

FINDINGS INTO THE DEATH OF MIJO GALINEC
[2014] ACTCD 2 (2 June 2014)

CORONERS ACT – *Coroners Act 1997 (ACT)* s13 – absconding patient policy – patients experiencing psychiatric or psychological issues in an open ward – clinical handover

Coroners Act 1997 (ACT) s13

Mental Health (Treatment and Care) Act 1994

No. CD 77 of 2013

Chief Coroner Walker
Coroners Court of the ACT
Date: 2 June 2014

IN THE CORONERS COURT OF THE
AUSTRALIAN CAPITAL TERRITORY

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No. CD 77 of 2013

In the matter of an inquest into the death of MIJO
GALINEC pursuant to section 13 of the
Coroners Act 1997 (ACT)

F I N D I N G S

Chief Coroner: Lorraine A Walker
Date: 2 June 2014
Place: Canberra

THE COURT FINDS THAT:

1. The deceased was Mijo Galinec, born [redacted]September 1943, late of Latham.
2. Mr Galinec died between 8.12 am on 21 March 2013 and 2 pm on 28 March 2013 at Gaunt Place, Garran in the Australian Capital Territory.
3. The cause of death was suicide in the form of asphyxia by hanging. The issues of public safety are those which are identified in the following. I make no adverse comment regarding any individual; however, my recommendations are directed to the issues included below and will be directed to the Director-General of ACT Health.

Scope of the inquest

4. An inquest was held into the death of Mijo Galinec. Submissions received at the close of the inquest were largely uncontroversial, in relation to the factual issues and I have drawn heavily on those facts detailed in the submissions of counsel assisting, much of which was agreed by the Territory, the other represented party. Following the inquest the

circumstances regarding the death of Mr Galinec are as clear as they are ever likely to be. Unfortunately a significant question remains as to just when Mijo Galinec took his own life.

5. Mr Galinec was born in Croatia, just outside the capital city of Zagreb on [redacted] September 1943. In 1970 he arrived in Australia where he and his wife raised five children. In 2011 Mr Galinec was diagnosed with prostate, thyroid and bowel cancer. Mr Galinec had operative procedures to remove these cancers, together with radiotherapy and chemotherapy. He had an ongoing problem with incontinence as a result of the prostatectomy and after various treatments he suffered some memory loss. He became very depressed. Mr Galinec decided to end his life as a result of his medical prognosis. He told his daughter that he had had in mind to take his life sitting in the car on a hot day, but eventually left and went home.
6. A further attempt was made in March of 2013 when he consumed a significant amount of alcohol intending to drown himself in Lake Ginninderra. He was taken to the Canberra Hospital's Intensive Care Unit. He had a 24 hour one-on-one attendant, (a "special") ordered due to the suicide attempt. After his physical condition improved he was discharged from the Intensive Care Unit and admitted to the Medical Assessment and Planning Unit, or "MAPU" on ward 7B. At that time a 'special' attendant was still in place. He was seen by the psychiatric team on the MAPU unit, that team being headed by Dr Bernadette Murphy.
7. The psychiatric team registrar, Dr Anuradha Thirupathy, examined Mr Galinec on his arrival on the ward on 13 March 2013. Mr Galinec's family was present and assisted Dr Thirupathy in understanding the history of his medical conditions and attempts at suicide. Dr Thirupathy found that he was distressed and overwhelmed due to the suicide attempt and the impact it had had on his family.
8. Dr Thirupathy continued the one-on-one 'special' and determined to review Mr Galinec the next day. Mr Galinec agreed to stay in hospital as a voluntary patient and was willing to accept treatment. A note was made that if he attempted to leave the hospital or refused medication, then an order to detain him pursuant to the Mental Health Act could be utilised. Mr Galinec was reviewed on 14 March 2013 by Dr Thirupathy. A full assessment of his psychiatric condition was undertaken and after consultation with Dr Murphy it was decided that he no longer required a one-on-one attendant as he was not experiencing suicidal thoughts or planning suicide.
9. Dr Murphy stated that a number of factors mitigated against continuing the special one-on-one attendant, which included the improvement in his mental state, his willingness to engage in treatment and to transfer to a mental health facility and his agreement to remain in hospital until his transfer. The fact that he had openly discussed with his family about his suicidal ideation and his promise that he would remain in hospital were also considerations.
10. On 15 March 2013 Dr Murphy and the team reviewed Mr Galinec. Dr Murphy noted that there was an improvement in his mental state, noting that his mood was cheerful and reactive. Mr Galinec was diagnosed with a major depressive disorder with psychotic

