CORONERS COURT OF THE AUSTRALIAN CAPITAL TERRITORY

Case Title:	**AN INQUEST INTO THE DEATH OF PAP**
Citation:	**[2017] ACTCD 2**
Hearing Dates:	28 November – 1 December 2016
Date of Findings:	23 March 2017
Before:	Coroner Cook
Legislation Cited:	*Coroners Act 1997* (ACT) *Mental Health (Treatment and Care) Act 1994* (ACT) *Human Rights Act 2004* (ACT)
Appearances and Representation:	Ms Baker-Goldsmith as Counsel Assisting Coroner Cook Mr Crowe SC for the Territory Mr McCoy for Dr Laeeq Mr Andrew Allan for Dr Hii, Dr Katsogiannis and Dr Burger Ms Mynott for Calvary Private
File Number(s):	CD 5 of 2015
Publication Restriction:	Non publication order in relation to the name of the deceased

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FINDINGS

An Inquest having been held by me, **ROBERT COOK,** a Coroner for the Territory, including a hearing conducted at the Coroner's Court at Canberra in the Australian Capital Territory into the death of:

PAP

I find that:

1. The deceased was PAP, born xxxx.

2. Mr P died between 28 December 2014 and 5 January 2015 at his home, xxxxxx, Florey, in the ACT having been found by his former partner, and next of kin, G P on 5 January 2015.

3. Mr P was declared life extinct by Dr Thompson on 5 January 2015. Pathologist Dr Sanjiv Jain conducted the post-mortem examination of Mr P at my direction. Dr Jain formed an opinion that the cause of death was septicaemia due to hydronephrosis and infection.

4. A contributing cause in Mr P's death was his own behaviour in refusing to accept medical treatment and services which were offered to him in order to provide ongoing treatment following discharge from hospital on a number of occasions.

5. Mr P was a hoarder and lived in squalor. I am satisfied Mr P had an undiagnosed mental illness. That he did not actively engage with medical or mental health services, although had frequent admissions to hospital prior to and following a mitral valve replacement operation.

6. I am satisfied no matters of public safety arose in connection with this inquest. I make no adverse findings to the effect that the quality of care, treatment and supervision of the deceased contributed to Mr P's death.

7. However, I provide recommendations given the unique opportunity afforded through the inquest to consider specific issues concerning first: the understanding of privacy laws and their application by health care professionals in decision making concerning referrals to other appropriate health care providers.

8. Second, establishing a mechanism by which health care providers could have access to a patient's health records across the health services entities within the ACT through the use of flags that identify areas of health care provided to the

patient both historically and currently without necessarily disclosing the illness or treatment regimes.

9. This it is hoped would alert health care professionals that broader considerations of other medical issues may need to be considered for example: a coloured coded flag on a patient medical record might indicate that a patient may have or have been subjected a Psychiatric Treatment Order with a strong medication regime and as a consequence treating the current physical injury/illness with an additional medication regime would need to be taken into account.

10. Or where a person appears to have an underlying mental health condition on presentation to ER, a flag mechanism may provide medical professional a more complete picture of the patient.

11. These recommendations would hopefully, enable where possible, timely access by health care professionals to such information or at least be placed on notice about its existence to allow effective diagnoses, treatment and delivery of in hospital and post discharge care, having afforded relevant health care providers the opportunity to consider holistically a patient's various medical conditions.

Recommendations

1. ACT health care providers should be reminded through either ongoing professional development and/or training about the extent and application of privacy and particularly its relationship to the lessening or prevention of a serious threat to the life, health or safety of an individual within the ACT.

   Additionally, they should be reminded that they have the capacity to ensure referrals can be made to relevant agencies that might potentially provide support to a person within the Territory, recognising that it will always remain that person's right not to accept that support or to consent to any treatment - provided they are not incapacitated or incompetent to do so.

2. That ACT health services examine their capacity to cross reference relevant data management systems, in particular mental health and physical health service providers, to enable health service providers to interact with respective data management systems so as to provide timely access to relevant medical information for health care

professionals to effectively diagnose, treat and deliver in hospital or post discharge care having been able to consider holistically a patient's various medical conditions.

DATED 23 March 2017

R. M. COOK
CORONER

Reasons for Findings

1. In cross-examination from the legal representative for the ACT Government there were relevant entries in medical progress notes concerning Mr P made on 10 October 2014. Aspects of those entries were put to Dr Katsogiannis as they reflected an assessment undertaken it seems at about 1410 hours with Mr P by that Doctor:

> *"Initial contact with patient this" - A.M. ... "Retrospective notes. Consents obtained," with a tick, which means we've got consent. "Patient reported the following when questioned by OT: lives alone in his own home, has a wife referred to as wife not ex-wife that lives nearby. Three children in Canberra, one in Sydney. Has had contact with OTs in the past but doesn't find them useful. Has been to rehab in the past." And we go to page 1854, OT continued, "Has private health cover. Has licence but the report has been decided he should not drive because it's not safe. He states it's because he's been unwell for two years, gave up driving six months ago. Does his own shopping online, cooks meals and does laundry. Describes that he doesn't clean. Reports independent with showering at home daily and mobilises to the toilet in the form of a walker. He states he owns his own shower stool and over-toilet frame. Reports he purchased an electric recliner from the Independent Living Centre (ILC). Denies contact with" - I'm not sure who CLOT stands for. Perhaps Community Living Occupational Therapy. That's a guess. "And having any recliner trials. Reports he's about to give up work in the Army as a project manager. Admitted that electric recliner was not delivered" - "was delivered in the day of admission to Calvary two hours before. Reports that the community care nursing called the ambulance service, but states he wouldn't have had if the nurse didn't. Refused to discuss," something, "that the patient had been seated in the lounge chair for three days prior to admission and he stated his biggest concern is food in the fridge at home and identifies that he needs rehab. He has not had any contact with anyone coming into the house because he refuses and will not have anyone coming into the house following discharge. He stated if the allied health arrangement supports" - we go to 1856 - "is a waste of time and he will sort something out," quote/unquote, "himself. He denied having any pressure areas of his bottom." If we go on, "He refuses requiring any more equipment at home, stating he has everything. He's happy for the OT to continue monitoring his progress. He reported his contact person is his wife. Advised the OT would not be able to get a hold of her or not able to leave a message. He denied being incontinent in the days prior to admission." They talk about the home environment and the assessment was, "From file review and notes on CRIS" - which is the clinical records system - "information that was conveyed by patient does not match documentation. Self-neglect and poor self-care was documented, however patient reports on adequate self-care at home. Possible cognitive or patient being truthful. Patient is keen to go to rehab and has private health cover, therefore possible private rehab for discharge planning. Patient will not have services come into the house and will not be independent to return home. Plan was monitor progress private rehab."*

2. I have included that quote in its entirety, because it sets out the crux of this inquest to determine what was provided to Mr P; what could have been provided; what should have been provided, and further what was accepted and what was rejected by Mr P.

3. The quote canvasses the willingness of service providers to engage with Mr P and the reluctance by the recipient, Mr P, to have any contact or involvement from those service providers on his discharge from hospital, in particular in the months preceding his death.

4. Mr P was declared life extinct by Dr Thomson on 5 January 2015. A post-mortem examination of Mr P was conducted by Dr Sanjiv Jain at my direction and it was his expert opinion that the cause of death was septicaemia due to left renal hydronephrosis and infection.

5. Having regard to the relevant information put before as part of this inquest into the death of Mr P pursuant to sections 13 and 52 of the ACT Coroners Act, I find a contributing factor in Mr P's death was his own behaviour in refusing to accept medical treatment and services which were offered to him following discharge on a number of occasions from public and private hospital facilities within the Australian Capital Territory.

