QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Melina Maree Cuttler** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | Ipswich |
| FILE NO(s): | 2013/548 |
| DELIVERED ON: | 13 March 2015 |
| DELIVERED AT: | Brisbane |
| HEARING DATE(s): | 6 January 2015, 16-18 February 2015 |
| FINDINGS OF: | John Lock, Deputy State Coroner |
| CATCHWORDS: | Coroners: inquest, mental health, psychotic presentation at Emergency Department, absconding from ED, fall from height, whether capacity for intent to suicide |

REPRESENTATION:

Counsel Assisting: Miss E Cooper, Office of the State Coroner

Counsel for West Moreton Health Service and Staff: Mr C Fitzpatrick of Counsel I/B Corrs Chambers Westgarth

Counsel for Various Nurses: Ms S Robb I/B Roberts & Kane

# Contents

## *Introduction*

Melina Maree Cuttler was aged 29. She was a single mother with two young children.

According to her family there had been no history of mental illness other than her mental state rapidly declining over the week preceding her death.

Shortly before 1pm on 12 February 2013, Melina's sister and a friend took her to Ipswich Hospital as they had concerns regarding her deteriorating mental health. The previous evening she appeared to be having hallucinations.

They were present in the waiting room at the Emergency Department (ED). Melina was triaged at approximately 1pm as a category 3 patient, which required she be assessed within a 30 minute period.

At 3pm a nurse from another service assessed her as almost certainly psychotic and requested an evaluation by a psychiatric registrar. That evaluation never took place.

At one point Melina and her sister had waited outside the ED building whilst the friend remained in the ED waiting for them to be attended to. At some time shortly before about 4.40pm Melina's sister left briefly to return to the waiting room to ask for help from ED staff due to concerns about Melina's behaviour. When she returned Melina was not present.

She then noticed that Melina had crossed the road and entered a construction site that was fenced off. Melina began to climb the building crane. By this time, she had completely undressed and was naked. Police were called and attended. She was seen to fall from the crane at around 4.50pm. A number of police and other bystanders witnessed the fall.

A coronial investigation gathered statements from the nursing and medical staff present at the ED that day. Medical records from Ipswich Hospital as well as from her GP were obtained.

In August 2013, the Ipswich Hospital completed a Root Cause Analysis with respect to Melina's death and provided a report to the coroner. The RCA report assisted the investigation considerably.

Assistance has also been provided to the coronial investigation by an independent medical review conducted by Dr Jill Reddan, Consultant Psychiatrist. She raises a number of matters in her report, particularly relating to the interaction between the ED and the Acute Care Team with respect to mental health patients, and further the ED's capacity to appropriately deal with presenting mental health patients.

Accordingly a decision was made to hold an inquest.

## *Issues for the Inquest*

A pre-inquest hearing was conducted on 6 January 2015 and the following issues were determined:

1. The findings required by s. 45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how she died and what caused her death;
2. The circumstances leading up to the death; and

3. The adequacy and appropriateness of the mental health care provided to the deceased by the Ipswich General Hospital Emergency Department.

## *The inquest*

A list of exhibits were tendered, which consisted of statements from a number of witnesses. The inquest heard oral evidence from a number of the most relevant witnesses who are listed below. It is not intended to detail all their evidence. Rather I will only be commenting on aspects of their evidence which may need further comment for the purpose of making my findings.

- Dr Jill Reddan
- ED Triage Nurse Kathryn Platell
- ED Triage Nurse Amanda Poulton
- RN Petrina French
- RN David Kaczmarek
- CNC Dorian Marshall
- Dr David Lincoln
- Dr Tess Greenwood
- RN Rachel Browne
- Dr Daniel Bitmead

## *Structure of Ipswich Emergency Department Mental Health*

Ipswich Hospital is a medium sized hospital. The ED had 17 cubicles with a Mental Health containment room (cubicle 13) and a Relatives Room. A new ED was also under construction at the time.

There was an ED Escalation Procedure which guides the hospital to respond effectively to early indications of increasing demand for service in order to provide timely, safe access to appropriate care to all patients. The procedure is applied at the earliest trigger point to avoid occasions of bed block, excessive waiting times, ramping, and ambulance redirection.

Level 1 indicates when the ED is running smoothly with only minor delays. Level 2 is when there are delays or ambulance ramping resulting in a degree of risk to patient safety (it is accompanied by a fax to the ambulance and a call to the on-call Medical Superintendent).

Level 3 is rarely reached, it means an extreme risk to patient safety due to ED workloads, and the situation is escalated to the Executive on call.

Evidence led at the inquest noted the escalation procedure was essentially directed to external agencies such as ambulances advising to send no more patients, rather than provoking an internal response to consider how to best direct resources within the hospital to counter the problems. The new escalation process is now the latter.

On 12 February 2013, the ED had escalated to Level 2. At around lunchtime, consideration was given to the need for further escalation but the decision was to remain at Level 2 (the ED is frequently on Level 2). Acuity and complexity was increasing and greater access to senior nursing and medical resources was required to manage the patient load.

The ED had access to a Rapid Assessment Team. This resource (consisting of 1 or 2 senior staff) was said to be able to be rapidly called together to review history and or

the patient to make a rapid assessment and commence treatment. Policy was that this should be utilised when any patient exceeded the recommended time for treatment under Triage Cat 3. This team was not accessed in Melina's case and a number of staff questioned were not aware of its existence.

The ED was assisted by the Department of Emergency Medicine (DEM) Mental Health Team. This provides a 24 hour mental health assessment service to the ED.

The Mental Health Team (MHT) comprises a Clinical Nurse (CN) working 12 hour shifts and a duty Psychiatric Registrar covering the ED shifts from 8.30am to 1.00pm and 1.00pm to 5.00pm and then an on-call Psychiatric Registrar after hours (remote call).

The MHT also had a Clinical Nurse Consultant (CNC) position working business hours who supplements the CN in assessment during periods of increased acuity for mental health. One difficulty that became evident is that this person was situated on another level.

The ED, as well as other hospital wards, had access to a Clinical Nurse Consultant with Alcohol and Tobacco and Other Drugs Service (ATODS) from Monday to Friday during normal business hours. This provided an assessment service for patients presenting with possible alcohol and drug issues. ATODS did not provide acute service or treatment.

## *The circumstances leading up to missed opportunities and a perfect storm*

The inquest investigation has revealed there were many missed opportunities to diagnose the severity of Melina's presenting symptoms and to commence treatment. If one or more of these opportunities were taken up, this may have led to a very different outcome. Dr Reddan described the events as a 'perfect storm', a phrase which had already formed in my mind during the course of hearing the evidence. It is a description I have been unfortunate enough to have utilised on other occasions.