features and was commenced on Olanzapine. Dr Murphy ordered that he be transferred to the Older Persons' Mental Health Unit at Calvary and he was placed on a waiting list for that admission. On 18 March 2013 Dr Thirupathy reviewed Mr Galinec in the presence of his family. It was agreed that Mr Galinec would take family accompanied leave on hospital grounds but that he would not leave the hospital.

11. Mr Galinec was also able to wear his regular clothes, whilst a patient in the hospital in order to feel more comfortable. On 19 March 2013 Dr Thirupathy reviewed Mr Galinec in the company of Dr Murphy. Mr Galinec reported that he had intrusive thoughts of suicide, but reassured the team that he had no plans or thoughts of harming himself and that he was committed to staying in hospital. Mr Galinec was to be transferred to the Older Persons' Mental Health Unit, however, a bed was not available and he was to continue as a patient on ward 7B until a bed was available.
12. Dr Murphy stated that she advocated strongly for his transfer as soon as was possible. However, Mr Galinec was one of seven patients awaiting transfer to one of three psychiatric units in Canberra, with the preferred option being the Older Persons' Mental Health Unit. It is a sad irony that a bed became available the day he disappeared from the hospital. Mr Galinec was not on any psychiatric treatment order at the time as it was not at that point considered necessary by his consulting team.
13. On 20 March 2013 Mr Galinec had appeared more settled, but still suffering from a significant depressive illness, however, he reported he was anxious to be discharged. He received psychological support on that day as well. He reported that he was distressed by suicidal ideation which was occurring frequently. Dr Murphy still considered that his condition was improved, probably as a result of the anti-depressive medication taking effect. Dr Murphy did not at that stage have any concerns that Mr Galinec would leave the hospital or harm himself.
14. During the night of 21 March 2013 Mr Galinec was observed to be comfortable and had no complaints. Soon after 7.30 am he was seen by a casual staff member, Enrolled Nurse Michele Robertson, who took over his care from night staff. Nurse Robertson gave evidence to the effect that she was not told at handover of Mr Galinec's attempted suicide. She stated that she attended to providing medications for the patients under her care, based on their medication charts before reading their progress notes. She said that had she been made aware of Mr Galinec's suicidality and the fact that he was waiting to be admitted to a psychiatric unit she would have kept a closer eye on him.
15. Nurse Robertson did not observe any unusual behaviour displayed by Mr Galinec. She noted that he took his medication, was smiling and polite and did not require any assistance with showering. Although somewhat uncertain, in retrospect Nurse Robertson stated that Mr Galinec was missing from his room at some time between 9.00 am and 9.15 am, and that she told someone else he was not there at about 9.45 am. She said that she changed a handwritten entry in the notes from 8.45 am to 9.45 am as she had originally written the wrong number. In giving oral evidence she said she felt upset, stressed and responsible and was worried that she had made a mistake.

16. At approximately 9.45 am to 10.00 am she said she notified the team leader on ward B, Nurse Hoban that Mr Galinec was missing. There is some evidence to the effect that this notification was actually earlier, perhaps as early as the 8.45 am in the original as suggested. However, I note that the AFP case note entry details record:

Missing person discovered missing at 9.45 am, reported at 12pm.