6. I am satisfied that prior to the time of Mr P's death there were no direct failings of medical services, including mental health services applied to or available for Mr P, that could be said to have contributed to his death.

7. I am satisfied that Mr P displayed conduct representative of an underlying mental illness which had remained undiagnosed. As the mental illness of Hoarding had not been accepted by the Australian College of Psychiatrists as a mental illness prior to or at the time of Mr P's death.

8. This was so, notwithstanding that hoarding was recognised in the DSM 5 which was published in 2013. Despite the illness being recognised within the DSM 5 did not incorporate it into the definitions of mental illness under relevant ACT legislation so as to be capable of having potential application to Mr P

9. I am satisfied that as a matter of law, a person who is mentally or physically competent cannot be made to consent to medical treatment. Based on the expert opinion before me as to his cognitive capacity, I am satisfied that Mr P was mentally competent, despite his physical decline and aspects of diminished mental capacity that were observed by family and friends.

10. Dr Berger explained it appropriately in her evidence in describing Mr P, a person of whom she made psychiatric assessment of as follows:

> *...So it can be that they have a cognitive deficit which means they don't see that that's what they're doing, that they don't recognise it or they don't choose to do anything about it because it doesn't bother them. So alcohol can affect the frontal lobe and the frontal lobe is important for organisation,*

planning, sequencing, thinking ahead, putting things in place in case something happens, recognising that your self-care is poor. Alcohol is notorious for doing that, which is one of the reasons I did the more detailed cognitive assessment because I felt if this man is drinking heavily, that may be why his Warfarin use is not reliable and may be why he's not looking after himself, why his wife has these concerns and he's not concerned. But that doesn't mean that he has a mental illness. Mental illness can make you do that, but it's not by definition the only cause of such difficulties.

Mr P indicated to me that he was demoralised by being in hospital, that he was frustrated, that he wanted to be at home where he could do his own thing. He showed me his model trains and told me he had numerous trains at home and wanted to go home to be with his own things. So he valued his independence. And I wonder whether he was cooperative in hospital so that he could be discharged sooner. If he was a heavy drinker, you're not able to drink in hospital ..., so he may have been cooperative because he wanted to go home and drink. And that's not something you can force someone to change. So I think it's very tempting to say, well, he must be mentally ill
... And perhaps more importantly her observation where she says in her evidence: *I was wondering whether that's what the family are concerned about, that he had an untreated mental illness and therefore if he had been treated, this wouldn't have happened.*

I am satisfied having regard to the initiating letter to the Coroner's Section raising issues of underlying mental health experience by Mr P's family that they had formed views about Mr P and in their respective eyes, their former husband or father was not acting normally, and to fair these were clearly their observations as they applied their standards to a person who had once occupied an important role in their lives and whom appeared to them to be declining quickly.

11. I am satisfied that Mr P was entitled to make decisions as he saw fit concerning himself. I am satisfied, as explained by Dr Berger, that even if a diagnosis under the DSM 5 was applicable in 2014, it would not mean a mental health order would automatically have followed. This is because it would seem the only psychiatric illness that might be diagnosed for Mr P so as to warrant a psychiatric treatment order was one of hoarding.

12. However, as Dr Berger noted in her evidence, there is no involuntary psychiatric treatment for hoarding disorder which may improve that condition. This, she explained, is due to the key feature of this disorder being a lack of insight.

13. Treatment for hoarding requiring the insight of the patient and effectively, a willingness to get better. Further, as Dr Berger articulated, Mr P could not see anything wrong with what he was doing and therefore, did not display a voluntary willingness to attempt to get better. I am not satisfied that this could be identified as a contributing factor in his cause of death.

14. I am however, concerned that privacy principles could inadvertently lead to the unavailability of appropriate services to a person within the ACT community where privacy as a concept in itself is given too much emphasis without appropriate consideration that personal information may be used or disclosed where that use or disclosure is necessary to lessen or prevent a serious threat to the life, health or safety of any individual as under section 16A of the Commonwealth legislation.

15. The *Human Rights Act 2004* (ACT) provides in section 12 that everyone has the right to not have their privacy, family, home, or correspondence interfered with arbitrarily or unlawfully.

16. However, these are not unfettered rights. I have explained that these rights can be impinged upon in order to ensure that appropriate action is taken in order to lessen or prevent a serious threat to the life, health or safety of an individual.

17. It is on this aspect, I am satisfied that ACT health care providers should be reminded through either ongoing professional development and/or training about the extent and application of privacy and particularly its relationship to the lessening or prevention of a serious threat to the life, health or safety of an individual within the ACT.

18. Additionally, they should be reminded that they have the capacity to ensure referrals can be made to relevant agencies that might potentially provide support to a person within the Territory, but that it will always remain that person's right not to accept that support or to consent to any treatment - provided they are not incapacitated or incompetent to do so.

19. It is clear on the evidence before me from the treating professionals that Mr P was a person who presented as a competent person, able to make his own healthcare decisions and displayed appropriate cognitive skills supporting that competency.

20. This is to be ascertained from the evidence given by Dr Katsogiannis and Dr Berger, who were strong in their findings that Mr P did not display a deficiency in his cognition that would warrant him being referred to Mental Health for assessment or treatment.

21. Based on those observations, I am satisfied Mr P was not failed by the delivery of appropriate medical or mental health services in the ACT.

22. In fact, I am satisfied that he received appropriate care and professional support from the relevant hospital specialist services and community nursing. Each health care provider on the information and through their evidence had Mr P's health at the forefront of their minds in the delivery of their professional services to him. He of course, had a different desire and lifestyle pursuit.

23. The fact it did not accord with that of his family's expectations or their own

standards of living did not mean he was let down in the delivery of those professional health services by relevant providers.

24. There are of course recommendations that come from this detailed insight into the interrelationships between the various supporting agencies in the delivery of medical and mental health services. It became apparent that creation of a flagging mechanism within patient management record systems, in particular between medical and mental health services could be advantageous in diagnosis on admission and treatment and subsequently on discharge for ongoing treatment and care.

25. This system could still provided protection of privacy regarding the underlying medical issue concerning any person.

26. In regards to the role of community nursing, as I have flagged there are underlying issues as to the understanding of the effect of privacy laws, but other than that it was clear that Mr P was afforded appropriate and professional care and I find no failing in delivery of that service on the evidence before me.

27. One key aspect of evidence to which I must refer is that of the suggestion made on 2 September 2014 by the Mental Health Multidisciplinary Team that Mr P be reviewed, that a referral be made to the Aged Care Assessment Team, that he be referred for review by a geriatrician and that consideration be given to guardianship. There appears to be no evidence of any confirmation Mr P was given that support.

28. I do note the information before me indicates that Mr P was considered too young for aged care support and that largely deals with that. In any event, notwithstanding that, I am not satisfied that any of those matters could be said to have contributed to Mr P's cause of death, even though they were not dealt with effectively.

29. The closing of mental health files when a person is admitted into a hospital needs to be properly addressed by government agencies based on the flagging issue I raised earlier. This should be done in a way that would allow at least someone like Dr Hii to have been placed on notice that there was perhaps an underlying mental health issue in regards to his patient sooner.

30. I am satisfied having regard to all the evidence before me that there was no sufficient basis for the making of any coercive or involuntary order that would in effect have taken away Mr P's right to make his own choices at the relevant time during the year following his recovery prior to discharge back into the community and return to his own home.

31. I acknowledge Mr P's family and the request they made to the coronial unit to address what they considered were failings in the provision of mental health services to Mr P.

32. I acknowledge their perceptions were genuine. There are difficulties in dealing with

Mr P's passing in the circumstances that he did decline from a person they all knew as once bright, articulate and intelligent. Watching this decline would have been most difficult and heart rendering. I acknowledge the profound loss of Mr P's family and extend my condolences.