Melina's sister, Melita Cuttler and another friend took Melina to Ipswich Hospital and initially presented at the mental health unit around lunch time on 12 February 2013. They were referred to the Emergency Department.

Melina was triaged by RN Rebecca Went at 12.54pm and allocated an Australasian Triage Scale (ATS) category 3.

The presenting problem is noted in the records as *bizarre behaviours, has illicit drug use in past few weeks and over taking usual medication, patient has been presenting to strangers claiming that they are her relatives, past mental health history unknown, friends state house is ramshackled.*

RN Went took details from Melina who at the time was laughing at some of the questions. She asked why she had presented to the ED and Melina stated she wanted a pregnancy test. She asked her questions regarding her alcohol, drug and illicit drug use. Melina stated she had not used any drugs in over a week but had previously used illicit drugs frequently in the past.

RN Went utilised the ED Mental Health Triage Assessment and Management Tool and specifically ticked the boxes for 'intrusive behaviour', 'thought disordered' and 'situational crises' boxes. She noted that this included medium risk factors consistent with an ATS 3.

The ED was quite busy on that day. There was already a patient occupying the room usually used for mental health patients and there was no other room available initially. It is also apparent that Melina was at times agitated and restless and left the ED on a number of occasions over the afternoon.

Enrolled Nurse Liftin was working as the Triage Support Nurse assisting RN Went. At 1.05pm she called Melina over the PA system twice with no response. At 1.30pm it is apparent Melina had returned to the ED and she took her pulse and blood pressure and other standard physical observations. She noted Melina displayed some agitation initially but eventually sat down and allowed her to take observations. Melina consented to supplying a urine sample and these were quickly tested with no abnormalities noted. Nurse Liftin documented a history that Melina had been displaying bizarre behaviour over the past few days, she had stopped drug use over the previous week, and that she had been hearing voices. During the course of the assessment she asked if she felt suicidal at all and Melina responded 'hell no'.

The ED mental health Clinical Nurse for the shift was CN Petrina French. RN Went says she spoke to CN French at about 2.10pm and CN French told her that she had referred the patient to ATODS. EN Liftin was present at this time and asked CN French if she wanted the urine sample to carry out a drug screen. The response was that it was requested they hang onto it as it might be needed later.

CN French says the triage nurse was not sure whether Melina came under her care under mental health or ATODS. She says she was provided with certain information including that Melina had recently used illicit substances; was disorganised and her house was a mess; she was exhibiting bizarre behaviours; showing evidence of disinhibited behaviour and believed she may be pregnant.

CN French says she informed RN Went that as the client presented primarily with illicit substance abuse she should be referred to ATODS for assessment. As the triage nurse was busy CN French says she paged the ATODS Clinical Nurse Consultant, David Kaczmarek, to assess Melina. The page was received at about 1.16pm. CNC Kaczmarek spoke to CN French who had not at this stage seen Melina.

The ED MHT Clinical Nurse Consultant was Dorian Marshall. CNC Marshall says he first became aware of Melina not long after she was triaged in the ED at around 1pm when discussing ED acuity with the morning shift Senior Medical Officer, Dr Bev Coyne. He says he discussed at the time with Dr Coyne that Melina would probably become a mental health assessment. He said this on the basis of the presentation of auditory hallucinations and a history of drug use but with no previous mental health history.

CNC Marshall did not document this opinion but says he discussed it briefly with CN French. She had mentioned an assessment from ATODS, which he says was not unreasonable but he expected Melina would also be reviewed medically but would also come back to mental health. CNC Marshall did not suggest to CN French she assess Melina.

It is still somewhat unclear why the ATODS assessment was requested in a situation where neither CN French nor CNC Marshall had met Melina and risk assessed her, even if briefly. Presumably CN French thought that her bizarre behaviour was drug induced. That almost probably is the case but the fact that there was no assessment was the first significant missed opportunity.

In any event CNC Kaczmarek attended at about 1.30pm. He says the ED was very busy and the waiting room was full and there were no cubicles or rooms available for him to review the patient. He therefore placed the triage notes back in the appropriate category 3 area and proceeded to another ward as he had several patients to see there. The fact that there was no room available caused a delay in the assessment of Melina and was another missed opportunity.

CNC Marshall had come back to the ED around 2.15pm and spoke to CN French regarding the workload in the ED and was told that it was manageable and psychiatric registrars were attending to other patients.

RN Amanda Poulton took over as triage nurse for the afternoon shift with RN Kathryn Platell as the triage support nurse. A hand over took place which included reference to Melina, who at the time was sitting in the waiting room with two female friends. Melina was said to be laughing and joking loudly. They were told that she had been referred to the mental health clinical liaison nurse. On at least two occasions Melina's sister approached the triage desk wanting to know what was happening. RN Poulton at one stage asked CN French and was told she had been referred to ATODS. It is apparent this information was not relayed to Melina or her companions.

In a breakdown of communication, CNC Kaczmarek does not appear to have told CN French he had not conducted an assessment of Melina due to there being no room available. He was subsequently contacted at 2.49pm by CN French and asked how he had gone with his assessment of Melina. He then returned to the ED and spoke to CN French who gave him the patient's notes and located a room for him.

It is by no means certain without the reminder that CNC Kaczmarek would have returned.

By some good fortune it is evident CNC Kaczmarek had very significant past clinical experience in acute mental health. The assessment took place at approximately 3pm in the relatives' room. CNC Kaczmarek described that Melina was expressing delusional beliefs and that she reported she was receiving messages over the television. In evidence he agreed she had features of psychosis but was not floridly psychotic. His assessment was that Melina had mental health concerns and he advised CN French that she required further evaluation from the psychiatric registrar. He said he did not consider her presentation required urgent attention but expected this would be followed up soon after.

CN French says she told CNC Kaczmarek that she considered that illicit substances can induce these perceptual disturbances and still considered she was primarily the responsibility of ATODS and advised him that he needed to get the client medically reviewed. He disagreed with this view and informed CN French that she needed to see Melina. The fact that CN French did not immediately conduct an assessment, including a risk assessment, was another missed opportunity. CNC Kaczmarek did not discuss the case with any other person such as the Senior Medical officer or the Clinical Nurse Consultant.

CNC Marshall says he attended the ED at 3.30pm to ascertain acuity and flow of mental health presentations. At no stage was any concern expressed for Melina, who was being seen by the ATODS nurse at the time he arrived. CNC Marshall did not assess Melina himself but he said he could have done if a room was available. By this time Melina had been in the ED for 2.5 hours and this was another missed opportunity.