17. Ultimately not a great deal turns on the particular time. In any event after the team leader was notified the family was then notified of Mr Galinec's disappearance.
18. It transpires that Mr Galinec, in fact, absconded from ward 7B in the hospital some time prior to one minute to 8am. He was captured on closed circuit television footage having a conversation with Dr Pieter Jansen at the front information desk at that time. A fellow patient, Mr Graeme , indicated to police that Mr Galinec had gotten up about 7.30 am and was dressed in a jumper and track pants with slippers on his feet.
19. Mr Graeme also stated that staff were fairly constant attendees on the ward at the time. He observed that Nurse Steve Foley seemed to keep a close eye on Mr Galinec. He said that the ward had been very busy that morning and he told police that he was asked by a nurse at about 8.30 to 9 o'clock if he had seen Mr Galinec that morning.
20. Following notification, a search by hospital staff was commenced to look for Mr Galinec. That search included security staff, nursing staff and wardsmen. An order pursuant to the *Mental Health (Treatment and Care) Act 1994* was made by Dr Murphy, requiring Mr Galinec's involuntary detention. Dr Murphy informed police as to Mr Galinec's condition and his high risk of suiciding.
21. Police were initially given a description of Mr Galinec which included that he was wearing a blue striped nightgown. This was incorrect information as he was dressed in outdoor clothing, later confirmed by his roommate and by closed circuit television footage. Several times incorrect descriptions of his clothing were given by hospital staff to police. The nightgown that Mr Galinec was believed to have been wearing was later found in the bathroom of his hospital room.
22. At approximately 8.10 am on 21 March 2013, Mr Brett Graham of the hospital security team received a report from security officer, Mr David Thompson, that a disoriented male had been seen in the multi-storey car park at the hospital. Mr Graham and another security team member, Mr Ben Holder, proceeded to the car park, but could not find anyone there that matched the description. Closed circuit television footage obtained from the hospital security system recorded a man walking into a stairwell in the multi-storey car park at 12 minutes past eight on 21 March 2013. He was then seen to enter Hospital Road.
23. Marianna Galinec, the deceased's daughter, confirmed that the person visible on that footage was her father. There was no subsequent sighting of Mr Galinec alive.

24. At 10.20 am a member of ward 7B nursing staff reported to security that Mr Galinec had gone missing from the ward and was dressed in hospital pyjamas and slippers. Both Mr Graham and Mr Holder performed patrols at the hospital grounds, including the car park at Gaunt Place, but did not see the person that had been described to them. At approximately 3.00 pm Mr Holder and Mr Graham met with police to review the closed circuit TV footage of the car park and the hospital foyer. Both security officers conducted a further search of the hospital and hospital grounds, without locating Mr Galinec. Mr Holder continued to look out for Mr Galinec on subsequent patrols.
25. Nurse Hoban was asked by police for an 'Absconder Form'. She was not familiar with the form and sent a different document to the police.
26. Meanwhile, a search of the surrounding area was conducted by family and police. Police spoke to family and friends of Mr Galinec, in order to gain a better understanding of where he might go after leaving the hospital. At a quarter past two a police media statement was released, in relation to his disappearance. A police command and control point was established and trained search commanders trained were appointed.
27. The search for Mr Galinec was conducted in accordance with the principles laid down in the 'National Land Search Operations Manual'. The police kept a log of events. The search priority level was 10, indicating an emergency response was required.
28. Constable Cain Denman was allocated the task of searching, along with Constables Turkich and Vince. They checked the Gaunt Place car park and searched the grassed area close to, but not in the exact area, where Mr Galinec was later found. Constable Denman subsequently returned to the scene and gave evidence that he would not have been able to see Mr Galinec from where he had entered and searched the car park and surrounding areas on 21 March 2013 as the area was on a slope and heavily vegetated.
29. On 22 March 2013 an helicopter with thermal imaging scanned a large area of green belts from Red Hill and the surrounding area, without success. The family suggested that Mr Galinec was drawn to water. Scrivener Dam, Lake Ginninderra, Point Hut Crossing, Kambah Pool and Lake Tuggeranong were all searched by divers, searching with sonar devices without success. The State Emergency Service searched the Red Hill Nature Park. An alert was issued to bus drivers, rangers and similar personnel. A general media release was made, with several reports being investigated and determined unrelated.
30. On 23 March 2013, Dr Katie Thompson reported to police that she had seen a person matching the description of Mr Galinec on Chaseling Street, Phillip at approximately 10.30 am. Dr Thompson had reviewed Mr Galinec on his admission to the MAPU ward on 12 March 2013. Police investigated the sighting, and First-Constable Danielle Leach spoke to the deceased's brother, Joseph Galinec. Joseph indicated to police that he lived in Chaseling Street and he had been walking on that street on the morning of 23 March in the area identified by Dr Thompson. It was concluded, and it seems to be reasonably concluded, that the person sighted by Dr Thompson was, in fact, Joseph.

