverly and Robert.

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16 Exhibit 2, Statement of Kym Lindner

[34] Ms Colahan was told by Beverly that Robert's mood had been fluctuating over the past two months. The night before there had been some sort of conflict in which Beverly became upset about previous events, and Robert had stated that she would be better off without him. Beverly also relayed the events of the day, receiving the phone call from Robert's work, Robert telling his colleagues he would not be back and the police finding Robert in a tree. The Emergency Department Records note the exchanges took place at about 6.20 pm on 27 June 2006.

[35] Mr Sullivan recorded some history provided by Robert as to previous ACT contact, issues of depression and suicidal ideation related to the recent break-up of a relationship. The notes record that Robert said he had become distressed that day after seeing the person in the workplace and that he had carried means for suicide for the last few days (rope in car). Robert told Mr Sullivan that he left work early at 1 pm, went home, accessed a rope and went out back of the property to hang himself. He had 6 to 8 stubbies and 5 to 6 Valium. Mr Sullivan recorded Robert's Blood Alcohol Level ("BAL") as 0.47 and noted that Robert appeared more intoxicated than the BAL suggested, with slurred speech and unstable gait when walking. In his oral evidence and statement, Mr Sullivan corrected the figure recorded as the BAL to 0.047[17]. Robert acknowledged to Mr Sullivan that his suicidal ideation was worse when intoxicated.

[36] The plan proposed by Mr Sullivan was that Robert should stay in the Emergency Department for a few hours and then Dr. Edema, a trainee psychiatric registrar, would review Robert around 10 pm. Mr Sullivan noted at that stage the question of discharging him was still to be decided.

[37] Robert was kept in the hospital until later that evening. Robert was then assessed. Robert was, by that stage, remorseful for the events of the day. He denied any suicidal ideation, intent or plan. His protective factors included family and friends. Robert told staff he felt loved and wanted. Robert wished to go home and did not wish to be admitted[18].

[38] After consideration of various issues, Dr Edema put a discharge plan in place for Robert to go home with Beverly for the night and to attend at Community Mental Health the following morning. Robert was agreeable to this. The hospital records note that when Robert was asked to contract for his personal safety, he seemed warm and genuine in that assurance.[19] The Plan for Robert was discussed by Dr.

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17 Exhibit 8

18 Transcript 11/12/06 page 172 line 10-20 Dr. Edema

19 Exhibit 5 Medical Records Cairns Base Hospital typed notes

Edema with Dr. Simpson, the on-call consultant psychiatrist. The discussion took place over the phone. The plan was that he was to present for a review with the ACT team the following morning, his medication was to be reviewed or rationalised with consideration to be given to prescribing an antipsychotic for ruminations. Robert was also to be encouraged to see his private psychologist regularly.

[39] The circumstances surrounding Robert's admission, treatment, discharge and final review the following morning will be examined more fully later in my findings. For the purpose of understanding the sequence of events leading to Robert's death I will continue with the chronology of events as they unfolded.

Circumstances of Death – 28 June 2006.

[40] During the morning of the following day 28 June 2006 Robert presented to Community Mental Health as proposed in the discharge plan the evening before. Robert was accompanied by his wife Beverly, though at his request, he saw Mr. Jones CN alone.

[41] Mr. Jones spent between 20 and 40 minutes[20] reviewing matters with Robert. Robert repeated what his proposed plan for the suicide attempt the day prior had been, stating he was relieved to be found before acting on suicidal ideation and that he did not believe he would have been able to carry out the act. Robert said he planned to leave his employment thus moving away from a perceived stressor. Robert believed that the private counselling he was receiving from his psychologist was of benefit. Robert was agreeable to contacting the ACT team in the future for any concerns. He was given a "Relationships Australia" brochure. The file is noted that the ACT team were to feedback to Robert's general practitioner.

[42] Robert left Community Mental Health and, even though he didn't have an appointment, he attended upon his general practitioner who gave him a script for the anti-depressant Antenex and a certificate to have the following week off work.

[43] Beverly contacted Robert's psychologist and made an appointment for a session at 5 pm that day. Beverly suggested that they eat out for dinner after the appointment. Robert was agreeable to this plan. Later the psychologist phoned back and offered an earlier appointment at 2 pm, however, both Robert and Beverley were tired from the events of the night before, so they headed home to rest and planned to attend the 5 pm appointment.

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[20] Transcript page 193 line 10 to 40

[44] Although they both lay down for a rest upon their return home, Robert told Beverly he had trouble trying to get to sleep and headed out on to the verandah. After a while Beverly thought she heard the car door, and on enquiry, she was told by Robert that he was just getting his hat to put on as it was cool on the verandah. Beverly returned to rest and Robert went to the computer room.[21]

[45] Beverly was later woken by the Police banging on the roller door. They were again searching for Robert. Unbeknown to Beverly, Robert had left the home and returned to the site where he had contemplated suicide the day before. Robert had phoned Life Line Townsville and they had contacted the Cairns Communications Room at the Cairns Police Station and spoken to operator Sharon Kelleher.[22]

[46] By co-incidence Senior Constable Stephen McCullough was again working a shift on 28 June 2008 when the Gordonvale Station received information that Robert from "yesterday's job" was in a shed and had a rope around his neck. The area around the property was too wet for 2WD vehicles. The 4WD at Gordonvale Police Station was required.

[47] After attending the property where Robert lived, checking the three sheds and finding that Robert was not there, Senior Constable McCullough proceeded to the same area where Robert had been up a tree the day before. Robert was found hanging from the tree in the same position as the day before.[23]

[48] Senior Constable McCullough checked for signs of life but Robert was deceased. A blue mountain bike was noticed on the bank of the creek and Officer McCullough believes the bike was used by Robert to ride to the location. At 1605 hours four QAS officers attended. Intensive Care Paramedic Oliveri advised that Robert was deceased.

[49] A life Extinct Notification was signed by Dr. Zimmermann in the Emergency Department at Cairns Base Hospital at 17.45 on 28 June 2006.

Issues for Consideration

[50] I now turn to the issues which have arisen for consideration concerning Robert's admission, treatment and care.

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21 Exhibit 4, Statement of Beverly page 3.

22 Exhibit 3, Statement of Sharon Kelleher page 1

23 Exhibit 1, Statement of Officer McCullough page 7.

[51] I am assisted in the task before me by Dr. William Kingswell who has prepared a report as Psychiatrist assisting the coroner[24]. By virtue of his qualifications and experience and having read all the relevant documentation and attended throughout the Inquest, Dr. Kingswell was able to report to the Court on a number of issues that he considered needed to be explored during the inquest including clinical governance, clinical decisions, evidence based practice, information sharing and other general issues.

[52] Both myself, and legal counsel involved, appreciate the timely fashion in which Dr. Kingswell provided his report which enabled each legal counsel and the Harris family to properly consider his recommendations prior to the Inquest commencing.

[53] I will deal in turn with each relevant issue at each stage as it arose during the course of Robert's direct or indirect engagement with the Cairns Integrated Mental Health Service and/or the Cairns Base Hospital which occurred following his planned suicide attempt on 27 June 2006 and his death on 28 June 2006.

Locating Robert on 27 June 2006

[54] The piecing together of information concerning Robert attending a private location on 27 June 2006 with a view to ending his life commenced through the action of Robert's work colleagues attempting to contact his wife Beverly to advise of his sudden departure from work. As soon as Beverly was informed, she contacted the mental health unit and then the Police. An officer in the Cairns Communications room located Robert via Robert's mobile telephone and realizing that Robert sounded upset and depressed, kept Robert talking whilst obtaining clues to his whereabouts to pass on to Police who had commenced a search[25].

[55] It was through the combined efforts of the communications room and the police physically searching various locations in and around Robert's home and well beyond into more isolated locations within cane farms and near creeks, that Robert was located. Only then was the call terminated by the communications room officer.

Locating Robert on 28 June 2006

[56] The following day, when he returned to the same location, Robert himself contacted Lifeline in Townsville via his mobile phone. Lifeline then contacted the Cairns

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24 Exhibit 17 Report of Dr William Kingswell of 21 June 2007.

25 Exhibit 2 Kym Lindner statement

Communications Room to advise that they had spoken with Robert who told them that he was going to commit suicide by hanging himself.[26] Della Merrit took the initial call from Lifeline.