33. I am satisfied that this inquest has produced a benefit in terms of the recommendations made. I am equally, however, satisfied that those professionals involved who gave evidence at the hearing and who provided statements for the purposes of this inquest are dedicated professionals in the delivery of health and mental services to the ACT community, and in particular at the relevant times to Mr P.

Background

PAP, born xxxxxx, died aged 55 years, sometime between the dates 28 December 2014 and 5 January 2015.

1. At time of his death Mr P was living alone and, it is a reasonable assessment having regard to the evidence before me, that he lived in squalor.

2. In 2002, Mr P and his former partner Mrs G P separated.

3. Mrs P moved out of xxxxxx, in the ACT with her four children to an address also in the suburb of xxxxxxx. Despite this, Mrs P maintained regular contact and made weekly visits to Mr P's home.

4. Mr P had remained living alone at his xxxxxx residence since 2002.

5. Mr P was found by Mrs P on Monday afternoon, 5 January 2015 deceased in the living room of his residence.

6. Mr P had a number of physical and mental health problems.

7. In the years leading up to his death Mr P had repeated hospital admissions resulting in numerous engagements with medical professionals, mental health staff and community nurses.

8. In 2004 Mr P underwent a cardiac mitral valve replacement operation in order to address his history of hypertension and cardiac problems. As a consequence he was required to adhere to an ongoing anticoagulation medicine regime.

9. Although Mr P had some history of depression for which he had been prescribed antidepressants in 2004, his family and friends suggest no history of or thoughts of self-harm or suicide.

10. By 2012 Mr P had stopped taking antidepressants and he was not on this anticoagulation medication at the time of his death.

11. From at least 2002, Mr P was an alcoholic who would drink a cask of red wine a day, coupled it seems, with a very poor diet.

12. Visitors also observed that the house was contaminated with faeces and urine and was vermin infested. Photographs taken by police of the inside of Mr P's home, at time Mr P's death was reported to them, reveal the extent of the living conditions and confirm my description of Mr P having, at least at the time of his death, lived in squalor.

13. Mr P would not allow his family to clean his house, although from time to time his family would try to clear pathways for Mr P to use his walking frame when moving about the house.

14. Mr P's friends Peter Helson and Grant Lever would also occasionally assist Mr P with cleaning the house.

Date and time of death

15. Mr P was certified deceased at 6.40 pm on Monday, 5 January 2015, by Dr Graeme Thomson, a forensic medical officer.

16. A full autopsy examination was conducted at the Phillip Forensic Medicine Centre on Wednesday, 7 January 2015.

17. The examination was conducted by pathologist Dr Sanjiv Jain, Director of Anatomical Pathology, at The Canberra Hospital. Dr Jain reported that Mr P died of septicaemia due to hydronephrosis and infection

Reason for the Inquest

18. On being informed of the cause of death following the Post Mortem and on behalf of Mr P's family, R M, the eldest daughter of Mr P, wrote to the Court's Coronial Unit to request a hearing to examine the family's specific claim concerning her father's death.

19. That claim was centred on Ms M's opinion that multiple failures in medical systems/services linked to, or involved in, her father's healthcare were a factor in his death, in that those services, she wrote: ... *allowed Mr P to continue residing alone in a property he refused to adequately look after and with a proven history of failure to remain compliant with required medication*.

The Role of the Coroners Court

20. The Coroners Court's jurisdiction in relation to Mr P's death arises under subsection 13(1)(d) of the *Coroners Act*, as it was in force at the time, which relevantly provides that a Coroner must hold an inquest into the manner and cause of death of a person who dies and a doctor has not given a certificate in relation to the cause of death.

21. The Coroners Court's focus then, is on the circumstances which give rise to the death of Mr P, and whether or not an issue of public safety arises, should it be established that there was a disconnect or failure in the provision of either public or private professional and/or allied healthcare services to Mr P, to the extent that they could be said to have contributed to Mr P's death.

The Hearing

22. Mr P's family did not attend the hearing.

23. However, two of Mr P's friends Mr Peter Helson and Mr Grant Lever did and gave evidence in relation to knowledge of Mr P's living arrangements and their general observations of him at relevant times.

24. For the purposes of responding to the family's concerns I have included in my reasons parts of the chronology in order to set both context and the mental and health services framework in which Mr P was treated. This provides, I am satisfied, a clearer picture of the extent of medical support afforded to Mr P immediately prior to his death. The extent of my historical search concentrates on medical events and living arrangements during the last year of Mr P's life.

29. In early November 2013 Mr P had a series of falls which resulted in a period of approximately eight weeks' hospitalisation, from which he was discharged on 7 January 2014.

30. On 22 January 2014 Mr P is found at his residence by a neighbour, having fallen at his front door and having soiled himself. He is taken by ambulance to Calvary Public emergency department, where he is admitted to treat his wounds and mobility issues.

31. Mr P is transferred for a short time to Calvary Private from 5 February 2014 before being transferred to the National Capital Private Hospital for rehabilitation on 9 February 2014, and he remains at National Capital Private until discharge on 22 February 2014.

32. Whilst at National Capital Private in February 2014, Mr P was under the care of Dr Chris Katsogiannis.

33. On 2 April 2014 Mr P attends on his general practitioner, Dr Nadia Laeeq.

34. Dr Laeeq, who provided a statement in support of her appearing as a witness at the hearing, reports that Mr P's compliance with medication and clinical appointments was poor. Importantly, Mr P was reluctant to involve his family in his medical care.

35. On 6 April 2014 the ACT Ambulance Service are called to Mr P's residence where they find Mr P in his hallway with medications on the floor and an empty cask of wine, complaining of back and hip pain.

36. Mr P is taken by ambulance to Calvary Public Emergency Department where he is admitted. During this admission Mr P is assessed by a drug and alcohol nurse, where he claims not to have a problem with alcohol.

37. Mr P is further assessed by a *Hospital in the Home* service nurse for possible transfer to treatment in his house; however he refuses to accept home visits.

38. From 10 April 2014, Mr P does not attend any of the scheduled clinics over the next three days nor does he return phone calls. On 4 April 2014 Mr P finally returns a call to the doctor at the *Hospital in the Home* service, saying that he had fallen on the floor and he was about to call the ambulance. The *Hospital in the Home* doctor notes that Mr P sounded confused or drunk.

39. Mr P calls the Ambulance Service saying he is unable to get up after the fall and that he is suffering pain to his back. He is subsequently transported by ambulance to

Calvary Public Emergency Department where he is admitted.

40. On 5 April 2014 Mr P is discharged to home having been given a coordinated care plan in which it is recorded in that he has specified no home visits and an unwillingness to see a social worker.

41. On 16 April 2014 Mr P's neighbour calls the Ambulance Service saying that Mr P has been sleeping all day and upon being woken he could not remember who she was. Ambulance officers attend and they decide that there is no need to transport him to hospital. He is observed to have low blood pressure and he was encouraged to drink water and to get up slowly.

42. On 18 April 2014 Gaynor P calls ACT Mental Health distraught seeking intervention as she had been to visit Mr P's house and she reported he was lying in urine-soaked trousers.

43. ACT Mental Health call Mr P and conduct a suicide risk assessment, but while he admits to feeling low for some time, Mr P does not indicate any thoughts of self-harm. He indicates a willingness to accept some help.

44. Two days later during the morning of 20 April 2014, Mental Health staff attend upon Mr P where they observe his medical condition has deteriorated and he has severe oedema in his legs, but he is adamant he does not wish to attend hospital.

45. However, Mr P is agreeable for ACT Mental Health to contact him to discuss a management plan.

46. In the afternoon of 20 April 2014 Mr P calls the Ambulance Service complaining of leg pain which is identified as bilateral leg oedema having been present for the last seven weeks. He is taken by ambulance to Calvary Public Emergency Department where he is admitted.