31. Mr Galinec's family continued to search for him, including his brother, who came from Melbourne for that purpose. At 2.00 pm on 28 March 2013, one week after he had gone missing, Mr Galinec was found hanging in a tree in grassland in Gaunt Place at the Canberra Hospital, approximately 20 metres from Hindmarsh Drive, close to the intersection of Palmer Street and Hindmarsh Drive. He was found by his brother, Stefan.
32. An autopsy was conducted by Dr McBride, and the finding was that the cause of death was asphyxia by hanging, with antecedent causes of failing health and chronic depression. No suspicious circumstances were noted by the police. Associate Professor Vanita Parekh reviewed the results of blood toxicology levels taken post-mortem. Blood had been taken from the femoral artery and preserved appropriately.
33. In Associate Professor Parekh's opinion the levels of Mirtazapine found on testing were in the therapeutic range and most likely reflected the levels that would have been found in a live person, however, conceded that there was a possibility that post-mortem changes due to decomposition may have increased or decreased this level. It is not known to what extent this may occur. In relation to the ethyl alcohol level found, Associate Professor Parekh opined that it likely arose as a result of decomposition. It is possible, however, that it may have been the result of consuming alcohol prior to death. It is impossible to distinguish between those two possibilities. There is no evidence either way.

Issues

The Handover

34. Following the close of oral evidence in this matter the Territory, by consent, provided further material addressing the process for clinical handover. In its submissions the Territory submitted that the handover issue was inadequately explored at the inquest. The inquest was, in fact, adjourned to allow Enrolled Nurse Robertson to give oral evidence. It is fair to say that she had limited memory of the handover, which had taken place prior to Mr Galinec absconding, as one might expect, given the passage of time. But what was significant was her very clear recollection that she was not made aware that he suffered with a diagnosed mental illness with suicidal ideation and the fact that she would have behaved differently had she been made aware. This is the essence of the failure with respect to the handover on this occasion.
35. Whilst it is impossible to say exactly what Nurse Robertson was told, and indeed what she might have become aware of, had she read the notes before attending to her patient's medication needs, the lack of any red flag in relation to a person suffering a psychiatric or psychological illness in an open general medical ward raises the potential for misadventure. This was a man who had already tried to commit suicide, who was getting increasingly restless to leave, who, having stated the day before that he wished to go home, did agree to remain in hospital at that point, but whom absent any agreement to stay would have been made subject to an involuntary psychiatric treatment order. It is clearly vital that incoming staff be made aware in such a situation of the risk of absconding or self-harm.
36. As is recognised in the ACT Health policy, "Clinical Handover":

“Effective clinical handover of information between health professionals is essential to ensure continuity of care and client safety”.

37. Even though the judgment that a one to one attendant was not required had been made by the treating psychiatric team, closer attention to the movements of a person in the situation such as Mr Galinec by a dedicated nurse or unit staff is a realistic expectation.