[57] Sharon Kelleher, who had worked the previous shift with Ms Lindner in Police Communications Room the day before, contacted the Cairns Base Hospital to try to locate Robert.[27]

[58] Ms Kelleher wished to ascertain on behalf of the Police, if Robert was an inpatient. If not, the Police would have to locate Robert again.[28] The relevant parts of the transcript of the tape recorded telephone conversation reveals Ms Kelleher asking the mental health unit regarding Robert "*he was admitted to you last night, he hasn't absconded or anything has he?*" The reply was recorded as "*according to our records he's not an inpatient at this Mental Health Unit"*.

[59] Ms Kelleher then asked "*can you tell me what happened to him last night"* to which the reply was "*I am not at liberty to say"*. Ms Kelleher then asked to speak to a supervisor. The call was transferred to Dr. Simpson. Ms Kelleher then told Dr. Simpson of the contents of the phone call from Lifeline and about Robert's threat to self harm by hanging and "*we just want to know, just checking up to see if he was in the hospital, if he has absconded"*. Dr. Simpson advised "*there is no Robert here" …No we do not have a Robert here"*. In response to a further enquiry from Sharon Kelleher "*well last night he was"* Dr Simpson advised that she was not in a position to give out patient information.[29] That telephone enquiry appears to have been made shortly after the initial call was received from Lifeline Townsville at 1438 hours[30].

[60] In relation to the exchange between the Cairns Communications Room and Mental Health, Dr. Kingswell observed that whilst the interaction was unhelpful, Dr Simpson would have been aware of her responsibilities to preserve a patient's confidentiality and the cumbersome requirements of the Health Services Act[31]. At that time the discretion for disclosure of information to prevent serious risk to life, health or safety still sat with the "Chief Executive" (Director General Queensland

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26 Exhibit 3 Sharon Kelleher

27 Exhibit 3 – Sharon Kelleher

28 Transcript 10/12/06 page 41 lines 40-50.

29 Exhibit 3 – transcript attached – pages 3 and 4.

30 Exhibit 3 – statement Sharon Kelleher page 1

31 Exhibit 18 – Dr. Kingswell's report – p6

Health) and had to be obtained in writing. Dr. Kingswell considered that this process is much too difficult to be used in an urgent situation as arose in Robert's case.

[61] Part 7 of the *Health Services Act 1991* imposes a duty of confidentiality on Queensland Heath staff and sets out the exceptions to the duty. Dr. Simpson felt constrained by this duty of confidentiality when she had her discussion with the Cairns Communications Room. Section 62I of the Act refers to an exception to the duty of confidentiality where the disclosure is necessary to prevent serious risk to life, health or safety of an individual. The statute has, since Robert's death, been amended to allow delegation of the authority from the Chief Executive to certain Queensland Health Staff and thus enable the disclosure of the kind of information that the Cairns Communications Room were seeking from Dr. Simpson in their endeavours to locate Robert.

[62] Dr. Janet Bayley the Clinical Director of the Cairns Integrated Mental Health Service ("CIMHS") confirmed that, since Robert's death, there has been a written memorandum between the Director General of Health and the Queensland Police Service to the effect that, where a person or patient is at serious or imminent risk, then the treating health professionals are able to give health information to the police to facilitate the safe management of that situation.

Removal of suicide implements

[63] When Senior Constable McCullough located Robert on 27 June 2006, Robert had a blue nylon webbing strap tied around his neck. This was secured to a branch. Officer McCullough convinced Robert to untie the knot on the tree and climb down. Officer McCullough stated "*whilst this was happening I believed that, if he did fall or go through with his actions, I would have to make an attempt to assist by climbing the tree. Because of this I took off my utility belt and signalled to A/Sergeant Flynn if she had something sharp to cut the strap with if necessary."*[32]

[64] Eventually with more encouragement from Officer McCullough, Robert removed the strap and the webbing from the tree and started to climb down. Robert fell into the creek.

[65] Officer McCullough's statement continued at paragraph 11 "*We assisted Harris through the creek and up the bank and seated him in the back seat of our police 4WD. As I was more concerned about Harris, I threw the webbing strap on the*

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[32] Exhibit 1 – paragraph 9

ground at the rear of his vehicle which we locked and left at the scene. I sat in the rear of the police vehicle with him".

[66] Officer McCullough was asked by Mr Fellows, Counsel for the nurses, why the device (rope webbing) was not confiscated given that it was to be used as part of Robert's plan to take his life. Officer McCullough replied that he had considered that issue since the incident but at the time of the incident he had focused on removing the strapping from Robert's head and was more concerned about Robert's well being.

[67] He said that he was not investigating a crime, and did not agree with the suggestion that in hindsight the rope webbing ought to have been confiscated. When questioned further about the Police routinely taking items such as the medication and the suicide note and what, if any, procedure applied, Officer McCullough responded that there was not a procedure for taking an item such as the rope.[33] He acknowledged that the same rope webbing appeared to have been used the following day when Robert took his life.

[68] Officer McCullough was not opposed to a set of instructions or standard procedures relating to removing any device or object that was used by a person in a suicide attempt so as to prevent a re-occurrence.

[69] I can well understand that Officer McCullough's first priority was rightly to assist Robert to safely come down from his most precarious and dangerous position up the tree. In the circumstances Officer McCullough was properly contemplating any number of dangerous scenarios that might have played out, whilst at the same time, maintaining a dialogue with Robert to prevent a tragedy occurring.

[70] I see merit and recommend that the Queensland Police Service introduce a standard procedure in relation to their attendance at an attempted suicide or where any person is acting out a suicide plan, to remove any item, implement, substance or device used in the suicide attempt. Whilst I accept that the person could well just purchase another item, implement, substance or whatever the person may use in an attempt to take their own life, removal may assist in making it more difficult if that person subsequently has another spur of the moment decision to take their own life.

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[33] Transcript 10/12/06 page 24, line 40-50

Communication between Police and Hospital Staff on 27 June 2006.

[71] Robert arrived at the emergency department at the Cairns Base Hospital in a police car and entered via the ambulance entry point. A nurse inquired of the officers as to what they were doing. Upon replying that they were bringing in a male person, they were told words to the effect "*Well you will have to wait outside… wait outside in your car... there are other people to see before that.*"[34]

[72] Understandably the police officers involved felt that this was a somewhat antagonistic attitude by staff at the hospital toward police, and Officer McCullough a most experienced police officer serving for in excess of 17 years noted, as a general observation, that from a policing perspective, there has not been a very harmonious relationship between police and hospital staff when police are transporting mental health patients to hospital[35].

[73] Whilst the welcome received by the police officers was less than satisfactory, the basis behind requesting the police to return to their car with Robert was explained during the Inquest. According to Dr. Pereira, the Director of Emergency Medicine at Cairns Base Hospital who gave evidence at the Inquest on 12 December 2007, there is no difference in treatment of the arrival of a mental health patient to any other patient. Dr. Pereira informed the Inquest "*We haven't actually separated mental illness from the general presentations. We don't treat mental illness any differently to a normal presentation. What we have changed is our documentation in that now if the patient with a mental illness arrives at least by ambulance, if they are ramped, the time of documentation actually starts at the time the patient arrives at the hospital rather than the time that the patient is Triaged and enters the department*"[36].

[74] Ramping was explained by Dr. Pereira as a system which has developed as a result of overcrowding where there is a situation where the beds in the Department are entirely full and there are no trolley spaces to accommodate a patient safely. *"We utilise ramping to expand the emergency department beds, utilising the resource that the patient has arrived in to expand the department into. So if we have ambulances ramp up, what we try to do is actually make sure the patient is stable in those ambulances and we may initiate treatment in those ambulances if need be".*

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34 Transcript 10/12/07 – page 20 line 1 to 10 – Officer McCullough

35 Transcript 10/12/06 page 23 line 30

36 Transcript 12/12/06 page 213 line 40

[75] Dr. Pereira also gave evidence that at the relevant period in June 2006, the Emergency Department experienced one of its worst periods for patient access and ramping. He said "*at the time the police brought Mr Harris to ED, we already had five mental health patients under the Mental Health Act. One of those patients had been in the department for 24 hours and the other four had presented between 11.30 am and 4 pm".*[37]

[76] Dr. Bayley gave evidence that she understood the position of the police officers upon arriving at the emergency department and being told to take the patient back to the car. Dr. Bayley said that the safest option for Robert at the time was with the police. Dr. Bayley said this was probably not explained to the police and that she understood the hostility generated as a result.