47. On 22 April 2014 Mr P is again admitted to Calvary Private where he remains until discharged on 13 May 2014. Whilst at Calvary Private on this occasion Mr P was under the care of Dr Chris Hii. Dr Hii was responsible for the mitral valve replacement operation.

48. On 23 May 2014 Mr P calls the Ambulance Service following a fall from a couch said to be due to peripheral oedema. Ambulance officers find Mr P on the floor, having soiled himself. He is transported to Calvary Public Emergency Department where he is admitted, and in particular a psychiatric review is sought.

49. On 26 May 2014 Mr P is transferred to Calvary Private, back under the care of Dr Hii. Mr P's hospital stay is lengthened by virtue of a foot wound becoming infected, which is possibly complicated by his refusal to shower or wash.

50. Mr P is discharged on 13 June 2014 with a plan for community nursing to attend every two days to assist him with wound care. Mr P declines a referral to the Community Mental Health Team at this point.

51. Nurses contact Mrs Gaynor P to advise of Mr P's discharge, and the note of this contact records that Mrs P advised the nurses that Mr P's family were available to support him, and Mrs P declined offers of assistance from the medical staff.

52. On 27 May 2014, whilst in Calvary Private, Mr P is seen by consultant psychiatrist Dr Anna Berger who notes concerns with Mr P's self-care, but observes no history of cognitive impairment or injurious behaviour. Mr P agrees that Dr Berger can contact his wife, GP and pharmacist to obtain corroborative history.

53. On 1 June 2014, Dr Berger sees Mr P again when she formally conducts a psychiatric review. She determines there is no evidence of significant cognitive impairment, but notes some frontal lobe impairment which she suggests may be due to longstanding alcohol abuse.

54. Dr Berger is unable to contact Mr P's GP or wife to obtain corroboration and while Dr Berger was able to contact one of Mr P's daughters, Mr P's daughter did not wish to supply information to Dr Berger.

55. On 13 June 2014, Dr Berger closes Mr P's file on the basis that Mr P has advised the hospital that he does not need community support as he has adequate support from his family.

56. On 16 June 2014 Community Nurse Nicole Royal visits Mr P for the first time to provide wound care assistance. Over the next few days and weeks the visits continue. The nurses note Mr P's house is unkempt and he appears to have difficulty with some activities of daily living.

57. On 1 August 2014 Community Nurse Jarrett attends to review Mr P's living and physical arrangements, but he declines her request to view his medications, bathroom and toilet, and he declines all offers of assistance.

58. On 1 September 2014 concerns about Mr P have reached a level whereby the Community Nurse refers Mr P to ACT Mental Health.

59. On 2 September 2014 Mr P is reviewed by ACT Mental Health's multidisciplinary team. They recommend that Mr P be reviewed by the aged care assessment team and a geriatrician, and that an application for guardianship should be considered. As is further examined below, nothing appears to develop from this plan of action.

60. On 2 September 2014 the attending Community Nurse Royal calls the ambulance due to concerns that Mr P is unwell with a history of vomiting and diarrhoea. Mr P is transported by ambulance to Calvary Public emergency department where he is admitted.

61. On 3 September 2014 Mr P is transferred to Calvary Private where Mr P falls under the care of Dr San Wong.

62. On 10 September 2014 consideration is being given to discharging Mr P, but over the

next few days his condition deteriorates, and on 15 September 2014 he develops a massive haemorrhage into his rectus sheath, which doctors believe is most likely a consequence of his failing to properly adhere to his anticoagulation medication regime, and he requires serious acute care and transfer to ICU, where he is again under the care of Dr Chris Hii.

63. Due to the seriousness of Mr P's condition, consultant gastroenterology surgeon Dr Phillip Jeans is contacted by Calvary ICU for opinion.

64. On 15 September 2014 following Dr Jeans recommendation, Mr P is transferred to the Canberra Hospital ICU. Mr P's family are notified of his transfer and of his poor prognosis.

65. Mr P receives acute treatment in the Canberra Hospital ICU over the next few days, which is ultimately successful in resolving his condition, but not before he becomes septic, acutely agitated and has to be sedated with antipsychotic medication on 19 September 2014.

66. By 1 October 2014, Mr P's condition has improved to a point where he is discharged from ICU to a ward at The Canberra Hospital. However, Mr P continues to have mobility and continence issues whilst recovering, and he seeks transfer to a private rehabilitation facility to continue his recovery.

67. On 21 October Mr P is transferred to Calvary John James Hospital.

68. On 23 October Dr Jeans writes a letter, to who he understands to be Mr P's GP clinic to update them on Mr P's admission and to comment on his future treatment. The letter is also addressed to other hospitals however through no inadvertence by Dr Jeans, the letter is not sent to the hospital to which Mr P is in fact transferred. Notwithstanding in any event, the letter is written two days after the transfer in fact occurs.

69. This should not be seen as any criticism of Dr Jeans; in fact, his frank observations and opinion were timely although I am satisfied not connected or attributable to any subsequent inaction by healthcare providers. This is notwithstanding Dr Geoffrey Speldewinde's observations during the course of hearing concerning the content of the letter which was never brought to his attention during his treatment of Mr P.

70. On 21 October 2014, Mr P is admitted to Calvary John James Hospital under the care of Dr Geoffrey Speldewinde. On admission, Mr P is noted as requiring assistance with self care, nutrition and ambulation.

71. On 27 October a tentative discharge date is set by occupational therapists and social workers as being a discharge date of 6 November. Mr P again declines post-hospital support, home visits and contact with his wife.

72. On 3 November 2014 there appears to be the first note of community nursing being engaged with Mr P in respect of his imminent discharge from hospital.

73. On 6 November Mr P is discharged to his home with instructions to keep follow-up appointments with his GP and with strong suggestions for home visits and contact with his next of kin; however Mr P declines those suggestions.

74. On 10 November 2014 Mr P refused to let the community nurse review his wounds, and he declines all assistance. The community nurse's file note of the visit further records that Mr P's home was very untidy, cluttered and that he hoards. The community nurses questioned whether Mr P therefore may need involvement from occupational therapy.

75. On 14 November 2014 community nurses again called to check on Mr P. Mr P is recorded by them as having said he felt fine and he did not require nursing services, and he refused to permit the nurse to inspect his wounds.

76. Subsequently on community nurse Nicole Royal's return to the office, Mr P was discharged from the community nursing program and a letter was written to Mr P's GP to advise of this fact.

77. On 20 December 2014 Mr Lever visits Mr P to deliver a package, and Mr Lever reports that Mr P appears well and is talkative.

78. On the afternoon of 28 December Mrs P visits Mr P who she reports later appeared to her to be okay, but this is the last time that Mr P is seen alive.

79. Mr P is discovered deceased in his living room on the afternoon of 5 January 2015 by Mrs P as earlier noted.

Constable Ying-Dah Li

80. Constable Ying-Dah Li, a member of the Australian Federal Police, was a member of the first response team attending at Mr P's home following the report of a deceased person being notified to police.

81. Constable Li recalled that Mr P's family had raised a number of specific concerns with him. He recalled in particular Mrs P expressed reservations about the role played by ACT Mental Health in the delivery of services to her husband. His evidence was that Mrs P was frustrated with trying to have Mental Health intervene into her husband's living arrangements and 'hitting walls' in regards to this.

82. Constable Li said in putting the brief of evidence together and reading all the relevant material and taking statements from various people including Mr P's family that he formed a view of Mr P as a person who was in denial of his immediate situation. By this, he meant that Mr P did not appear to want help from anyone in terms of his immediate family and all people outside of his immediate family. He further made the observation that Mr P appeared in public to be a person very much in control of the situation, however, his actions in private indicated otherwise.