At around 4pm CN French informed CNC Marshall that Melina had been referred back to mental health. He advised that the patient should be assessed, have a urine drug screen and a medical review. CNC Marshall says he took a urine drug screen kit to the ED at approximately 4.15pm, but by that time Melina again was no longer in the relatives' room. No-one seems to have recalled that urine had already been taken and was available for drug testing.

Dr David Lincoln who was the Senior Medical Officer came on shift at 3pm. There did not appear to be any handover of patients at the commencement of the shift. He noticed on EDIS that Melina was the next person to be medically assessed and was in the relatives' room.

Dr Lincoln attended at 4.25pm but Melina was not present. It is still unclear why a medical assessment had not taken place since 1pm or at least from 3pm when Dr Lincoln came on shift. This was another missed opportunity.

Melina was discussed with CN French and perhaps CNC Marshall and it was considered the patient needed to be assessed psychiatrically and medically, given a urine drug screen and some medication to assist with settling Melina. It is apparent that Dr Lincoln wrote up an order on a medication chart to administer 10mg Olanzapine orally if the nurse considered it was required by the time Melina was brought in. RN French says that CNC Marshall left to get the medication and returned with it.

CN French says she spoke to the psychiatric registrar, Dr Tess Greenwood about assessing the client. This was at about 4.30pm. It was agreed she would do this once she was finished with another client. Subsequently Dr Greenwood told her that as she was due to finish at 5pm she should speak to the next psychiatric registrar to organise the review.

Dr Greenwood had not read any part of the file and was not aware of an assessment by ATODS. She stated that usually nurses would do a risk assessment, even if it was a quick one and if the matter then became urgent the psychiatric registrar would be contacted. She stated that if a degree of urgency had been expressed, even at the late stage of 4.30pm, she would have stayed on to make the assessment.

At approximately 4.30pm Melina's sister and her friend presented at the triage desk stating that Melina was lying on some concrete pillars at the top of the ED driveway and she was refusing to return. Melita Cuttler states she was informed by a staff member at the triage desk that as Melina was not on hospital property she would need to ring the police if she was worried about her. Melita walked back to the area but Melina was no longer present.

The staff member was RN Poulton. She says she was told that Melina was at the top of the emergency entrance driveway lying on a concrete pillar and acting strangely. She says the informants appeared calm and did not indicate any urgency in addressing their concern for Melina's safety and never mentioned she was suicidal.

She accepts that she told them that as Melina was a voluntary patient she was not sure what they could do for her and if they were really concerned they should contact the police. She also stated she checked this was correct with her shift coordinator.

The shift coordinator was RN Rachel Browne. She has no independent recollection of the events but does not deny the version of events expressed by RN Poulton. She stated she has no recollection of the severity of the complaint being escalated to her. If that had been the case she states, perhaps in hindsight, that personally she would

have attended outside the ED and may have sought help from medical staff or other psychiatric services.

RN Poulton states she passed this information on to the two companions and said that if they cannot get Melina to come back in they should call the police straight away or otherwise if they can get her to come back in they had a room that she can go into. She states that the companions indicated that they thought they would be able to get her to come back in.

In any event, no attempt was made by any staff to try and locate Melina and encourage her to return at any time during the afternoon and certainly not at this critical time. This was another missed opportunity.

At approximately 4.40pm Melina was seen on the crane at the nearby building site.

Queensland Police received multiple 000 calls and attended. When they arrived Melina was sitting on the platform; she was naked. Police began to disperse the crowd below. Whilst Melina's sister was giving details to the police, the friend began scaling the scaffolding of the crane. Melina was yelling out and screaming obscenities to the friend demanding that she undress and join her at the top of the crane. Whilst this was occurring Melina had climbed over the safety railing and was hanging from the railing with her hands. Police requested the friend climb back down the crane which she did. Police continued to disperse the crowd and before they could speak to Melina or have negotiators speak to her, she released her grip and fell some 26 metres. She was clearly deceased.

## *Autopsy results*

An external autopsy examination together with toxicology testing and post mortem CT scan was ordered. This found multiple disruptive injuries and fractures of the face and skull, chest and other extremities, which would have led to instant death and were consistent with having been sustained following a fall from a height.

There was no evidence of needle puncture marks in the arms or any other tentative marks, which would have been associated with suicidal ideation or previous self-harm.

No alcohol or drugs were detected in toxicology analysis. The presence of an active ingredient of cannabis and its inactive metabolite was found.

## *Other Investigations*

### Workplace Health & Safety Queensland (WHSQ)

WHSQ investigated the incident to determine whether or not any workplace health and safety issues arose.

It concluded that no issues were identified from the investigation to suggest a broad workplace health and safety issue, which required a specific organisational response.[1]

It concluded that the only way Melina could have accessed the Watpac construction site at this level was by scaling a 1.8m high hoarding fence. The fence had no toe holds to assist her in traversing the fence and accessing the site. Vehicles were observed to be parked alongside the fence and it is thought she may have climbed on to the vehicles to assist in accessing the site.

[1] Exhibit D1.1

The investigation has shown that she deliberately accessed a fenced construction site, climbed the tower crane and fell from the crane some 26 metres. The information indicated that this does not give rise to a contravention of a duty to place reasonable controls in place. In particular, it was noted that the security fencing met or exceeded the general requirements of the Australian Standard for temporary fencing and hoardings.

## *Root Cause Analysis*

The Root Cause Analysis (RCA) was commissioned by Ipswich Hospital very quickly on 18 February 2013 and completed on 26 July 2013.

To the considerable credit of Ipswich Hospital, the report provided to the coroner, indicates the investigation was comprehensive and rigorous in its findings.

The report noted there were a number of system and process issues identified during the course of the analysis that may have contributed to the outcome in this case. The issues were discussed under individual headings.

### *Triage*

It was considered the patient was correctly and appropriately triaged as a category 3 ATS. This implies an expected time to treatment of 30 minutes.

The ED Mental Health Triage Assessment and Management Tool was initiated in keeping with local practice. It was noted that a portion of the document where there is the recording of visual observations was not completed. There may have been a level of comfort in the fact the patient was accompanied by two support persons. The report noted however, in response to a medium risk it would be considered a good practice to initiate visual observations at 10 minute intervals. This would enable monitoring and documentation of the patient's mental status and behaviour and any signs of escalation in the behaviour. Verbal handover was provided by the triage nurse to the ED mental health clinical nurse however the patient's details were written on a 'post it' note.

The triage support nurse called the patient twice over the public address system. The first secondary assessment was undertaken by this nurse at approximately 1.25pm where observations of vital signs and a urine test were undertaken. It was noted there were some behavioural signs of agitation at this stage and a denial of any suicidal ideation.

The report considered that the process of referral needs to be strengthened as details were not physically written/documented about the handover and further education is required in the use of the Management tool and annual competency must be strongly recommended.