[77] Dr. Bayley acknowledged the importance of establishing good communication between the Queensland Police Service and the Cairns Mental Health unit. Dr. Bayley invited the police service to contact her so that "*we can actually establish a proper liaison between our two departments"*. Dr. Bayley said in her written report [38]that the communication issues highlighted in Robert's case have been addressed at working party level between the two services.

[78] Dr. Bayley reported to the Inquest that Queensland Health is introducing a State-wide Mental Health Intervention Project aimed at establishing District level Mental Health clinician positions whose role it is to liaise with emergency services about patients who are mentally unwell. The project was due for establishment in July 2007.

[79] I have had the opportunity of reading the documents tendered during the Inquest in relation to the Mental Health Intervention Project[39] (MHIP).). I note that the project has arisen due to funding provided in the 2005/2006 State Budget to the Queensland Police Service (QPS), Queensland Health (QH) and the Queensland Ambulance Service(QAS). The MHIP News[40] describes this project which is to be implemented over 3 years in the following terms:

> *"MHIP is a tri-agency partnership aimed at the prevention and safe resolution of mental health crisis situations.*

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37 Transcript 12/12/06 page 205 line 30

38 Exhibit 12 final page

39 Exhibits 20, 21 and 22

40 Exhibit 22

The MHIP is a state wide project being established in 17 Health Service Districts from 2006-2009. The project relies on the three agencies working together at a district level and building upon existing collaborative protocols, with emphasis on agency specific training, pre-crisis planning, information sharing and improved referral pathways for individuals experiencing a mental health crisis.

The project provides additional resources for the establishment of district Mental Health Intervention Co-ordinator (MHIC) positions in each of the three agencies to enable police, ambulance and health staff to work together at district level, to seek local solutions to local mental health issues.

The MHIP aims to enhance the capacity of exiting services to respond more effectively in day-to-day and mental health crisis situations and, as such, recognises the need to develop:

- *Agreed responses to individuals who are experiencing a mental health crisis;*
- *Improved safety for individuals, mental health staff, police, ambulance and the community;*
- *Improved continuity in communication and liaison;*
- *Meaningful information sharing between the three services;*
- *Adequate and timely responses;*
- *Improved access to a range of services for individuals experiencing a mental health crisis."*

[80] The introduction of the MHIP should improve the effectiveness of and responses to the treatment of mental health patients in a crisis situation. This initiative has been introduced since Robert's death. Such a project can only enhance the system of communications between the services concerned and their ability to jointly respond to crisis situations.

[81] Dr. Kingswell stated in relation to what he described as the "intersection of the two departments" (police and hospital) that it ought to be a priority to re-instate liaison meetings between the two which were discontinued some years ago according to the evidence given by Dr. Pereira. Dr. Kingswell applauded the mental health intervention project outlined by Dr. Bayley[41]. Dr. Kingswell recommended that

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41 Transcript 12/12/06 page 269 line 30

"*the executive director of medical services at the Cairns Base Hospital might consider making those liaison meetings one of the requirements of the Direction of Emergency Medicine, and those meetings are reported to him as to their frequency and their outcome so that there is some process that prevents them from falling off the agenda because clinicians get very busy, and things like this, which are clearly very important, have just fallen by the way side".*[42]

[82] Dr. Bayley acknowledged:

> *"The CIMHS has great respect for the committed work that the Queensland Police Service provides to patients with mental health needs in our community and would like to endeavour to support the relationship between the two services and support the QPS in continuing to provide high level services to people with mental health needs."*

[83] I am satisfied that the communication shortfalls highlighted in this inquest have been acknowledged at the highest level at the CIMHS and that steps are being taken to address future communications.

Suicide Note

[84] Once police conveyed to the medical staff that Robert was not an involuntary patient, that he was actually a patient with Mental Health, he was seen within 5 minutes by ACT staff.[43] Mr Sullivan CN spoke with police officer Flynn and Megan Colahan, psychologist with ACT, spoke to Beverly. Officer McCullough saw Officer Flynn handing the "suicide note" and some medication to Mr Sullivan. During the evening the suicide note was misplaced.

[85] When questioned at the inquest about the existence of the suicide note, Mr Sullivan gave evidence that he vaguely remembered that there was a note in a clear plastic bag containing Robert's medications which was in the possession of the Emergency Department nurses.

[86] Mr Sullivan was also questioned about his failure to record in the clinical notes that Robert had written a suicide note. Mr Sullivan stated this was an oversight on his part[44].

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42 Transcript 12/12/06 – page 269 and 270

43 Transcript 10/12/06 page 21.

44 Transcript 11/12/06 page 143, lines 10-20.

[87] Dr. Edema confirmed that neither of the ACT team members mentioned the note to him. He was not aware of the existence of the suicide note at the time he assessed Robert or made the decision (in consultation with Dr. Simpson) to discharge Robert from the Emergency Department. Dr. Edema gave evidence that he discovered the note *"whilst adding my notes to his medical record. The note was not with the clinical information that I read prior to reviewing Mr Harris and it appears to have been kept in a separate area at the nurses' station*[45]*"*.

[88] Dr Edema stated that when he did read the note, it was consistent with Robert's negative cognition of worthlessness and hopelessness. However, when Dr. Edema interviewed Robert, Robert demonstrated that these thoughts were no longer representative of his mental state. Dr Edema could not say whether knowledge of the note would have affected his decision to discharge Robert, although it may have.

[89] Beverly was not told of the existence of the suicide note until after her husband's death. She felt that if she had known about the note, or the note had been given to the Doctor that night, things might have been different.[46]

[90] The Harris family submitted that there ought to be a system in place to account for items received by the Emergency Department such as the suicide note. Evidence relating to the whereabouts of the plastic bag containing the suicide note revealed there was no formal procedure for placing such items in a known location, or ensuring that the treating psychiatrist saw the suicide note.

[91] The Harris family submitted that consideration ought to be given to establishing a dedicated space where such items are held together with a register recording the item as being received, by whom and when. Once the patient's file has been obtained or created, copies of any notes or documents should be attached to the file forthwith.

[92] I consider it imperative that the existence and contents of a suicide note be known and conveyed to the clinicians diagnosing and treating the patient. Systems must be put in place to cover this eventuality. I accept that a register should be established with a dedicated location for the placement of such items, known to all the staff.

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45 Exhibit 10 page 5 -

46 Transcript 10/12/06 page 56, line 1-10

Isolated Location

[93] Dr Edema and Dr Simpson were unaware of the isolated location of Robert's suicide attempt on 27 June 2006. Dr Simpson conceded this was the result of insufficient collateral information and communication.

[94] Dr. Edema was under the impression, from the notes that the ACT team had recorded, that the tree was at the back of Robert's property. He was not informed until after Robert's death, that it was located at an isolated spot. Other information that was not made known to Dr. Edema at the time of assessment was the fact that Robert remained on the telephone talking with police communications for 50 minutes until the police arrived. On hearing this information at the Inquest, Dr. Edema considered it supported the view that Robert was ambivalent about committing suicide, was taking some measures to avoid detection, yet, at the same time, was taking other measures to be found.[47].

[95] Dr. Edema believed that the fact the suicide attempt occurred in an isolated location showed that Robert had gone to more extremes to remove himself from safety. When asked if he had known about both the isolation of the attempt and the suicide note, would he have then recommended admission of Robert to Dr. Simpson, Dr. Edema stated that isolation suggests minimising the chance of discovery which is a big warning sign and that would have been weighed up with the overall balance between protective factors and risk factors. Dr. Edema said "*I think it would have been more equivocal in my mind about what to do and so I would have had to have deferred to Dr. Simpson"*.

[96] Dr. Simpson was asked whether knowledge of the remote location would have changed the decision to discharge. Dr. Simpson considered that if Dr. Edema had been given details of how far away the first attempted suicide location was from the Harris's home it might have led her to reconsider Robert's attempt[48]. Dr. Simpson conceded that, if she and Dr. Edema had knowledge of the suicide note and the isolated location, they might have perhaps reconsidered sending Robert home.[49]

[97] Dr Bayley gave evidence that she considered it unusual and surprising for the ACT Team not to have passed on details of the suicide note and the isolated location as, generally, that information makes its way to the psychiatrists. Dr. Bayley suggested

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47 Transcript 11/12/07 page 183 lines 30 to 50.