Grant Lever

83. Grant Lever, a friend of Mr P for about 35 years, said that he and Mr P joined the Army in 1978, going to Royal Military College Duntroon. He said they both subsequently ended up in the same graduating class and over time remained friends, class friends, but their friendship really got a kick along in about 2000 when they both worked on the same floor in the Defence Materiel Organisation, at the Department of Defence.

84. Mr Lever said that Mr P and his xxxx residence was only about a kilometre from where Mr Lever lived.

85. Mr Lever said that in the last year of Mr P's life 2014 he would call in and see Mr P at least once or twice a week. He stated Mr P wasn't driving so he would go and collect things from the shopping centre or the post office for Mr P.

86. Mr Lever said he had made the observation that Mr P's health had declined in 2014. He said when Mr P first moved into xxxx in 2002 he kept the home immaculately.

87. Mr Lever made the observation of his friend that not only did Mr P's physical health deteriorate but there was a decline in Mr P's mental well-being. Mr Lever said he had made comment on Mr P's overall health and had formed the view and expressed to friends that he would have been surprised to see if Mr P was alive in five years time.

88. It was Mr Lever's observation was that Mr P could not look after himself for any period of time to get back into reasonable health. Mr Lever explained that there was a spiral of going to hospital, getting fixed up, getting three meals a day, getting back to a level of health, then being discharged again and then him repeating the same process.

89. Mr Lever said that in 2014 Mr P had started to detach himself from the rest of his friends, and that Mr P increased some obsessive compulsive behaviour in that he was ordering more things over the internet. Mr Lever said he would be constantly at the post office picking up packages for him.

90. Mr Lever was able to draw a comparison from when he knew Mr P in the Army - someone he described as a bright, vivacious, extremely intelligent person - to someone in 2014 who was withdrawn, almost in a vegetative state, and whose appearances and actions resembled flat lining, with no peaks or troughs. In other words, he described Mr P as not really unhappy but not really happy, more like a person who did not appear to have a future.

91. Mr Lever said he formed the view that Mr P appeared to be dependent on alcohol and that as he understood it, that is why Mrs P left the marriage in 2002.

92. Mr Lever said Mr P had revealed to him that he did suffer from depression. Mr Lever recalled that on one visit to see his friend in 2014 he found him underneath a

blanket, sitting in the lounge room, and that Mr P had been in that a position for some 3 to 4 days.

93. Mr Lever also confirmed that he and Peter Helson would regularly visit Mr P when he had been admitted into hospital.

94. Mr Lever made the observation that Mr P when he was in hospital was in a good state of mind as he was being looked after, being cleaned up and he was being fed three times a day He observed that Mr P had everything on tap so he was in a pretty happy state of mind each time Mr Lever visited him in hospital. .

95. Mr Lever confirmed that Mr P would seek help if it suited Mr P's purposes, such as the purchase of alcohol or the collection of his parcels from the post office.

96. Mr Lever said Mr P never asked to have his home cleaned, although Mr Lever would often clean it, recalling on one occasion spending 8 to 10 hours of cleaning in order to make room so as to enable Mr P to use his Zimmer frame walker to move about the house.

97. Mr Lever agreed that from his observation Mr P was not in a state to make decisions about his own treatment or care. He held the view that Mr P was in a downwards spiral and needed to be institutionalised so that he could get the proper respite care that he required, because at that stage he wasn't walking, he had poor health and a poor diet.

98. Mr Lever said in the last month prior to Mr P's death, Mr P appeared to consume a lot less alcohol from what he had previously seen. Mr Lever's overall observation was that Mr P was actually quite ill.

Dr Nadia Laeeq

99. Dr Nadia Laeeq, a general practitioner at the Florey Medical Centre, Kesteven Street, Florey was Mr P's main GP during 2012 and 2013.

100. Dr Laeeq recalled Mr P as a patient from 2012. She stated that Dr Tang was Mr P's GP but when he was unavailable he would come and see her. The doctor made the observation that Mr P was a non-compliant patient.

101. Dr Laeeq stated she had informed Mr P she was going on maternity leave and that Mr P needed to follow up with appointments she had made for him to see Dr Tang and that he should obtain the prescriptions the doctor had provided for medication.

102. Dr Laeeq said that on her return Mr P had not complied with any of her instructions. Dr Laeeq however, said she was satisfied Mr P was cognitively able to understand her concerns, management advice and treatment regimes.

103. Her last contact with Mr P was when she saw him on or about 2 April 2014 following Mr P's hospital admission and subsequent discharge. The doctor recalled receiving number of discharge summaries from the relevant medical institutions that Mr P had

had attended in recent months.

104. Dr Laeeq said she was aware of the application and preconditions required in the ACT concerning psychiatric treatment orders and community care orders. The doctor confirmed that she had discussed and expressed her concerns to Mr P and that he had agreed to come in for a follow-up visit with Dr Tang, and that a voluntary pathway might be identified as to Mr P accessing a psychiatrist.

105. In response to a question as to whether or not the doctor as of 2 April 2014 formed the view that Mr P met the preconditions for a psychiatric treatment order or community care order, the doctor's response was:

> *It was very difficult because the thing is that he had been assessed by psychiatric team in the past and from what I could gather, they did not find any mental health - definite mental health ground for him. He did have history of depression and he did present twice I think, just from my recollection, ... after probing him he accepted that his mood was low. But he attributed that to his physical health rather than through mental health. He felt that, ... his recurrent physical health issues, is what was making him low in mood, and his feeling was that,... if he physically improved, there were no grounds for concerns regarding his mental health. He said, "I have had depression in the past but I don't think I'm depressed. I get low but I pull myself out of it." So that was his reason for not accepting any intervention.*

106. When pressed by counsel assisting, the doctor stated that she formed the view that Mr P had depression and that this was probably reactionary depression given his recent readmissions to hospital.

107. Dr Laeeq was pressed as to whether or not she had formed the opinion that Mr P was or was not under a mental illness in terms of the legislative requirement for making either a psychiatric treatment order a community care order. Her response was:

> *...I felt that, yes, he did have few issues which needed to be treated but that he wasn't acutely depressed. As I mentioned ... he did have reactionary sort of depression depending on what was going on in his life on certain points, but he didn't - again, this is based on my assessment knowing him over a few years that there were times when he was, ... very reactive, he presented well, he was very intelligent in his conversation and his understanding. So there were only a few occasions where, yes, I did notice that there was decline in his mood, but that was not enough basis to say that he had a prolonged sort of acute depression that in essence required some form of coercive action such as a psychiatric treatment order*.

108. As to Mr P's use of alcohol, Dr Laeeq formed the view based on conversations with Mr P that whilst alcohol had been a problem for him at an earlier point in time he had expressly stated to her it was not a problem currently (in particular throughout 2013), although she recollected Mr P attending on one visit where he appeared unkempt and smelt of alcohol.

109. As to Mr P's issues with the activities of daily living from time to time the Doctor said:

> *... when I confronted him, his explanation was that because of his physical health - again, on two occasions I think he mentioned that he had gastro and that was the reason that - ... because with frequent visits to the toilet he said that he just gave up and he wasn't really active in washing himself before coming in for the appointment, and he apologised for that. And I recall that there was an assessment for his capacity to work by Dr Niven, I think and he spoke to one of our practice nurses because I wasn't there and the nurse reported that there were concerns that even for that consult he presented with faecal material on his clothes and he was smelling of urine. So when I confronted him again he said that he wasn't given enough notice to prepare for this interview and that he was unwell on the day and he didn't have enough time to have a shower and put on clean clothes for it so he just left the way he was.*

110. It was the doctor's observations having been informed by Mr P that he had been admitted to hospital following a fall at home that an occupational therapist might be of some benefit to him and provide support. She said Mr P had refused to allow that to occur.