### *Referral to the Emergency Department*

The RCA noted the triage nurse was aware of the acuity of the ED at the time and was also aware of delays in registering patients on the hospital information system. It was considered there was a timely referral made to the ED mental health clinical nurse who was provided with a brief verbal handover.

Usually the ED mental health nurse is paged and attends but on this occasion the ED mental health clinical nurse made a decision to request an assessment from ATODS without having seen the patient.

The patient had no previous history of contact with either mental health services or ATODS.

The RCA noted one of the features suggesting the need for more urgent assessment during the triage is that the patient had no known psychiatric history. The RCA team considered the patient should have been seen by a mental health clinician prior to being referred and seen by ATODS. This is because the patient had presented displaying symptoms of a possible psychotic disorder, which would make it primarily a mental health issue, regardless of whether drugs were involved or whether drugs contributed to the illness.

### *Assessment by ATODS*

At some time around 1.15pm the ED mental health clinical nurse paged the ATODS clinical nurse consultant. Upon arriving in the ED the ATODS CNC found the ED was very busy and there were no available rooms to see the patient. He returned to continue other duties in other wards.

The ATODS CNC was again paged at 2.49pm and he returned. A room was organised for him to assess the patient. The assessment clearly documents the presence of psychotic symptoms and states there is no evidence of an acute intoxication. Verbal handover was made to the ED mental health clinical nurse on the outcome of the assessment and the patient was then correctly referred back to ED mental health. The ATODS CNC commenced writing notes of the assessment and left them on the mental health clinical nurse's desk.

The RCA recommended that a process be developed in relation to the outcomes of referral within the ED. Any assessment performed by an external consultation within the ED needs evidence that a written and verbal handover of the outcome is made to the medical officer in charge.

### *The capacity of the Emergency Department*

The hospital had an ED Escalation Procedure to assist guiding staff to respond effectively to early indications of increasing demands to the service. It noted the procedure is routinely applied at the earliest trigger point to avoid occasions of bed block, excessive waiting times, ramping and ambulance redirection. Level I occurs when the hospital is running smoothly with only minor delays. Level II is when there are delays or ambulance ramping resulting in a degree of risk to patient safety. Level III is an extreme risk to patient safety and is rarely reached.

On 12 February 2013, the ED had escalated to level II and around lunchtime consideration was given as to whether a further escalation was required but the decision was made to remain at level II.

At times when the ED has extreme waiting times, primarily for category 3 patients in the waiting room, resources can be rapidly called together to review history and/or the patient to make a rapid assessment and commence treatment. The RCA recommended that any patient who exceeds a recommended time to treatment under triage category 3 in the waiting room should have a Rapid Assessment Team review and care plan instigated.

On the day in question between 8am and 5pm there were six mental health presentations to the ED. All referrals were given a category 3 ATS. Two patients who arrived early in the morning were fully assessed by the mental health clinical nurse and discharged home with Acute Care Team follow up in the community. Another patient

was admitted to the mental health unit. They were all seen by a psychiatric registrar or case manager. The patient to arrive after Melina was seen by the clinical nurse and later the psychiatric registrar and was admitted to a private hospital.

The RCA noted that notwithstanding the ATODS assessment, the patient's condition or the waiting times, a flag was not raised about the need to escalate.

The RCA noted that given this was a first presentation in a psychotic state, a medical examination to rule out any general medical condition would be considered very important. In keeping with protocol a locum medical officer was allocated to Melina for this examination. The medical officer attended at 4.25pm by which time she was no longer in the clinical area. The medical officer wrote a prescription for oral olanzapine after having spoken to the mental health clinical nurse and advised of the outcome of the assessment of the ATODS clinical nurse consultant, but without having seen the patient.

The RCA noted there was minimal documentation during the presentation with the majority of the notes written retrospectively. It was known that the patient had psychotic symptoms and this was noted at the time of triage, and the patient met the criteria for medium risk. The high vulnerability risk was not formally acknowledged but this was mitigated to some degree by the presence of the two support persons, up until the time that the patient's behaviour became unmanageable.

The RCA stated there needs to be greater accountability for communication from the ED mental health to the ED proper.

There was no escalation of concerns for the patient to the shift coordinator. Where there are concerns, the usual practice is that the shift coordinator would find a safe location for the patient within the ED. The RCA noted the patient should have been seen by the ED medical officer and/or had a mental health assessment performed by a mental health clinician within the allocated 30 minute time frame. The RCA recommended that if a patient has not been seen within the time for treatment as allocated, this must be escalated transparently through all levels of staff. The ongoing review of the patient needs to be documented including all aspects of care, observations, communication with family along with any intervention or escalation to senior staff.

### *Request from support persons for assistance*

The RCA noted that the patient's sister and friend presented to the triage desk at 4.30pm and reported words to the effect the patient was lying on the concrete pillar in the ED driveway and would not come back. They were advised to contact the police if they required assistance to bring her back.

There was no active intervention made by staff of the ED to support the sister and friend to return the patient. Consideration was given to the fact that the patient was voluntary and was not subject to the provisions of the Mental Health Act. Based on known information at the time there were no immediate concerns for the patient's safety and so no consideration was given to the use of the Guardianship & Administration Act to return the patient to the ED.

The RCA stated there was a duty of care owed to the patient and there should have been some attempt made by staff to provide assistance and to support the return of the patient to ED. There needs to be an internal escalation process for when staff at the front end of the ED have concerns, or when relatives raise concerns, in relation to

a patient's presentation. There also needs to be further education on the legal aspects of care in the ED, including duty of care, the Mental Health Act and the Guardianship and Administration Act. This education should include both ED clinical and ED mental health personnel.

### *Conclusion*

In conclusion the RCA stated the importance of developing a safety plan at the time of triage to support the patient's journey within the ED could not be overstated. There were 2 main issues highlighted in this case.

1. There was a significant delay for various reasons before the mental health clinician attempted to assess the patient; and

2. There had been no medical examination of the patient. Given that the patient was psychotic and her accompanying support parties were requesting the assistance of hospital staff to return her to a safe environment, this assistance should have been provided in the context of a duty of care to the patient.

### *Recommendations made by the RCA*

### First contributing factor – Patient not seen within the recommended time to treatment for Cat 3 (ATS) by either the ED Medical Officer or the MH Team

1. Further education for relevant ED clinicians (both general and mental health) on the use of the ED Mental Health Triage Assessment and Management Tool to be completed by 31 October 2013.

2. The DEM Mental Health Clinician will liaise with the ED SMO and/or Shift Coordinator as soon as practicable after triage of a mental health presentation to discuss and confirm that the Risk Management Guidelines within the Tool are appropriate for each individual patient, that the safety plan is adequate to support the safe management of the patient within the ED and that this confirmation is documented into the Tool. To be completed by 31 October 2013.