48 Transcript 10/12/06 page 91 line 40-50

49 Transcript 10/12/06 page 83, line 20 to 50.

that she would like to see funds for the enhancement of the ACT Team to ensure a 24 hour presence in the Emergency Department. This was supported by Dr. Simpson.[50]

[98] Dr. Edema gave evidence that he was an advocate for improving the system of the transfer of information. He spoke highly of the systems in Randwick Hospital, Sydney which he had previously observed. There the procedure is, if a patient is brought in by police or ambulance for assessment, the assessing registrar actually directly questions the policeman who brought the person in to obtain all the important information[51].

[99] During the course of the Inquest, a draft document prepared by the Queensland Police Service was tendered. I am satisfied the Queensland Police Service has been pro-active in trying to ensure that all information is passed on from Police Officers to hospital staff when admitting voluntary patients. The document was admitted as Exhibit 13. Dr Pereira described it as a most constructive document to introduce. I commend the Queensland Police Service in Cairns for devising this document with recommendations to follow.

[100] I accept the submission from the Harris family that if further information comes to light regarding the likely or greater risk of suicide to a patient than has already been explained to the family, the family ought to be contacted forthwith. Any additional concerns or risks ought to be conveyed to the family and a re-assessment made of the decision to discharge the patient.

Diagnosis and discharge on 27 June 2006.

[101] During the course of the Inquest, differing professional opinions emerged on two issues, namely Robert's diagnosis and the decision to discharge Robert on 27 June 2006 as opposed to admitting him to the Cairns Mental Health Unit .

[102] Dr. Kingswell, having reviewed all of the records in this matter, considered there was insufficient information obtained (or recorded) by clinicians prior to Robert's death to allow a definitive diagnosis. In Dr. Kingswell's view the differential diagnoses available were either Major depressive disorder of severe degree or Adjustment Disorder with depressed mood of mild to moderate degree.

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50 Transcript 11/12/06 page 116, line 40-50

51 Transcript 11/12/06 page 177 line 30 - 50

[103] Dr. Kingswell noted there was variance in recorded observations which posed a difficulty in arriving at a diagnosis. He compared the mental state recorded by Dr. Edema on 27 June 2006, which noted a number of positive features of severe depressive disorder "poor eye contact, flattened affect with some reactivity, slowed speech and thoughts of worthlessness", with the notes of Mr Jones CN (which were not written until 29th June 2006) recording Robert's presentation as being of a milder depressive state. Dr. Kingswell also noted the contradictions between what Beverly told Ms Linder of the Cairns Communications Room on 27 June 2006 (that her husband was very depressed and she was concerned for his welfare) as compared to the reported comment made by Beverly to Dr. Edema (that Robert had been in good spirits in the preceding week).

[104] With the benefit of the known outcome, Dr. Kingswell considered that major depressive disorder of severe degree was the more likely diagnosis.

[105] It was Dr. Kingswell's view that the most important decision to be made in this case was whether to admit or discharge Robert. The decision was left to a first year psychiatry trainee with support from a consultant psychiatrist who had not met the patient and who did not have the benefit of the clinical record.

[106] Dr. Kingswell, when reviewing clinical decisions in this case, could not readily understand the decision made to not admit Robert. In his view, at face value, a man 60 years of age presenting for the first time with a depressive illness associated with two serious suicide attempts required admission as a matter of urgency. Dr. Kingswell considered that Robert's diagnosis, his age, gender and the fact that he had undertaken two recent attempts on his life placed him at significant risk of suicide attempt.

[107] Dr Kingswell stated it was not apparent to him why the on-call psychiatrist was not physically present on 27 June 2006. He noted the pressures on the mental health service that day: it "*was in crisis that afternoon. No beds were available. Five patients detained on MHA orders were waiting in the ED, one for more than 24 hours. The Director of Emergency had declared that the ED was not a place of safety*"[52].

[108] Coupled with his contrary view on the decision to discharge Robert, Dr. Kingswell also said from his own experience, that it is an expectation that prior to the Emergency Department "by-passing" mental health patients, the consultant on-call will be called in to review current inpatients for potential discharge and review those patients waiting in the Emergency Department for admission. Dr. Kingswell

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52 Exhibit 18 page 6.

said that the ACT team leader in his own service, would in such situations contact surroundings hospitals and check their capacity. Dr. Kingswell acknowledged that in Cairns any surrounding hospitals would be limited to Townsville some hours away.

[109] The decision to discharge Robert was made by Dr Edema in consultation with the Psychiatric Consultant, Dr Simpson, who approved the plan. The decision to discharge was made after Dr Edema completed a mental state assessment and then reviewed the decision over the telephone with Dr Simpson.

[110] The ACT team gave Dr. Edema a brief history of Robert's suicide attempt however, as referred to elsewhere in these findings, not all of the extrinsic information was made available to Dr. Edema.

[111] Dr. Edema read Robert's medical record which noted his earlier admissions, earlier assessments and his other suicide attempt about a month earlier by polypharmacy overdose. Dr. Edema then spoke with Robert in the absence of his wife Beverly to enable Robert to have a more candid discussion.

[112] Dr. Edema gave evidence concerning his assessment of Robert prior to discharging him. He noted many factors requiring consideration. Robert had previously made an impulsive attempt on his life, triggered by particular interpersonal events. Robert demonstrated very quick improvement in symptoms, which then resolved quickly. This led to Dr. Edema considering that Robert's attempts to suicide were circumstantially based rather than being a pervasive disturbance in mood.

[113] Dr. Edema believed that it was in this context (together with intoxication) that Robert undertook his suicide attempt on 27 June 2006. Dr Edema considered that Robert's suicidal behaviour demonstrated marked ambivalence (readily accepting police requests to come down from the tree and ongoing statements of remorse) that supported his current assurance of safety. Robert conveyed to Dr. Edema that the circumstances which triggered this suicide attempt had been adequately neutralised by the rallying of support by family and friends, and he did not anticipate that his level of distress would deteriorate again.

[114] Dr Edema believed that Robert was demonstrating a depressive illness characterized principally by negative cognitions, without the required neuro-vegetative features for a DSM-IV-TR diagnosis of Major Depressive illness. Dr. Edema's belief was corroborated by information from Beverly and Dr. Ali's earlier assessment.

[115] Dr. Edema then spoke to both Robert and Beverly, with Beverly standing behind Robert, allowing the Doctor to observe her non-verbal communications without

Robert noticing. Doctor Edema stated that he told Beverly that her opinion was very valuable to his assessment as he had only just met Robert whereas she had known Robert for many years. Beverly informed Dr Edema that her husband had been consistently remorseful while in the emergency department that evening and his current manner of speaking (i.e. slow) was typical for him and not due to drowsiness or connected with low mood. Beverley told the Doctor that she felt his contracting for safety was genuine and warm.

[116] In her evidence Beverly stated that she did not think she should have been asked whether or not she trusted Robert to take him home.[53] Beverley said, as Robert's wife of 30 years, she did not think that she was in a position to say no to the Doctor. Beverley would have preferred to be asked such a question in private, though she conceded thoughtfully that, if she had been asked in private, she did not know if her answer would have been different.[54]

[117] Robert told Dr. Edema that he was seeing a clinical psychologist with whom he was very happy. Robert wanted to go home and did not wish to be a patient in the hospital.[55] Robert gave an assurance that he had no thoughts of harming himself. He appeared to Dr Edema to be most genuine and sincere in this regard. He appeared to understand that he had an illness.[56]

[118] Dr. Edema considered, from the evidence available to him, Robert did not meet criteria for involuntary treatment under the Queensland Mental Health Act 2000. Significantly Dr. Edema states that Robert did not appear to pose a significant risk of harm to himself or others, nor was he at risk of significant mental or physical deterioration. Mental Health Unit admission was not the least restrictive way of managing Robert, who had already demonstrated an ability to comply with outpatient follow-up, had a supportive wife and was compliant with treatment. Also, Robert did not lack the capacity to refuse admission as demonstrated by his clear sensorium, insight regarding mental state, comprehension of the issues involved and ability to consistently evidence a choice regarding management.