111. Dr Laaeq, while not fully aware of the condition of Mr P's home, made the observation from her engagement with him and particularly in response to questions concerning Mr P's mental health that Mr P often presented in reasonable moods, he would crack jokes, make good eye contact, could give a good history of his hospital admission and discharge, and could tell her about the assessments he had while in hospital and their outcomes.

112. Accordingly, Dr Laaeq had formed the view that on those presentations and from the information that he had provided to her, Mr P did not present as warranting a mental health intervention. Although the doctor conceded that by 2 April 2014 in an overall sense there were problems concerning Mr P that were becoming evident, she had also been made aware that Mr P was to be reviewed by a psychiatrist and that services were available to him, however, he simply refused to access them.

113. Dr Laaeq confirmed that she had taken leave until August 2014, and after the April 2 2014 visit, had not seen Mr P for the remainder of 2014. She had assumed that he had followed up with Dr Tang. Further, she was not aware that the practice had sent on 26 August 2014 a letter from Dr Lo indicating to Mr P that unless he made an appointment and attended it, he would be directed to find another general practitioner.

114. Dr Laaeq was afforded the opportunity to express an opinion as to whether she felt she was properly informed in relation to Mr P's admissions in hospital and whether his discharge paperwork was properly provided. It was the doctor's evidence that she received notifications and relevant discharge summaries noting that they would give Mr P a few days medication which ultimately required him to be reviewed when

he came in for obtaining prescriptions. She formed the view that she did not have any concerns regarding his treatment and no further intervention was warranted.

115. Dr Laaeq did offer the suggestion however, that in circumstances with someone like Mr P with a complex medical history and management that a combined community-based team and medical services system could recognise the different health issues and interventions played by the various health services and that would be a practicable outcome.

116. Dr Laeeq also raised the role of the family in dealing with a person with a complex medical history and treatment regime such as Mr P. She records expressing to Mr P she wanted a whole family meeting and asked if he would bring his family or friends along with him on the next occasion to which she said he was not willing to do so.

117. Mr P told her his friends were busy and that he did not have contact with his kids. He told her he would not provide her with relevant telephone numbers because he said his family did want anything to do with him.

118. The Doctor confirmed Mr P did mention his former wife did have contact with him and that she would visit him in hospital and at other times they would communicate by telephone.

119. The doctor recalled that at her insistence Mr P relented and gave his wife's telephone number to her, however the Doctor did not call Mrs P until Mr P had at least been given a chance to speak to Mrs P and explain what was going on. Mr P indicted that it would be unlikely that his wife would pick up a call from the doctor and that she would be unwilling to come in even if contact had been made.

120. Dr Laaeq confirmed that at no time did she ever speak to Mrs P notwithstanding she had called Mrs P.

121. Dr Laaeq further noted that a Florey Medical Centre note showed the last contact with Mr P appears on about 25 November 2014 and then again on the following Wednesday and Thursday when the Florey Medical Centre's practice nurse Helen Cook attempts to contact him. This of course, follows his discharge from John James rehabilitation unit on 7 November 2014.

122. Dr Laaeq further confirmed that Mr P required weekly monitoring by a GP of his INR levels because of the anticoagulation therapy regime that he was on following the mitral valve replacement.

123. Dr Laaeq's evidence was that from the notes that had been presented to her during the giving of her oral evidence she was able to confirm that there was no information before her which revealed Mr P was actually having those blood tests following his discharge from John James Hospital on 7 November nor did he attend the doctors at the Florey Medical Centre before from that discharge date to his death.

124. Dr Laaeq further confirmed that when Mr P was in hospital he had informed her that

he had undergone an aged care assessment to identify relevant needs in order to determine relevant support services to be provided. However, Mr P had informed her that he did not qualify for these services because of his age as he was under the age threshold.

125. Dr Laaeq said there were private health providers who would be able to support Mr P, however he refused such services.

Registered Nurse Nicole Royal

126. Registered Nurse Nicole Royal treated Mr P in 2014 as part of community health services.

127. RN Royal recalled attending Mr P's house on 1 August 2014. That was in response to the visit about which she had made a two-page note which captured that Mr P had food and groceries delivered to him, that he attended to financial affairs online and that he cooked his own food at home and further that he declined the offer of services to assist in his independence at home. RN Royal confirmed that Mr P said to her he was managing at home.

128. RN Royal however formed the view that Mr P's house was in a state of disarray. RN Royal did not challenge Mr P self-assessment that he was managing at home - despite her observation of the physical conditions in which he was living and her assessment of them.

129. It was RN Royal's observation that her role was to go and assess with a patient to determine how they feel they are managing and what services they require. Having done that, additional services are offered depending on the outcome of the assessment. She observed that where such services were offered to Mr P he had refused them.

130. RN Royal recalled that the range of services that Mr P refused included assistance in the management of his financial affairs, obtaining food and groceries and support in the provision of closer attention to personal care such as assistance with showering and other personal care needs.

131. RN Royal confirmed that she was aware that services could be provided by the ACT Government Belconnen Community Health Service that would have assisted Mr P organise things within his home but before that could be done, it was her clear view that Mr P needed to consent to the provision of those services - in particular clearing the items and food remnants that Mr P was hoarding.

132. RN Royal said that following a patient's refusal to consent to any additional services nothing further would be done, although a letter would be written to the GP to outline possible non-compliance with the medication regime so the GP would be aware of what was happening with the patient in the community.

133. RN Royal confirmed she was aware that coercive orders could be made in respect of patients under the *ACT Mental Health (Treatment and Care) Act*. She was equally

clear in her position that having questioned Mr P she believed his answers to be appropriate in that he had made choices for himself on what he wanted to be in place to help him and what he did not want in place. RN Royal clearly saw herself as having to respect that choice made by the patient. Without Mr P' consent, no referral to other agencies would be made.

134. RN Royal further confirmed that she attended on Mr P at his home on 2 September 2014 and made the observation he required medical assistance. She called an ambulance for him.

135. She recalled entering the house seeing Mr P visibly shaking and that he appeared to be unwell and that he had not eaten since the morning of the previous day.

136. RN Royal confirmed that as a community nurse having made a clinical assessment of his condition, she did not require the consent of that person to call an ambulance.

137. RN Royal confirmed that it would be up to the paramedics who attended to deal with a refusal to go to hospital indicating that from her perspective, it was within a patient's rights not to go to hospital. However, as history shows, Mr P was taken to hospital that day.

138. RN Royal's description of Mr P's house was that it was an extreme example of hoarding and squalor. RN Royal confirmed she was aware of the possibility that someone had made a possible referral to ACT Mental Health on an earlier occasion but that she herself had not done so - although she conceded it was an option open to her without Mr P's consent.

139. RN Royal when pressed about whether not she had ever considered making a referral to ACT Mental Health following any of her visits to Mr P at his home said:

> *No, because when he - you engaged with him he was always appropriate in his manner and response to you, when you engaged with him in conversation.*

140. RN Royal agreed this also extended to Mr P's orientation as to time and place. Importantly, RN Royal conceded that Mr P's physical appearance and stated living conditions had no bearing upon her assessment as to his mental health for the following reasons:

> *....Because sometimes what happens with people is they can make choices in how they wish to live and also make choices in terms of their health as well. So Mr P, because he was always appropriate and always answered appropriately the questions - and also in terms of assessing mental health where obviously I'm a general community nurse and we're not qualified.*
>
> ...Have you ever received any training in relation to making assessments of mental health?---*No, because it's generally - specific mental health issues is generally not within our practice. We obviously - if we identify a problem and then we can do a referral. But if there's no actual specific problem that we can identify then no...If I identified a specific problem, I would make a referral*

to Mental Health.