3. A process needs to be developed in relation to the outcomes of referral within the ED. Any assessment performed by an external consultation within the ED needs evidence that a written and verbal handover of the outcome is made to the Medical Officer in charge of the Department or their delegate. This process needs to be formalised into a Work Instruction by 30 September 2013 – all work instructions and protocols need to be published on the intranet.

4. The current process for Rapid Assessment Team review needs to be formalised into a work instruction so that any patient located in the ED waiting room who exceeds the recommended time to treatment under the Triage Cat 3 has a timely review and a care plan instigated – all work instructions and protocols need to be published on the intranet. To be completed by 31 October 2013.

5. The ED Work Instruction for Rounding in the Waiting Room needs to be updated by 30 September 2013 to include a clear matrix of escalation for Triage staff, for any at risk or deteriorating patient, or Triage Cat 3 patients who have exceeded their recommended time to treatment. A

continual review of the patient needs to be documented and all aspects of care (e.g. visual obs, communications with family and intervention or escalation to senior staff) - all work instructions and protocols need to be published on the intranet.

6. An internal escalation process needs to be developed by 30 September 2013 for when staff at the front end of ED (triage/waiting room) have concerns, or relatives raise concerns, in relation to a patient's presentation. To be completed by 31 October 2013.

7. There needs to be further education on the legal aspects of care in the ED (including duty of care, MHA, GAA) that targets both general ED and DEM, MH personnel. An annual refresher should be built into the program. To be completed by 31 October 2013.

### *Outcomes and implementation of RCA recommendations*

Dr Bitmead and Dr Stedman detailed in their respective statements, the outcomes and implementation of the RCA recommendations. Many of the recommendations had been implemented. Some were in the process of this occurring. Others were completed shortly after the inquest and others are still ongoing and will be for some time after the conclusion of the inquest. A further report from WMHHS was received by my Office on 6 March 2015.

It was clear that communication of the recommendations needed to be improved as some of the clinical staff who gave evidence, were not aware of some of the changes or packages. Examples were in relation to the Rapid Assessment Team and the Escalation Policy. In submissions, Counsel for the Hospital, Mr Fitzpatrick, acknowledged this on behalf of his client and stated his client will address these concerns. Below is a brief summary of some of the work being done to implement the recommendations.

1. *Further education for relevant ED clinicians (both general and mental health) on the use of the ED Mental Health Triage Assessment and Management Tool to be completed by 31 October 2013.*

- An educative poster was developed and located in the triage room for staff to refer to. This amongst other things prompts triage staff to consider the presence of psychotic symptoms (bizarre or agitated behaviour) or mood disturbances (elevated or irritable).

- A Copy of the poster and a booklet titled 'Emergency Department Mental Health Assessment and Management Tool Education Package Pre-Readings (attach 5) provided to each triage nurse within ED and one-on-one small nurse group education sessions were then held with the Nurse Educator from the Nursing and Midwifery Education Service.

- A revised triage tool now provides great detail about the types of observations that may be made of atypical presentation and specifically prompts staff to consider the presence of psychotic symptoms such as bizarre or agitated behaviour has was reported this case.

- To date 91% of targeted staff have now completed further education in the use of the tool as well as a 4 hour refresher course for staff who have previously received training will be commenced.

2. *The DEM Mental Health Clinician will liaise with the ED SMO and/or Shift Coordinator as soon as practicable after triage of a mental health presentation to discuss and confirm that the Risk Management Guidelines within the Tool are appropriate for each individual patient, that the safety plan is adequate to support the safe management of the patient within the ED and that this confirmation is documented into the Tool. To be completed by 31 October 2013.*

- Work was still ongoing to achieve implementation of this recommendation at the time of the inquest but the latest advice is that this has now been created and was undergoing review. A pathway in the form of a checklist for mental health consumers to progress through the ED has been drafted and will be trialled commencing 1 April 2015 for a period of 2 months. The process being proposed is that:
    - The patient is triaged by the ED triage nurse using the ED Mental Health Assessment and Triage Tool including any reference to the MHA
    - The triage nurse then contacts the DEM-MH clinician via pager or phone
    - The DEM-MH clinician then checks CIMHA for history and/or alerts – the ED mental health clinician to acknowledge to advise the ED clinician of any pertinent clinical information
    - The DEM-MH clinician to attend and review the triage tool and plan and to advise of any anticipated delays with commencing the assessment
    - The DEM-MH clinician to assess the patient as clinically indicated
    - The DEM-MH clinician to refer the patient to Psychiatric Registrar as clinically indicated
    - The DEM-MH clinician communicates the progress of the assessment and the proposed plan to the nominated ED clinician and ED shift co-ordinator

- A Major clinical redesign project took place commencing in June 2013 – demand rostering and staff increases were a result of that redesign. There is now a Psychiatric Registrar onsite with the DEM-MH team 24/7 except for overnight Fri/Sat and on-call Sundays. There are also 2 Clinical Nurses from the DEM-MH team on duty for almost all shifts within the ED
- The Electronic Journey Board is another development of WMHHS – the Board displays patient information for clinical staff and allows this information to be updated throughout the care delivery process, from admission through to discharge.
- WMHHS has also increased its consultation space for MH patients – at the time of Melina's death there only one consultation room (room 13). The ED now has four dedicated examination rooms as a result of the ED redesign

- At the time of Melina's death the DEM-MH office was located on a separate floor to the ED – since the redesign it is now located on the same floor, just behind the triage desk such that communication can now flow more efficiently and easily.

3. *A process needs to be developed in relation to the outcomes of referral within the ED. Any assessment performed by an external consultation within the ED needs evidence that a written and verbal handover of the outcome is made to the Medical Officer in charge of the Department or their delegate. This process needs to be formalised into a Work Instruction by 30 September 2013 – all work instructions and protocols need to be published on the intranet.*

    - An internal workplace instruction has been developed which describes the process for referral to a specialist team to attend patients within the ED The work instruction also outlines the process for teams to notify ED staff of the outcome of the referral
    - Since Melina's death, WMHHS has also developed a number of other procedures with a view to improving clinical handovers.

4. *The current process for Rapid Assessment Team review needs to be formalised into a work instruction so that any patient located in the ED waiting room who exceeds the recommended time to treatment under the Triage Cat 3 has a timely review and a care plan instigated – all work instructions and protocols need to be published on the intranet. To be completed by 31 October 2013.*

    - Since the death, the RAT review process has been formalised into a workplace instruction – the aim of the RAT is to ensure a timely review by a senior clinical decision maker who initiates a care plan for those patients who do not have an allocated treatment area or clinician within the ED
    - The RAT process is a targeted history and examination of the patient which should be completed in less than 10 minutes – if the assessment identifies a deteriorating or unstable patient, the Logistics nurse is to be contacted immediately to find an appropriate treatment space for the patient and the SMO team leader also needs to be notified.