[119] Dr. Edema considered that Robert was not suffering from a Major Depressive Illness, but rather an Adjustment Disorder with depressed mood. Protective dynamic factors included Robert not expressing suicidal ideas, plan or intent, not expressing high levels of distress and not describing hopelessness. Overall Dr.

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53 Transcript 10/12/06 page 55 – line 40

54 Transcript 10/12/06 page 57, line 1- 10

55 Transcript 11/12/06 page 172, line 1-30

56 Transcript 11/12/06 page 163, 161 line 40, p 177

Edema's assessment was of low acute risk of suicide and possible moderate intermediate risk requiring psychiatric follow-up[57]. Dr. Edema stated that essentially what he did on the evening of 27 June 2006 was make a provisional diagnosis, very much weighted upon earlier assessments by other clinicians.

[120] In light of all the aforementioned circumstances, Dr. Edema, having consulted with Dr. Simpson Consultant psychiatrist, came to the conclusion, as did Dr. Simpson, that it was appropriate to discharge Robert rather than encouraging admission.

[121] Having made this decision Dr. Edema tailored a discharge plan to cover what he considered to be appropriate future treatment.

[122] The discharge plan was recorded by Dr. Edema and involved Robert re-attending at the Cairns Mental Health Unit upon the ACT team the following morning. Dr. Edema intended that the following issues would be dealt with on Robert's return the following morning at 10 am by the ACT team:

- a review or rationalisation of Robert's medications to be undertaken
- cessation of diazepam was indicated and to be reviewed
- consideration to be given to antipsychotic medications for ruminations
- encouragement to have regular psychologist attendance.

As noted by Dr. Edema, Robert "probably requires more frequent Mental Health contact".

[123] In his oral evidence Dr. Edema stated that he believed that Robert had a therapeutic relationship with his psychologist which should continue. He was aware that Robert had only been once to his psychologist however, Robert told him it was a good interview and that he felt comfortable with his psychologist.

[124] In relation to medications, Dr. Edema suggested that Robert's medications could be altered somewhat as he felt that giving benzodiazepines to Robert could worsen the situation and they should consider reducing them. Dr. Edema considered that something like Seroquel in a low dose might be helpful in quelling agitation and ruminations that were occurring. Dr. Edema said that either Robert's general practitioner or the mental health service could make a decision on that.

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[57] Exhibit 10 – 3,4,5

[125] Dr. Edema said he spent time with Beverley Harris explaining the crisis team protocols. If she became concerned she should make contact.

[126] Dr. Bayley reviewed both Dr. Edema's typed assessment from Robert's clinical record, which was contemporaneous with Robert's presentation, and also Dr. Edema's statement tendered during the Inquest. Dr. Bayley believed that both documents showed Dr. Edema undertook a thorough and detailed history and performed an appropriate Mental State Examination and assessment of Robert's mental health.

[127] Dr. Bayley's opinion was that Dr. Edema showed that he carefully considered the risks Robert presented for a repeat suicide attempt and weighed up those risks against the need to treat Robert in a "least restrictive setting". Dr. Bayley noted that Dr. Edema tried to engage Robert in a therapeutic alliance to formulate a management plan that centred upon out patient treatment of his mental health problems.

[128] Dr Bayley supported Drs Edema and Simpson's decision to discharge Robert on 27 June. Dr Bayley also supported the discharge plan. Dr Bayley stated in evidence that she had plenty of experience working with both Doctors. She considered the information concerning Robert which Dr Edema had at the relevant time. Dr Bayley stated: *"If they (Edema and Simpson) had felt that there was a serious risk at that time of Mr Harris going home and hurting himself then they would have admitted him, I think, regardless of the beds, because we frequently have people in ED overnight for reasons of safety."* Dr Bayley surmised that she also may have chosen the less restrictive out-patient care as opposed to admission after balancing all the circumstances and information personal to Robert. She noted that Robert did in fact stick to the plan of attending ACT the following morning (when a different plan was put in place).

[129] Dr Kingswell has acknowledged previously that, from time to time, professional minds differ about treatment and diagnosis in the very complex area of Mental Health.[58] Dr Kingswell certainly made no adverse comments about the competency of Drs Edema or Simpson.

[130] After considering all of the evidence, both oral and documentary, I accept that the decision to discharge was made after careful consideration of many factors by Drs Edema and Simpson. I note that Dr Edema had the benefit of attending upon Robert and assessing Robert's mental state. In retrospect it may be that a decision to admit

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[58] Van Putten Inquest delivered 15.12.08

Robert would have led to a better outcome, but I find no evidence of any negligence or lack of competence on the part of either doctor.

Space and bed block in the Emergency Department.

[131] It emerged from Dr. Pereira's evidence and also from the evidence of Drs Bayley and Kingswell, that one of the issues in the Emergency Department was lack of sufficient space and beds to accommodate emergency mental health patients' admissions. Dr. Pereira stated that there was not sufficient capacity for mental health patients in the Emergency Department. He said if there had been five extra beds in the mental health unit on that day, there would not have been a problem with Mr Harris accessing a bed in the department at the time[59]. Dr. Pereira said that every week there are probably one or two instances where there are more than four psychiatric patients in the department for whom accommodation cannot be found.[60]

[132] Dr. Pereira stated that there are now plans for redevelopment of the Emergency Department pursuant to additional funding that was provided to Cairns Base Hospital after lobbying by a local minister. He said that a design brief has been created and approved by Queensland Health in regards to a redesigned emergency department at Cairns Base Hospital. The new proposal includes four rooms available for assessment and prolonged observations within the emergency department. This will of course bring with it, staffing requirements. Dr. Pereira was hopeful this would be met in the form of 24 hour mental health trained nursing staff covering the area.

[133] Dr. Kingswell supported renovating the emergency department and employing extra staff to ensure adequate assessment facilities and a safe environment for both staff and patient.[61]

[134] Dr Kingswell was concerned that a reason for Robert's discharge from the hospital was the lack of beds available. Other inquests concerning mental health patients have noted the worrying unavailability of bed space for urgent cases. Subsequent to earlier recommendations arising out of these inquests, Dr Bayley has implemented a workplace protocol to staff outlining the processes to follow when there are no Cairns Base Hospital Mental Health Unit beds available for new admissions.[62]

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59 Transcript 12/12/06 page 214 line 30

60 Transcript 12/12/06 page 215 line 30

61 Transcript 12/12/06 page 270 line 30

62 Titled "No Beds Available Protocol"

[135] Dr. Kingswell speculated that, whilst the reason for not admitting Robert is not specifically stated, upon consideration of the available documentation, the Emergency Department was struggling to cope with the number of presentations, a number of them mental health patients, and no beds were available in the mental health ward. Dr. Kingswell believed that a clinician would not be completely oblivious to the pressures being experienced by the Emergency Department and the pressure being experienced by the in-patient unit would intrude into the thinking of the decision maker. Dr. Kingswell speculated that Dr. Edema was under tremendous pressure to discharge and avoid any further stress in an overwhelmed system.

[136] Dr Bayley emphasized that the decision to send Robert home was not due to the lack of bed availability at the hospital. This was confirmed by Drs Edema and Simpson. I accept their evidence on this point but note with concern the valid observations made by Dr Kingswell regarding bed unavailability.[63] (See [129])

Clinical Governance

[137] Dr. Kingswell made the observation in his report that he could find no evidence that Robert was reviewed by a consultant psychiatrist during his contact with CIMHS or that a psychiatrist reviewed the documentation any time during Robert's contact with the CIMHS. Dr. Kingswell acknowledges that Robert's presentations were discussed directly between three psychiatrists.

[138] In Dr. Kingswell's experience there have been a number of poor outcomes in parties separating from Emergency Departments. He is also aware of systems introduced in Queensland hospitals and mental health services to address these poor outcomes. As an example, Dr. Kingswell cites the experience of his own service where the ACT psychiatric consultant is required to conduct a chart review of all separations and on week-ends, the on call psychiatric consultant is rostered to conduct the reviews.