141. RN Royal confirmed that ordinarily if she was able to identify a specific problem then she would refer someone to ACT Mental Health.

142. RN Royal records particularly a visit on 14 November 2014 with Mr P when he was:

> *... sitting up in a recliner chair, ... looking at me, very engaged in the conversation. He had the appearance of looking well and he was quite surprised to see me. He said, you know, "You" – he was surprised that I had even come. And I said to him obviously I was just informing him that Community Nursing would no longer be coming... .*

143. RN Royal confirmed that the basis for her attending on 14 November 2014 followed a visit by communing nursing staff on 10 November 2014 who had expressed the view that Mr P had no wounds and that community nursing need no longer attend.

144. RN Royal stated that before they could cease attending that she had to make sure that Mr P was aware that he would be discharged from the community nursing support services and that is what led to the visit on 14 November 2014.

145. RN Royal's evidence was that Mr P was more than happy with being discharged from the community nursing support services and she formed the view that Mr P was not in need of any other care.

146. RN Royal confirmed that at no time did she have permission from Mr P to discuss his medical issues with Mrs P and so she did not.

147. Although RN Royal conceded that Mr P had never really refused and while she was aware that Mrs P held a Power of Attorney on behalf of Mr P, at no time did she discuss the extent of the Power of Attorney with Mrs P or Mr P as to the sharing of relevant medical information.

148. RN Royal was clear in her belief that unless she had formed a view about a specific mental health problem concerning Mr P she would not have engaged with his ex-wife in any other circumstance concerning Mr P requiring allied health support services.

149. RN Royal stated that everything possible within the scope of practice for community nursing had been afforded to Mr P.

150. RN Royal was clear that Mr P had a right of choice and that he chose to refuse and that needed to be respected.

151. RN Royal conceded that even if she had received some specialised training in relation to mental health there was only so much she could do, stating that mental health was a specialised field and that nurses working within this speciality were very highly trained to deal with patients who might require mental health services.

152. RN Royal conceded that it would have been a benefit to her, in Mr P's case, to have

had a closer liaison with officers of ACT Mental Health. However as nothing stood out for her in the delivery of services from her community nursing perspective having regard to the physical disarray within Mr P's home environment, RN Royal considered specialised mental health nurses may have been able to assist or provide guidance as to the underlying mental health issue that may have been able to be addressed through treatment.

153. RN Royal, on questioning from the ACT Government legal representative, confirmed that she did have some experience in dealing with patients who required mental health interventions. In these situations she had contacted Mental Health services in order to secure their involvement in an emergency. However that was not the situation which presented to her when she met Mr P - from her perspective, there was no emergency and there were no underlying issues as to Mr P's mental health.

154. RN Royal confirmed that his house was in a squalid condition. It was her evidence that this did not require mental health intervention because as she expressed it people have choice in how they want to live and, as she had said previously, a choice in their health as well, they make choices as they feel appropriate.

155. RN Royal's evidence was that Mr P had not reached a point of dysfunctional mental illness based on her observation using her professional skills and as a consequence he did not require any intervention from mental health services.

156. Importantly RN Royal held the view, having described Mr P's living arrangements as an example of extreme hoarding and squalor, that her scope of practice prevented her from contacting any other agency which may have been able to provide services as to the environmental conditions upon which Mr P lived - that is in extreme hoarding and squalor.

157. RN Royal's response to that is that she would have needed consent from Mr P before making any referral and that without consent, no referral would be made. This seems to be linked with her deep-seated conviction as to the rights of individuals in her respect for those rights and to their privacy.

158. I make no adverse findings against RN Royal for her belief and her application of community nursing which in all respects, appeared to be professional and appropriate.

159. In fact overall I am satisfied that no one has failed to meet their duty of care or obligations in relation to Mr P. However, there does seem to be a blurring in relation to beliefs concerning privacy and the rights of individuals over appropriate referrals for treatment that could be made to other supporting agencies who may make enquiries on their own behalf of that person and let that person make their choices to whether they want assistance or not.

160. Instead, what appears to be happening is that a view is taken of 'I cannot refer because of a privacy issue' when that is clearly not the case where a person's health or well-being is at risk or harm to life is a real possibility.

Dr Geoffrey Speldewinde

161. Dr Geoffrey Speldewinde is a specialist medical practitioner in pain and rehabilitation in the ACT.

162. Mr P was admitted to Calvary John James Hospital under Doctor Speldewinde's care on 21 October 2014. The doctor confirmed that Mr P had signed a Privacy Consent form consenting to the provision of information to a nominated next of kin however the doctor also confirmed that Mr P throughout his admission in hospital repeatedly refused permission for medical staff to talk to his wife or anyone else.

163. The doctor indicated this was evidenced in a medical file note which recorded that Mr P was offered:

> *...patient post-hospital supports. Patient declined. Offered home visits but declined. Asked if wife could be contacted to see if she had any concerns, but the patient declined.*

164. The doctor also confirmed that discharge summaries were not forwarded to a patient's general practitioner. He confirmed that ordinarily the patient takes discharge summaries with them so that they could read their contents and passed them on, should they choose to do so, to their GP.

165. The doctor also confirmed that at the time of Mr P's discharge on 6 November 2014 he was not attending a GP. Dr Speldewinde expressed the view that had he been aware of that situation at the time of Mr P's discharge, he would have targeted that bit of information more specifically given that Mr P was required to have his prescribed medication of Warfarin reviewed, which requires regular blood tests with a GP.

166. For that particular reason, he would have been instructed Mr P to see a GP within days of discharge.

167. Dr Speldewinde confirmed that Mr P had undergone a blood test before discharge to make sure his blood pressure was stable and if it was not, he would not have been discharged.

168. Dr Speldewinde was shown a two-page letter from Dr Phillip Jeans dated two days after Mr P was discharged. Dr Spendlewinde noted that the letter was addressed to Mr P's GP - a person whom he was no longer seeing.

169. Dr Speldewinde observed having read Dr Jeans' letter of 23 October 2014 that it was in some ways consistent with the nature of this man's complex history and his co-morbidities. The doctor said it explained the issues around Mr P's admission in the first place and supported the doctor's observations that Mr P was living two lifestyles: one out of hospital and one in hospital.

170. Dr Speldewinde said had he been aware of the letter, he would have more closely

discussed those issues with Mr P with an emphasis on Mr P's standard of living at home and involving the community nurses more to ensure compliance with follow-up treatment regimes.

171. Dr Speldewinde said not having the letter from Dr Jeans was an error, as Mr P otherwise presented in hospital as a compliant patient following directions and there were no particular reasons for those on the ward to have any concern for him on discharge, given his wife was attentive to Mr P while he was in hospital.

172. Accordingly, Dr Speldewinde had no rational basis for forming a view other than that Mr P was looking after himself in a general sense when he returned home. Hence there was no referral to community nursing.

173. The doctor also referred to instances of where Mr P was faeces incontinent in hospital. The doctor was of the opinion that it was likely to have a medical explanation in an overall sense - he felt that it wasn't deliberate, but was unable to elaborate further. This was because the progress notes largely indicated it was an isolated incident and given that by the time of discharge it was his recollection that Mr P was continent.

174. The doctor further confirmed that at no time had it been brought to his attention that there may be an underlying mental issue concerning Mr P.

175. Notwithstanding there were clearly some issues facing Mr P, Dr Speldewinde held the opinion that Mr P did not need an involuntary living arrangement that which Mr P could be placed under.

176. Dr Speldewinde's overall assessment was that while he had only seen Mr P once, Mr P had chosen a lifestyle preference to live at home without any assistance or support. To have regard to that information available to him at the relevant time concerning Mr P, the doctor formed the view there was no proper basis for removal of Mr P from his lifestyle prior to his death, notwithstanding there could have been more community support had he chosen to accept it.