5. *The ED Work Instruction for Rounding in the Waiting Room needs to be updated by 30 September 2013 to include a clear matrix of escalation for Triage staff, for any at risk or deteriorating patient, or Triage Cat 3 patients who have exceeded their recommended time to treatment. A continual review of the patient needs to be documented and all aspects of care (e.g. visual obs, communications with family and intervention or escalation to senior staff) - all work instructions and protocols need to be published on the intranet.*

    - Work instruction has been developed and published on the intranet. It requires that all patients in the ED waiting room have a secondary assessment completed by the triage nurse in a timely manner – once this is completed, follow up routine rounding will be completed
    - The instruction applies to all ATS Category patients – in particular for ATS Cat 3 patients, the rounding is to occur half hourly with a view to briefly assessing and detecting any deterioration

- Physical observations and interventions are recorded in the patient's notes along with the assessment of any interventions given to the patient. Communication with the patient and/or family must also be documented appropriately.

6. *An internal escalation process needs to be developed by 30 September 2013 for when staff at the front end of ED (triage/waiting room) have concerns, or relatives raise concerns, in relation to a patient's presentation. To be completed by 31 October 2013.*

   - Extensive consultation has occurred between the ED and the Mental Health Specialised Service Division – the RAT Work instruction works towards eliminating the risks posed by patients who have been waiting longer than the ATS timeframe
   - WMHHS has also committed to the implementation of 'Ryan's Rule' within the health service – this Rule ensures that clinical staff and teams ensure that they recognise and act on clinical responses for all patients who deteriorate. Recognising signs and symptoms of deterioration must be accompanied by appropriate and timely clinical care
   - The 'Patient Flow and Access Targeting Model' is supported by a suite of procedures and standardised daily work instructions that prescribe a whole of search approach to better manage the journey for patients. One such example is the 'ED Internal Escalation Procedure'.

7. *There needs to be further education on the legal aspects of care in the ED (including duty of care, MHA, GAA) that targets both general ED and DEM, MH personnel. An annual refresher should be built into the program. To be completed by 31 October 2013.*

   - Nursing and Midwifery Education Services in consultation with the Queensland Centre for Mental Health Learning designed an online training program relating to 'capacity assessment in mental health'. – the training is designed to assist clinicians to understand the requirements for assessing capacity in relation to consent for mental health assessment and treatment and general health care. The training explores the avenues that staff can take for substitute decision making if a person has impaired decision capacity

   - At the time of the inquest, compliance rates were at 66% - the update provided by WMHHS on 6 March 2015 shows that figure has risen to 99%.

   - With respect to Dr Reddan's opinion in her report of the insufficiency of ED staff merely instructing Melina's sister and partner to call the police if Melina would not come back inside the ED on her own – WMHHS has in place a procedure which relates to circumstances in which patients wish to discharge themselves against the medical advice from the Adult Mental Health Unit.

   - A whole of service framework needs to be created so as to address this situation – WMHHS is in the process of developing a procedure which will:

     - Clarify the boundaries of health service facilities

- Clarify the duty of care owed to patients (whether on or off facility grounds) and how this is to be balanced with a patient's right to refuse treatment
- Ensure that appropriate advice is given to patients (or their friends or relatives) in circumstances where they have left hospital grounds against medical advice, or are refusing to wait or return for treatment
- Ensure staff consider alternate methods (other than the police) in the first instance for achieving a result whereby the patient returns voluntarily to the hospital (i.e. contacting the ACT team leader or a SMO and asking them to approach/contact the patient)
- Ensure that appropriate internal escalation pathways are triggered according to the needs of the individual patient and the urgency attaching to them

WMHHS provided an update regarding this whole of service framework on 6 March 2015. The update had specific regard to Dr Reddan's opinion that merely instructing Melina's sister and partner to call the police if Melina did not want to come back to the ED was insufficient.

WMHHS advised that a whole of health service overarching procedure was being developed for patients in situations where they are refusing to wait or return for treatment or wish to discharge themselves from the hospital against medical advice. The aim of the procedure will be to ensure that staff first adopt a practical and common sense approach in making attempts to prevent a patient from leaving including for example:

- Asking for a relevant medical officer and or social worker to attend and talk to the patient or make contact with the patient
- Considering/enquiring as to the reason for why the patient wishes to leave or refuses to return for treatment in the first place and whether there are any solutions to address the reason
- Identifying family members or friends who might be persuasive in getting the patient to return for treatment or helping to eliminate the need for a discharge against medical advice.

WMHHS will continue to provide me with updates as to the development of this procedure.

### *Structure of the mental health service within the ED*

The MHSS provides entry to the service through the Acute Care Team (ACT) – this team includes the community based ACT, the Department of Emergency Medicine Mental Health (DEM-MH) and a hospital based Consultation-Liaison Team.

The ACT sits within the MHSS Division. The DEM-MH team works with the ED whereby patients attending the ED remained under the care of the ED while the mental health team assessed the patient and provided a recommended treatment plan.

New pathways regarding urgent and non-urgent admissions are currently being developed which will include avenues for direct admissions. WMHHS provided an

update on 6 March 2015 advising of new procedures aimed at ensuring that a patient's admission does not need to occur via the ED. This includes direct admission patients known to the acute care team or continuing care team and those requiring admission following a court hearing or from custody. Where an admission from the ED is required, a new work instruction has been implemented outlining the process and documentation required for this process.

Dr Reddan commented that once the ATODS assessment confirmed that Melina was psychotic (approx 3.30pm), her care should have been escalated. It was stated that extensive consultation has occurred between the ED and the MHSS to improve the internal escalation pathways and reporting on the outcomes of referrals made by the ED to the DEM-MH team with draft work instructions completed.

Dr Reddan gave evidence to the effect that in her opinion, the Department of Emergency Mental Health Team should be led by a psychiatric registrar. Dr Bitmead considered that subject to resources within mental health services within the hospital, this could be a positive possibility.

## *Report of Dr Jill Reddan*

Dr Reddan is a consultant psychiatrist with extensive experience both in the private and public mental health systems.

She was asked to review the medical records, statement of witnesses and Root Cause Analysis.

Dr Reddan noted that Melina appears to have first presented at Springfield Medical Centre during the first half of 2010 and was at this time taking the antidepressant and anxiolytic medication, fluoxetine. It was noted she was a single mother of two children and appeared to have been suffering from stress, anxiety and some degree of depression largely due to her circumstances and perhaps family problems. There are references also to her taking other antidepressants as well as the appetite suppressant Duromine and Sudafed (pseudoephedrine), both of which are essentially stimulants and can be abused.