[139] Dr. Kingswell commented on known poor outcomes generally for the depressed older person. I accept Dr. Kingswell's recommendation that the Clinical Director of CIMHS introduce some stricter requirements for the direct involvement of psychiatrists in the assessment and management of patients over 50 years of age presenting to mental health services for the first time with depressive illnesses, particularly in the setting of a first suicide attempt.

Business Rules and Documentation

[140] One of the issues touched upon by Dr. Kingswell, in his observations regarding documentation, is that in his experience from a number of reviews around the State, clinicians are highly variable in their approach to obtaining and assessing information. Dr. Kingswell stated it is common to find assessments that have taken an entirely cross-sectional view or alternatively an entirely longitudinal view and fail to integrate the information from both dimensions of the history. Dr. Kingswell states that it is very common for there to be no reference to any collateral source of information. In Dr. Kingswell's experience clinicians seem particularly reluctant to talk to police, ambulance, family and other important witnesses to a mentally ill person's presentation. Dr. Kingswell concludes that mental state examination is often limited and risk assessment documents are often completed in a highly formulaic way.

[141] Dr. Kingswell's observations are apt in this case where it is clear to me that information regarding a suicide note and the location of the attempted suicide may have been relevant to Robert's treatment or diagnosis and, through a lack of established system, the persons holding that information either did not convey it or were not given an opportunity to convey it to those treating Robert.

[142] Another issue relating to the keeping of proper records raised by the Harris Family was of concern to me. That is the timing of the recording of notes by Mr Jones CN. It became apparent during Dr. Kingswell's review of the notes, and was acknowledged by all concerned, that the notes were written on 29 June, the day after Robert had died. When asked to provide an explanation for the delay in recording his notes about Robert's attendance, Mr Jones said in his evidence *"Well not being able to recollect, but – the exact circumstances, but the only reason that would happen is if, being so busy you do things that come up as priority, so there may have been other walk-ins that needed to be seen and then.. the aim I guess is to do your notes as soon as is practicable and if I was still working with other things up at that time I may have – would have decided that I would do it the following day"*[64]. Save in the event of an emergency, notes ought be completed contemporaneously and not the following day.

[143] Dr. Kingswell, Dr Bayley, Mr Freele (Executive Director of CIMHS) and the Harris Family have supported the introduction of electronic records. Dr. Kingswell, at this and other Inquests, has advised me of the obvious benefits of such a system. Dr.

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63 See para [129]

64 Transcript 11/12/07 page 190 line 30-40.

Kingswell has indicated that the Cairns Mental Health Service is one of the pilot sites to trial assessment documents produced by the Patient Safety Centre in consultation with the Mental Health Unit. As Dr. Kingswell notes, the forms themselves will not improve assessment, but rather the forms need to be accompanied by monitoring of performance. He says and I accept, that there needs to be clear rules around what tasks are done by which staff member and by when. Ensuring that tasks are completed in a timely fashion becomes the responsibility of the consultant psychiatrist responsible for the patient's care.[65]

Families of mental health patients.

[144] Throughout the Inquest I have heard the psychiatrists in this matter acknowledge the importance of the patient's family being included in the process of gathering collateral information regarding the patient, both in relation to diagnosis and also in relation to any discharge plan. Dr. Kingswell and Dr. Simpson have both made reference to this concept[66] and so too do the Harris family.

[145] I note the additional suggestion of the Harris Family that when a patient is admitted or has contact with a mental health unit, that a medical professional explains to the family the medical/mental health condition of the patient and also provides information on depression and suicide to the family. I believe that this suggestion has merit however it is restricted by rules of confidentiality. There is no similar restriction on hospitals giving general information on depression and suicide to patients' families.

[146] Similarly, I have noted that families of mental health patients who have attempted suicide are, from time to time, entrusted with the care of their family member upon discharge. This factor is considered by the treating professionals as part of a patient's protective plan. I accept the submission of the Harris family that if this is contemplated by the treating clinicians, the family member involved must be given:

- the opportunity to speak privately with the clinician involved and express their agreement or opposition to being part of the protective plan;

- some explanation about depression, major depression and the stressors or circumstances that may trigger an impulsive response;

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65 Exhibit 18, page 5.

66 Exhibit 18 page 5; Transcript 11/12/08 page 114 line 10-20

- an explanation about the level of supervision or monitoring required, whether or not the patient should be left alone and if so, the period of time and other suggested care arrangements at home.

[147] During the two Inquests that I have conducted involving mental health patients and suicide deaths I have had the opportunity of hearing many experts discussing the array of symptoms and factors and the multitude of variables which play a part in the complicated illness of depression. I have watched the anguish and grief of families of mental health patients struggling to understand all of the complexities and permutations of the illness. I consider it is essential that as with any other serious illness, if a patient is to be discharged to the care of family or other significant persons, they must be alerted to the nature of care to be provided and of any risks and risk factors which are cause for alarm, and what to do in such circumstances. Given the gravity of the consequences in discharging a patient who has already and may again, attempt suicide I consider that the patient's family ought to be fully appraised of their responsibilities.

[148] I note also that it has been universally accepted by the clinicians appearing before me, that the obtaining of collateral information from family members is fundamental to the process of arriving at a proper diagnosis. The opportunity for direct communication between a patient's family and treating clinicians, as the patient navigates their way through the mental health system, is of benefit for all concerned. The diagnosis will likely have greater accuracy, the treatment may therefore be more effective, and the families will have a better understanding of the effects of the illness and how they might best play a part in the patient's home care.

[149] I therefore commend and recommend the submissions of the Harris family in relation to communication and education of families of mental health patients.

Assurances of personal safety

[150] As part of his assessment on 27 June 2006, Dr. Edema noted that Robert appeared *"warm and genuine when he was contracting for safety. It's an awkward term, but, you know, when he was assuring us that he would be okay, that he didn't have ongoing thoughts of harming himself."*. Dr. Edema later said, qualifying his earlier response, "*contracting for safety is overall not a good strategy*" and that his use of the phrase was poor, whereas what he should have said was that "*Mr Harris was consistently saying he had no plans to harm himself and he was saying you know – he was saying he would be safe..... he had been giving assurances that he had no current ongoing thoughts of harming himself and that was what I meant"*.[67]

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67 Transcript 11/12/06 page 169 lines 20-60

[151] Later in his evidence when further discussing Robert and how genuine Dr. Edema found Robert to be in his assurances, Dr. Edema said that he has, since Robert's death, become more mindful and circumspect about such apparent assertions.

[152] I note the submissions of the Harris Family about their concern of the use of any method of assurances or contracts for safety with patients.

[153] The practice of eliciting from patients an assurance to guarantee their own safety seems to permeate the whole mental health system. It is used by Doctors, social workers, psychologists and nursing staff. I accept Dr Kingswell's opinion that it is of little or no benefit and needs to be reviewed.

Changing Robert's Treatment Plan by the ACT on 28 June 2006

[154] On the morning of 28 June 2006 Robert and Beverly returned to the Cairns Mental Health Unit according to the plan envisaged by Dr Edema. Robert had complied with his assurance of personal safety to that time.

[155] Robert was seen by Mr Jones CN. The plan adopted by Mr Jones was to give Robert an ACT team card noting that Robert was agreeable to contact the unit if he was either not managing or had any concerns. Mr Jones referred Robert back to his own general practitioner for review, noting that the ACT Team would feedback to the general practitioner. Mr Jones provided Robert with a Relationships Australia brochure, noting that Robert stated he would make contact with a view to seeking couple counselling. The file noted that Mr. Jones discussed Robert's case with the handover team. The recommendation was that, once feedback had been given to the general practitioner, no further action was required.

[156] Dr Kingswell who reviewed the records gave evidence that, at the point of Robert returning and presenting to the ACT team, a clear dispute emerged. Dr Edema's plan from the previous night indicated Robert was a man with a significant mental illness who needed more frequent mental health care. The assessment by Mr Jones the following morning was that Robert didn't have a significant mental illness and less mental health care was required.[68]

[157] Dr. Kingswell stated in his oral evidence that when such a dispute occurs "*you need a third umpire and that should be the consultant psychiatrist on call and perhaps [that's] what should have happened. In this case we have a significant difference of opinion. The registrar thought that treatment was required, nursing staff didn't*

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[68] Transcript 12/12/07 page 275 line 30-50.

think treatment was required and the current opinion prevailed rather than.. we've got a contest, we need a resolution".