Arrangements between MAPU and the Hospital Mental Health Service

38. The evidence is that a number of patients on MAPU suffer with psychiatric or psychological as well as physical illness. This unit appears to be a staging post to either release from hospital or reallocation to a more appropriate specialist area. According to Dr Murphy, Mr Galinec was kept in hospital, not because of his physical condition, but because of his psychiatric state. There is clearly a good relationship between the Hospital Outreach Mental Health Service, which is notoriously stretched, and of the unit.
39. Dr Murphy and her team members attended Mr Galinec regularly. Dr Murphy was clearly strongly advocating for Mr Galinec's placement in an appropriate unit but was stymied by the also notorious shortage of beds. A number of mental health policies were in evidence. Dr Murphy, however, gave evidence that had Mr Galinec been in a dedicated psychiatric unit, given the acuteness of his illness, he would likely have been subject to a check either every half-hour, or even every 15 minutes, given that he had indicated suicidal ideation.
40. Clearly, there is a significant resourcing issue in providing that kind of oversight on a general ward. However, if such close attention would be deemed necessary to ensure the safety of the same patient on a psychiatric ward, and no bed was available in such a unit, it is difficult to comprehend why a lesser standard should be applied in some form on the general ward. On the available evidence, MAPU generally operates as an open ward, but it capable of being secured. If resourcing is such that closer observation is not available to ensure the safety of suicidal patients, albeit it somewhat inconvenient, a cost-effective alternative would be to either monitor or control access to and egress from the ward.

Absconder Arrangements

41. In this case, the incorrect description of Mr Galinec's clothing when he absconded came about as a result of the failure to make any investigation or inquiry, such as checking his belongings or speaking to his roommate, which might have better informed the measures taken by hospital security and the police. It is impossible to speculate as to whether a correct description might have impacted on the outcome. However, the establishment of simple procedures in the event of a person absconding would assist to avoid such a basic error.
42. Although ward staff responded quickly once they became aware that Mr Galinec had absconded, their efforts were to an extent hampered by the lack of a proper system to report, and report accurately, in relation to a missing person. Whilst the police were aware of some form of absconder form, staff on the unit were not. It appears that no standard reporting system has been developed which is readily accessible to and guides staff in dealing with this issue.

43. The current head of hospital security, Mr Ken Barnett, indicated that it would be appropriate to include the development of an absconder report form and protocol in the process of rewriting hospital security policies. Centralised monitoring of a closed circuit television system is also being pursued, and this may offer one avenue for assisting in relation to potential absconders, for example, by having particular arrangements in relation to the observation of people leaving wards in which it is known that psychiatrically ill patients are housed.

Recommendations

44. ACT Health should give consideration to requiring a review of the handover protocol by Clinical Handover Standards Group which might consider requiring staff to review at least the basic handover sheet, which would highlight any particular risk issues, before commencing clinical duties.
45. ACT Health should give consideration to the development of a Standard Operating Procedure [SOP] and report form in relation to patients who abscond from wards in the hospital, which would assist in guiding staff in relation to gathering information and informing appropriate personnel in a timely and accurate manner.
46. ACT Health should give consideration to securing or monitoring access to, and egress from, wards other than dedicated psychiatric wards which accommodate mobile patients suffering psychological or mental illness.
47. ACT Health should give consideration to amending the *“Mental Health, Justice Health and Alcohol and Drug Services Access and Acute Mental Health Service SOP, the Suicidal Behaviour: Treatment and care of consumers who display suicidal behaviour”* document in order to address the particular circumstances of patients with psychological or psychiatric conditions housed in other than psychiatric units, for example, the Medical Assessment and Planning Unit [MAPU].

I certify that the preceding forty-seven numbered paragraphs are a true copy of the Reasons for Judgment herein of Her Honour, Chief Coroner Walker.

Associate: Amy Winner
Date: 12 June 2014

Counsel Assisting:	Ms M Hunter Office of the ACT Director of Public Prosecutions
Counsel for the Territory: Solicitor for the Territory	Ms A Tonkin ACT Government Solicitor
Date of hearing:	31 March 2014 – 3 April 2014
Date of findings:	2 June 2014