She was referred to a psychologist in May 2012 and was seen on two occasions. At that time she was taking Pristiq (desvenlafaxine).

From the records, it appears that at no time did Melina inform either her general practitioner or the psychologist that she was smoking marijuana and abusing amphetamines and possibly abusing other drugs. Her last visit to her general practitioner was on 2 February 2013 when she complained of anxiety.

Dr Reddan said that of significance there is no reference in these medical records of any evidence that she presented as psychotic or with an elevated mood or any oddness or bizarreness about her.

Her sister noted that in approximately February 2013 she was beginning to make some quite odd and strange statements. Dr Reddan considered the overall clinical picture suggests that Melina's psychotic illness came on rather quickly and escalated rapidly.

Dr Reddan was requested to address a number of specific issues.

1. *The appropriateness of the suicide and/or risk assessment conducted by staff at the Ipswich Emergency Department*

Dr Reddan stated it was by no means clear that Melina suicided and it is more likely her death was accidental but nonetheless directly related to the psychotic illness she was suffering from at the time. She stated this was a matter for the coroner to determine.

The assignment as a category 3 case based on the Australian Triage Scale (ATS) was reasonable given the information available to the triage nurse when Melina presented, but that does imply that further assessment and treatment should commence within 30 minutes. There was no evidence at that time that Melina presented a major risk to herself or to others beyond the general risk that psychosis entails.

The ATS does include behavioural or psychiatric indicators as part of the triage process but it is not a high risk assessment scale beyond providing a guideline as to the urgency and timeframe of further assessment. Dr Reddan said that there is no substitute for a risk or clinical assessment. In the first instance this could be nurse or junior doctor led and in an ED setting, does not have to be a comprehensive assessment.

2. *Whether the level of the observations of the deceased during her attendance at Ipswich Hospital ED were appropriate*

Although Melina was spoken with and observed by staff on a number of occasions there appears to have been no formal or standardised observations recorded until approximately 1.30pm when the triage support nurse took some observations of her vital signs and organised a urine test. From then on no further observations, other than general ones and the assessment by the clinical nurse with ATODS, are recorded.

The determination that Melina warranted an ATS score of 3 suggests that more regular observations should have been undertaken, even if those observations were visual only. It is likely the fact she was with two adults may have caused the attending staff to be complacent.

3. *Whether the care and treatment of the deceased during her attendance at the emergency department was appropriate*

Dr Reddan stated it is a little unclear why the mental health clinical nurse asked the ATODS nurse to come to see the patient, when the initial history suggested the patient was psychotic. The mental health clinical nurse should have seen the patient herself, even if briefly, to determine what priority was or was not required.

Whether her mental state arose from drug use or not is a relevant consideration for later treatment but not necessarily an immediate relevant consideration in the ED. It is possible that as the ED was busy and crowded, this influenced this decision. However, once it became clear from the ATODS nurse's assessment that Melina was psychotic, her case should have become more of a priority. Dr Reddan stated that the mental health CNC Dorian Marshall should have ensured that Melina was being regularly checked or he should have sought to reduce what had already become a relatively lengthy delay.

Dr Reddan stated it was unclear as to what other duties the CNC had that day but that person is in an ideal position to deal early with the triage nurse and

short circuit obstructions or delays. Dr Reddan stated in evidence a senior clinician should have been providing leadership and structure as to what to do.

Dr Reddan stated that in her view the mental health clinical nurse should have been informed about Melina refusing to return to the ED and then checked on her. If she refused to return, further assistance, whether from staff or police may have been needed. Dr Reddan stated there was too much focus by many mental health staff in hospitals generally on the police doing their job for them.

Dr Reddan stated there were lapses in communication and no medical staff were involved and no-one was giving direction.

4. *Whether adequate steps should have been taken by hospital staff to return the deceased to a safe environment*

Dr Reddan stated that clear instruction or advice needs to be given to hospital staff about what they are to do if or when a disturbed patient leaves the hospital premises. Merely instructing family or friends to call the police is insufficient. This is an area of ignorance for many hospital employees and the health region should take steps to resolve any uncertainty.

Dr Reddan stated in evidence that a more commonsense approach should have been taken on this issue. Clinical staff move all over the community and simply leaving it to the police lacked commonsense.

5. *Other issues*

Dr Reddan stated that Emergency Departments are far from ideal places for mentally ill persons to be initially assessed, but understandably very often patients and their concerned relatives or friends have nowhere else to go. Dr Reddan stated that patients should be assessed relatively quickly in the ED and the long delays that often occur can be shortened by some creative practices and goodwill which needs to be driven by senior and experienced medical and nursing staff.

At some services, the Clinical Director and/or Team Leader of the Acute Care Team would be in frequent contact with the ED staff to short circuit delays and supervise what is going on. Involvement of more senior medical and nursing staff from the Acute Care Team can support staff in the ED to make quicker and more effective decisions.

Melina's death in this manner was a very rare outcome, however it does remind everyone that an undiagnosed and unassessed psychotic illness can be a medical emergency.

Dr Reddan was of the view the RCA was very good and the level of attention to detail excellent. She stated that one area that was not addressed is whether there may be a better way than attendance at the ED for patients with acute/severe mental illness. There also is no attention paid to how, if a patient does have to go to the ED or presents there, the patient can be more quickly assessed and moved on to the next stage of care. That would require a more service wide approach to the assessment and management of patients presenting to the service.

Dr Reddan noted the many recommendations but noted the most significant changes were:

- More rooms available for assessments;
- The mental health clinical nurse consultant was now situated within the ED;
- More mental health clinical nurses on each shift;
- A demonstrated shift in clinical governance.

Dr Reddan stated the substantial improvements to the NEAT targets in less than a year was impressive and this was good for patients.

Dr Reddan stated the only concern for her was how and where the psychiatrists fit in the governance and in her opinion a psychiatric registrar should be in charge.

## *Conclusions*

### Suicide or misadventure- the circumstances leading up to the death

Suicide has been defined as[2]:

> *Voluntarily doing an act for the purpose of destroying one's own life while one is conscious of what one is doing*.

It has been said elsewhere[3] that *a coroner cannot make a finding that a deceased person died by suicide if the person lacks the mental capacity to form an intention to end their life. The deceased may have lacked capacity if they were mentally ill, intellectually impaired, psychotic, extremely distressed, under the influence of alcohol or drugs or very young.*

In practice, the issue of whether the deceased lacked capacity to form an intention to take his or her own life does not often arise, largely because most people suicide alone or in private and there is little or no evidence as to what the person was thinking at the time. More often there is other collateral evidence such as previous threats to suicide or notes left (or as is more frequently now occurring social media messages) indicating the intention.