[158] Beverly gave evidence that she was not included in this review and up to this time, had not received any information from the medical professionals that assisted her to understand her husband's condition or to understand the level of risk of self harming involved. Beverly said all she knew was that her husband was on anti-depressants.[69]

[159] As stated above, Mr Jones recorded his consultation with Robert posthumously on 29 June 2006. Dr. Bayley gave evidence that it makes good clinical sense "*to write your notes as you do them"*. Both Drs Bayley and Kingswell considered that the notes were inadequate in the circumstances, failing to make the diagnosis clear and containing no risk assessment.[70]

[160] Dr Bayley conceded it would have been ideal for Robert to be seen by either a Psychiatric Consultant of a Psychiatric Registrar the following day. She criticized Mr Jones' documentation as inadequate. She believed the assessment was lacking depth, and should have been more considered and comprehensive.

[161] I am of the view that Robert should have been more thoroughly reviewed on 28 June. This review should ideally have been performed by a psychiatrist, or at least reviewed by a psychiatrist in accordance with Dr Edema's discharge plan.

[162] Gavin Harris and, perhaps other members of Robert's family may feel that some form of disciplinary action should be taken. As stated earlier, that is not the purpose of an inquest. I accept the evidence of Dr Kingswell that, although a number of errors occurred, there is no evidence that any staff require disciplinary action or dismissal.[71]

[163] Mr Freele advised the court that Mr Jones has been counselled concerning his documentation and assessments. As Dr Kingswell stated, what is of greater importance in this case is for improvement to occur in the performance and monitoring of staff and systems to ensure similar errors do not occur in future.

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69 Transcript 10/12/07 page 54 line 20

70 Transcript 12/12/07 page 252 line 10-30 and Exhibit 18, page 3.

71 Transcript 279

Final Thoughts

[164] In relation to what appeared to be Robert's sudden decision to commit suicide, Dr. Bayley stated in her oral evidence, that she found it incredibly difficult to know what happened in the ten minutes before Robert decided to do it. Dr Bayley said that Robert appeared to be someone going down a positive path and then suddenly something seems to have happened that led him to take his life which was not apparent to Dr. Bayley from the evidence she had heard. Dr. Bayley wondered if Robert, whilst being open with his therapist, may not have been as forthcoming with those close to him.

[165] Beverly described her observations of Robert's depression as: *"Bob never showed on the outside exactly how sick he was on the inside. So he was fine. He presented to us not be as sick as he was. He never mentioned that – how bad he was."*[72] In relation to the period leading up to his death, Beverley said that "*He didn't talk to me much about it. When I knew he was going [to the mental health unit] I said I would come too. He just said he is doing fine. So, each time he was doing fine. He never changed at home"*[73].

[166] My observation, in now conducting two Inquests into deaths of patients following discharge from the Cairns Mental Health Unit, is the stoicism of each of the patients concerned who suffered privately whilst keeping a brave face to family, friends and treating staff. Through reading and hearing the evidence involved I have gained some insight into the pain and anguish of Robert, suffering a mental health illness which caused him to contemplate suicide, attempt suicide, and then end his own life.

Findings required by s 45

[167] I am required to find, as far as possible, who the deceased was, when and where he died, what caused the death and how he came by his death. As a result of considering all of the material contained in the documentary exhibits and the evidence given by the witnesses I am able to make the following findings in relation to this matter.

1. The identity of the deceased was Robert Harris
2. His date of birth was 10 June 1946
3. His last known address was 76 Harris Rd, Edmonton, North Queensland

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72 Transcript 10/12/07 page 49 line 20/30

73 Transcript 10/12/07 page 50 – line 3-=40.

4. At the time of his death he was employed at Bunnings Hardware in Cairns.

5. The date of his death was 28 June 2006

6. The place of his death was Mackey Creek, Gordonvale

7. The formal cause of his death was asphyxsia sequential to hanging due to depression.

8. The cause of death was not suspicious.

Concerns, Comments and Recommendations

[168] Section 46, in so far as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in the future. What follows is a summary of some of the progress that has thus far occurred and a number of recommendations.

Coroner's Action Plan and Other Improvements

[169] At the time of this inquest changes were already taking place to the Cairns Integrated Mental Health Service. These changes have occurred since June 2006 and include additional mental health services to the Cairns Emergency Department ("ED"), a successful recruitment process providing for a full compliment of psychiatrists and psychiatric registrars, the creation of additional educational positions to educate staff in mental health processes and the implementation of the standardised suite of forms relating to risk assessments, admission and discharge of patients to hospital.

[170] On 15 December 2006 Coroner Previtera delivered her findings into the cause and circumstances of the deaths of Baggott, Lusk, and Barlow. Coroner Previtera conducted a thorough review of the delivery of Mental Health services in Queensland and made over 50 recommendations for the implementation of mental health policy and service reform. I note Coroner Previtera's recommendations were released six months after Robert's death and 12 months prior to the current inquest.

[171] In early 2007 the Northern Area Health Service, the Clinical Support Unit Mental Health, the Alcohol, Tobacco and Other Drug Team and the CIMHS commenced analysing Coroner Previtera's report in order to evaluate existing State-wide and Local Practices and to develop an action plan to implement her recommendations. At the time of the present inquest Queensland Health had reviewed the findings and developed a response titled "Coroner's Action Plan". Some of Coroner Previtera's recommendations were in the process of being addressed.

[172] Relevant improvements and/or changes that were occurring at the time of this inquest include the following (this list is, by no means exhaustive):

- The amalgamation of the Cairns, Innisfail and Tablelands Health Service Districts. This move has enhanced communication between clinicians and staff and promoted uniformity of decision making regarding care for mental health patients in the area;

- uniform suite of documentation introduced as a pilot program to be used by all mental health services state-wide;[74]
- introduction of the Northern Area Strategic Services Plan 2007-2012.
- the appointment of a nurse educator and the introduction of training programs currently being developed in the local district in relation to mental state examinations, completing mental health documentation and risk assessments.
- Identifying the need for increased resources to fund after hours work by Community Mental Health Services.
- Introduction of the Workplace Protocol – "No Beds Available". (already referred to above).
- Update of the Cairns Mental Health Service Staff Orientation package which includes guidelines for correct documentation procedures and information for all staff working within the Mental Health Service.
- Introduction of the Queensland Health Clinical Governance Implementation Standard which sets out the mandatory auditable requirements regarding the roles and responsibilities for clinical governance; issued in April 2007 and reviewable annually.

[173] Dr Bayley and Mr Freele gave evidence of further procedures and workplace protocols which have been introduced and include:

- psychiatric registrar is to review charts for mental health patients assessed and discharged home from Cairns Base Hospital Emergency Department[75]
- the allocation of an on call psychiatric registrar to respond to Emergency Department mental health presentations[76]
- a protocol outlining the procedure to be followed where there are requests by police for patient information where there is serious and imminent risk[77]
- the introduction of the Mental Health Intervention Project which will improve collaboration between the Queensland Police Service, Queensland Ambulance Service and Queensland Health. The project is a state-wide program to educate and train staff from each organization to have knowledge and understanding of the operations and work practices of each agency. The project is aimed at staff of the three agencies working together to share expertise, resources

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74 Exhibit 16

75 Exhibit 16

76 Exhibit 16

77 Exhibit 16

and to respond to emergency mental health situations so as to achieve prevention and safe resolution of mental health crisis situations.[78] Dr Kingswell applauded this project.[79]

- creation of a new position at Cairns Base Hospital titled Mental Health Intervention Co-ordinator.[80] A similar position has been created in the Queensland Police Service.[81]

[174] I acknowledge that, since February 2006, many positive changes have been implemented within the Mental Health Service in Cairns and the surrounding areas. Dr Kingswell agrees progress has been made. There is still much to be achieved.

Recommendations

[175] In addition to the recommendations below, I also endorse those recommendations in Coroner Previtera's Report to which I have not specifically referred. Some of the following recommendations mirror a number of earlier recommendations by Coroner Previtera and other Coroners made prior to the current inquest and requiring attention by Queensland Health. This reflects the need for proper dissemination and action by Queensland Health and the Government to address all recommendations.