As Dr Reddan reflected, Melina's death was in a rare category of cases where the tragic outcome and circumstances of her clearly psychotic state was witnessed by many.

Importantly in this case, as noted by Dr Reddan, there was no history of depression, past threats of suicide or any history of self-harm. She was not talking about ending her life in the few hours she was in the ED. It is also clear from the evidence of eyewitnesses outside the ED who spoke to Melina as she approached the area of the crane and stating she wanted to see the crane driver, that she was psychotic. She was not talking about taking her own life.

It is evident that from the time around 3.30pm and over the next hour that her condition deteriorated quickly and her psychosis became florid.

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[2] *R v Cardiff City Coroner, ex parte Thomas* [1970] 1 WLR 1475 at 1478

[3] *Suicide Reporting in the Coronial Jurisdiction,* Coronial Council of Victoria Consultation paper, 23 April 2014

I have come to a conclusion that Melina lacked the capacity to form an intention to take her own life and in this case her death was due to misadventure. However, her psychotic condition was responsible for placing her on the crane and falling, and is therefore directly causal to how she died.

## The adequacy and appropriateness of the mental health care provided to the deceased by the Ipswich General Hospital Emergency Department.

There is little doubt that what occurred on this day was not capable of being predicted. As Dr Reddan stated, these events were a very rare outcome.

That does not mean the death could not have been prevented. There were multiple opportunities available during the afternoon of 12 February 2013 where a different outcome could have been achieved by some form of intervention of mental health staff. It is likely Melina would have been provided medication, observed closely and perhaps admitted to a more secure mental health ward at any one of these opportunities.

It is accepted the ED that day was very busy, although the evidence suggests this was always a busy ED. Interview rooms were at a premium. Melina was also not displaying overtly concerning behaviour. There was no previous mental health history or presentations to consider. She was at times seen to be laughing and jovial. At other times she was restless and agitated but was not loud or aggressive. She was with two support persons. Accordingly, it may be a sense of complacency set in, as this type of presentation drew no particular alarms over and above usual presentations.

However, as Dr Reddan stated, *you need the infrastructure, the processes and good staff, to deal with most of the cases pretty well."* Some of this was absent this day.

The infrastructure that failed that day included;

- the lack of sufficient waiting rooms
- limited numbers of staff to cope with a busy ED
- the fact the clinical nurse consultant was not based on the ED floor
- generally a lack of leadership in decision making on the ED floor.

The processes that were absent or failed included:

- no internal escalation process
- no clear post triage process where there was a plan made by relevant mental health ED staff to manage the patient through the ED
- inadequate handover processes
- no known process to utilise a Rapid Assessment Team member
- no clear process to escalate when a patient has exceeded the recommended time for treatment
- a failure to escalate in the face of family concerns (Ryan's Rule)
- no clear understanding or process as to what to do in situations where the patient was refusing to come back to the ED.

This combination of infrastructure and process issues compounded in a number of staffing judgments. These include:

- The fact that the MH Clinical Nurse did not assess the patient initially on the basis of the triage assessment, even if briefly
- The delay in the ATODS assessment due to there being no assessment room
- The fact the MH Clinical Nurse did not assess the patient soon after the ATODS assessment

- The fact no medical officer examined or assessed Melina in the 4.5 hours she was there
- Leaving the family to try and encourage Melina to return to the ED and the fact no-one thought to actually go to Melina outside the ED when her companions expressed concerns.

The Perfect Storm hit. Melina's family had taken her to Ipswich Hospital, having properly recognised she was experiencing a deterioration in her mental health. There was sufficient information available to suggest this was a psychotic deterioration. Melina and her family had a reasonable expectation she would be assessed and treatment considered and commenced in a reasonable time. That did not occur. Despite the fact she was clearly psychotic, no treatment commenced in the 4 to 5 hours she attended at the hospital. If that treatment had commenced, it is more likely than not this tragic death could have been avoided, at least at that time.

## *Findings required by s. 45*

**Identity of the deceased** – Melina Maree Cuttler

**How she died** – Melina had been experiencing a deterioration in her mental health over a short period. She attended Ipswich Hospital mental health unit and was directed to the Emergency Department. She was triaged such that she was meant to be assessed within a 30 minute period. That assessment was delayed and due to failures in a number of areas, no treatment commenced. Her psychotic state deteriorated rapidly. She left the Emergency Department. Despite requests to staff by her companions for assistance to return her, this did not occur. Melina made her way to a nearby construction site, undressed, climbed a crane and shortly after fell from the crane at a height of 26 metres. Due to her psychotic state she did not have the capacity to form an intention to take her own life. Her death was due to misadventure.

**Place of death** – Chelmsford Avenue Ipswich QLD 4305

**Date of death**– 12 February 2013

**Cause of death** – 1(a) Multiple injuries due to
1(b) Fall from a height

## *Comments and recommendations*

I am generally satisfied that the Ipswich Hospital has taken very seriously, structural and process failures, which contributed to the combination of events which all met and produced the environment for these events to occur. The

WMHHS has expressed its sincere condolences to her family and acknowledge the difficulty they must have experienced in the years that have followed.

A comprehensive Root Cause Analysis has recognised these failures and has produced a significant body of recommendations, which if implemented in an effective manner, should mean that patients meeting Melina's criteria would not be left in the waiting room for over a four hour period without treatment having been commenced.

I have some concerns with respect to the effectiveness and progress in implementation of the recommendations, given the evidence from a number of staff which indicated that some of the stated improvements in processes and training had not yet reached them.

Fortunately, the inquest has highlighted those matters to senior hospital staff and I have received some assurance that the hospital will take this on board.

Training and effective processes are of course important but only part of the solution. Of some significance in my view are the staffing changes and infrastructure improvements to the ED building, which have already been implemented. With or without processes and training, it is distinctly possible that with more staff on board that afternoon, and rooms available to complete an earlier assessment, the tragic events would have been avoided.

On that basis, I do not intend to make any other specific recommendation other than I expect my office should receive appropriate updates as to the implementation of the improvements over the next 12 months.

I have also noted the evidence of Dr Reddan to the effect that in her opinion, the Department of Emergency Mental Health Team should be led by a psychiatric registrar. Dr Bitmead considered that subject to resources available to mental health services within the hospital this could be a positive possibility.

**Accordingly I recommend that West Moreton Hospital and Health Service consider the structure of the Department of Emergency Mental Health Team at Ipswich Hospital and in particular as to whether its leadership structure should include a position for direct psychiatric input and leadership.**

My own condolences to the family are expressed. I close the inquest.

John Lock
Deputy State Coroner
Brisbane
13 March 2015