Clinical Governance, Education and Improvement of Mental Health Services

1. Queensland Health continues to develop and implement a competency based training module on Clinical Documentation Standards to provide for competency based education modules to mental health and primary health staff in the Cairns Integrated Mental Health Service (CIMHS). Education modules should include risk assessment, mental status examination, Mental Health First Aid and Indigenous Mental Health First Aid training. The evidence of Mr Freele was that this has already commenced with the appointment of two clinicians to educate staff. Clearly, these positions need to be extended. Further funding is required.

2. The CIMHS introduce a training package with competency based assessment for all clinicians working in acute mental health services where they might have responsibility for initial assessment. The package should cover history taking, mental state examination, provisional diagnosis, risk assessment and initial management planning.

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78 Exhibits 20-24

79 Transcript 269

80 Exhibit 25

81 Transcript 301

3. Enhancement of the CIMHS internal audit system to allow clinical audits to be regularly conducted in all CIMHS services.

4. Redesign of the Cairns Base Hospital Emergency Department be undertaken as soon as possible to provide a better environment for optimum assessment and treatment for the increased population. This will enable mental health patients presenting to the Emergency Department to be appropriately assessed and managed within the Emergency Department environment until discharged to another area in the hospital or other service. Some funding has already been allocated.

5. Urgent Funding for the Cairns ACT team to expand their clinical cover to the Cairns Base Hospital Emergency Department and the community so as to provide immediate clinical care and support for the redesigned Emergency Department Mental Health area (referred to during the inquest as a "Pod"). As a priority, the Cairns Acute Care Team expands their clinical cover in Cairns Base Hospital Emergency Department to 24 hours a day, 7 days a week.

6. Allocation of funding to the CIMHS for the creation of a second ACTACT Psychiatry Registrar position to provide efficient Psychiatric medical treatment in a timely manner and decrease the "after hours" burden in the Emergency Department. This position would cover Emergency Department Mental health emergencies during working hours five days per week and also participate in the Psychiatry Registrar After Hours On Call Roster. The addition of more Psychiatric Registrars to the After Hours On Call pool decreases the Registrar On Call burden.

7. The Clinical Director of the CIMHS to ensure all clinical staff in the Emergency Department are aware of Queensland Health's guidelines relating to the management of people with suicidal behaviour or risk.

8. Queensland Health immediately ceases the practice of requesting patients with mental health issues to guarantee their own safety.

9. The CIMHS introduce a system to review separations from the Cairns Base Hospital Emergency Department. A Consultant Psychiatrist should be allocated this duty. The psychiatric duties should include conducting a chart review of all separations to ensure the adequacy of the following: history and collateral history, description of mental state, risk assessment, clear clinical reasoning, management plan, recommendations for ongoing management, compliance with Mental Health Act, and provision of a summary to the referrer or GP. The Psychiatrist should be responsible for pursuing and correcting any deficiencies.

10. Whenever possible, two (2) mental health workers complete a mental health risk assessment. In the event of any difference of opinion, a Consultant Psychiatrist review the assessment.

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

12. The CIMHS introduce a system to allocate a Consultant Psychiatrist to supervise each mental health patient's management. This would ensure consistency in treatment and identify to patients and their families a specific Consultant Psychiatrist with whom they can communicate.

13. The CIMHS consider the recommendation by Dr Kingswell that the service consider introducing stricter requirements for the direct involvement of consultant psychiatrists in the assessment and management of patients over 50 years of age presenting to mental health services for the first time with depressive illness, particularly in the setting of a first suicide attempt.[82]

14. Plans and funding to increase the number of Mental Health Inpatient Beds at the Cairns Base Hospital continue so as to meet existing and projected need.

15. The Queensland Health Patient Safety Unit and the QLD Director of Mental Health should follow up on the recommendation from the Lees Inquest that all findings from Coronial inquests into the deaths of mental health patients be summarised and distributed on a regular basis to Executive and Clinical Directors of District Mental Health Services**.**

Information Sharing

16. The Director of Mental Health accelerate the implementation of a state-wide electronic network of patient information that allows treating health professionals, including both inpatient and community professionals, such as general practitioners, to rapidly access patient data throughout the State. Queensland Health must provide the necessary funding as a matter of priority. This should incorporate Mental Health Database applications and clinical notes.

17. Consideration be given to establishing a regular formal minuted meeting between the public and private sector medical staff that facilitates frank discussion of problems experienced from both perspectives and generates workable action plans to resolve identified difficulties.

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82 Transcript 268

18. The CIMHS receive funding to implement the "Partners in Mind" primary mental health care framework. This will improve referral pathways and collaborative management of mental health patients between the public and private system.

Families

19. State-wide development and implementation of a family focussed model of care that recognises the importance of the views and needs of families and carers of patients in the development of care plans. This should be underpinned by policy statements, clinical care guidelines and competency based training around the topic**.** This should also include the provision of information to families concerning mental health illness.

20. Medium to high Risk Mental health patients should only be placed under the supervision of family members or friends when the Mental Health clinicians are satisfied that the family/lay carers have the capacity to provide appropriate supervision, are properly informed of the risks that they are assuming, and they have enough information to do their job including when and who to call for assistance.

Confidentiality

21. Queensland Health continues to review the provisions of the *Health Services Act 1991 Qld* as they relate to the disclosure of confidential information and implement such changes to remove any doubt that the confidentiality of information relating to a person receiving a health service is balanced with the duty of care to that person, the rights of the public to protection against the risk of harm and the rights of carers and support networks to meet their responsibilities to the person and other members of the household.

22. Queensland Health to develop, implement and provide training in state-wide guidelines to all mental health workers defining the issues of confidentiality of mental health the circumstances in which it is appropriate for mental health staff to share information regarding the person.

23. Removal of the requirement in s 62I *Health Services Act* to have the authority of the chief executive in writing for a disclosure to be made of confidential information that is necessary to assist in averting a serious risk to the life, health or safety of a person, including a person to whom the confidential information relates; or public safety. (Section 62I has been reviewed since June 2006 and the powers of the Chief Executive are now delegable. In Cairns there are now delegations in place to enable timely exchange of information in emergency situations relating to mental health service provision. It remains to be seen how effective this amendment will be).

Community Mental Health Support

24. The Queensland Government to increase funding to a range of community-based services to assist both adults and children with mental health problems in the Cairns and the Integrated Mental Health Service Clinical Network. The Queensland Government ensures this includes both clinical and non-clinical services, both generic and mental health-specific services, in addition to nurses, allied health workers, psychiatrists, psychiatry registrars and indigenous mental health workers and life promotion officers.

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

Queensland Police Service and Cairns Base Hospital

26. When presenting with patients suffering from suspected mental health issues to Cairns Base Hospital Emergency Department, the Queensland Police Service provide a written summary of the circumstances of the patient coming into contact with the Police and any available collateral information. Where there has been an attempted suicide, the document should record relevant details including times, location of attempt, means of attempt, any medication or other relevant real evidence, any information supplied by witnesses or next of kin, suicide notes, calls for assistance, details of patients' families and their contact details and any other collateral information that police, in their experience, believe may assist the CIMHS.

27. The Cairns Base Hospital Emergency Department reinstate, as soon as possible, lines of communication with Queensland Police Service to ensure a better working relationship, co-operation and the timely exchange of information. The Mental Health Intervention Project is currently addressing this recommendation. The Executive Director of medical services at the Cairns Base Hospital should consider making liaison meetings the responsibility of the Director of Emergency Medicine, who should receive reports as to the frequency and outcomes of any meetings.

28. The Queensland Police Service introduce a policy for the disclosure to families of the existence and content of any suicide notes (subject to issues of confidentiality and ongoing police investigations)).

29. The Queensland Police Service consider introducing a policy that all items found and suspected of being used in a suicide attempt are to be seized for safety reasons.

Conclusion

[176] Before closing the Inquest I wish to extend my condolences on behalf of the Coroners Court to Robert's family and friends. The court accepts that the period of time that has elapsed since Robert's death has been particularly difficult for those close to him. I thank them for their patience and contributions during the inquest process.

[177] I also thank Sergeant Michelle Dodds, the investigating officer, counsel assisting, Dr Kingswell, and the legal representatives appearing at the inquest for their assistance and cooperation.

[178] I close this inquest.

K McGinness

Coroner