177. The doctor concluded in his evidence that Mr P was not incapable of making a decision at the time he had been discharged and sent back home.

Peter Helson

178. Peter Helson gave evidence that he first met Mr P in 1992 having both been at the Australian Defence Force Academy for a Master of Defence Studies.

179. Mr Helson stated that he and Mr P became very close friends, seeing each other a couple of times a week before Mr Helson moved to Bungendore in New South Wales in 2010.

180. In 2014, Mr Helson said he was seeing Mr P either once a week when he was at home or perhaps every second week when he was in hospital.

181. Mr Helson described Mr P's home as a garbage tip and said it had been that way for about the last 12 months of Mr P's life.

182. Mr Helson said in Mr P's living area, it appeared that Mr P had never taken out the garbage. It appeared to Mr Helson that Mr P would finish a cask of wine or a packet of chips or something similar and just leave it where he had finished with it.

183. Mr Helson stated that Mr P's mail was delivered in boxes and cartons and Mr P would just open it and then sort of dump it where it had been opened. He recalled that one spare room in the house was full of empty cardboard boxes mainly from the online retail store Amazon.com.

184. Mr Helson recalled that when he first met Mr P, he was very friendly, outgoing, very much the life of the party, very sociable, had lots of friends but over the years he became very, very reclusive.

185. Mr Helson then recalled that sometimes Mr P would ask him to help clean up his home, go shopping for him or to collect his mail. However most times he said Mr P did not want any help with cleaning - it was as simple as that.

186. Mr Helson was of the view that Mr P would seek medical assistance when he needed it, but did not recall him ever seeking assistance for his depression.

Dr Wong

187. Dr Wong was the on duty doctor when Mr P was admitted on 2 September by ambulance to Calvary Hospital, and made observations on admission that Mr P was unkempt, unable to cook, had not been mobilised for three days and was possibly eating contaminated food.

Dr Chris Hii

188. Dr. Chris Hii, a consultant cardiologist medical officer at Calvary Clinic, was on two occasions in 2014 involved with care of Mr P at Calvary Private Hospital.

189. Dr Hii held concerns as to whether or not Mr P was a person who was capable, in a hygienic sense, of looking after himself. The doctor's recollection was that Mr P had cellulitis as a 55-year-old. On that specific issue he sought the assistance of Dr Berger, a psychiatrist, to determine whether or not Mr P could look after himself.

190. Dr Hii accepted that on 28 May 2014 he had written to Dr Berger requesting that she review Mr P as soon as possible.

191. Dr Hii stated that he had observed that Mr P had a markedly elevated INR and the doctor was concerned that Mr P may have been taking his medications, including Warfarin and anti-coagulants/blood thinner in an erratic and unreliable way.

192. Dr Hii also requested Dr Berger to determine whether or not Mr P's failure to take to

his medication was being done intentionally so as to elicit care or facilitate hospitalisation.

193. Dr Hii expressed that it was clearly of importance that patients were dealt with appropriately in hospital but also that their transition back into their normal life in the community and their ability to transition into that normal life was an important consideration for discharge planning.

194. Accordingly, Dr Hii made enquiries of Dr Berger before Mr P's discharge. Specifically, the doctor recalled asking Dr Berger to determine whether or not Mr P was capable of looking after himself back out in the community.

195. Dr Hii said that his recollection of Mr P after having spoken to him was that Mr P was friendly, cooperative and jovial and that he appeared to listen to you and would cooperate with you in hospital.

196. Dr Hii did make the observation from looking at the documents during the hearing that it appeared Mr P was two different people: the one that presented at hospital and the one that lived at home. By that I take was the Doctors understanding through the hearing that Mr P declined any ongoing home based medical support on discharge.

197. Surprisingly, Dr Hii was unaware that he could apply for a coercive order under the *Mental Health Act*. However, in response to questions about what he might do should he form the view that someone was in need of mental illness or had a mental dysfunction he said he would refer that person for psychiatric help.

198. When Mr P was discharged on 13 June 2014, Dr Hii confirmed that he and the discharge planner formulated a discharge summary considering an appropriate discharge date, the services that needed to be put in place and he specifically referred to whether or not there would be services that would be required to clean Mr P's wounds when he returned home. They also considered if blood monitoring could be done through his GP of Mr P's INL level. Dr Hii stated he did not see what the finalised plan looked like.

199. Dr Hii said he was subsequently unaware of what follow-up was put in place other than the patient being directed to call again or make an appointment with their GP if they need ongoing assistance.

200. Dr Hii was shown a patient progress note dated 12 June 2014 with a sticker on it called discharge planning. Dr Hii said that there were entries made in Mr P's planning notes that indicated Mr P had declined a number of referrals to relevant health agencies and/or services.

201. Dr Hii's response to that was that it is a difficult role for doctors to play where a person presents to hospital unwell and they are treated leading to them becoming well enough to be discharged. They are spoken to and support services offered to them. Dr Hii said it is difficult to then compel a patient to accept those services if the patient did not want to accept them or utilise them on discharge.

202. Dr Hii said there is no easy way in such a situation and that it is always a judgement call, but ultimately the patient is allowed to return home because medically, they are ready to be discharged.

203. Dr Hii recalled that on to 3 September 2014 Mr P had been referred to him after being admitted to Calvary Public and subsequently transferred to Calvary private. Dr Wong could read from Mr P's history that had previously been dealt with by Dr Hii, hence the transfer.

204. Mr P was now back in Dr Hii's care for the second time. The doctor accepted that Mr P had presented initially to Dr Wong, the duty doctor, suffering from diarrhoea, lower leg oedema and possible infected ulcer and it was then further discovered Mr P was not taking his Warfarin and that his INR was low.

205. Dr Hii was taken to relevant progress notes which revealed that Mr P would urinate in bottles as opposed to using the toilet or walking notwithstanding Mr P had been strongly encouraged by hospital staff to do so.

206. Dr Hii had no recollection about Mr P's continence or incontinence either at home or in the hospital. Nor did the doctor have any independent recollection of Mr P's mental state when he was transferred from Calvary Private to The Canberra Hospital on 14 September 2014.

207. Dr Hii said that he held a usual concern which arises in private discharge as to whether or not a person, in this case Mr P, was capable of looking after himself and what services need to be put in place if deficiencies were found in his confidence concerning that aspect - hence the role of the discharge planning a few days before discharge date.

208. Dr Hii said in this instance a discharge planning meeting occurred on 10 September 2014 but Mr P had a significant decline and was transferred to TCH ICU and fell into the care of Dr Jeans.

209. Doctor Hii was not able to recall a letter supposedly sent to him from Dr Phillip Jeans concerning Mr P dated 23 October 2014. When given the chance to read the letter the doctor confirmed it had no address next to his name and he was unable to ascertain to where it had been sent. In any event, the doctor confirmed it had not arrived it would seem after Mr P had already been transferred to another hospital.

210. Dr Hii provided an explanation as to the potential effect of the letter as simply to be placed on Mr P's medical file, it being it no more in effect than perhaps a progress note than an actual request to any particular person or entity to actually do anything about it.

211. Dr Hii was candid in his response when asked as to whether or not he would have contacted Mr P himself to follow-up at any particular point in time having regard to the surgery which had been performed in his specialist role as a cardiologist and he said that he probably would not have.

212. I am satisfied there is nothing adverse about that approach or that could be considered as detrimental or as a failure in a standard or delivery of a service to a patient having regard to these particular circumstances and interactions between the various medical service providers and the agencies with whom they belonged.

213. That is so for the simple and pragmatic reasons offered by Dr Hii that without being aware of whether or not a patient has moved on or has simply transferred to another medical service provider in circumstances where there are numerous patients and high workload, in the absence of being involved in the discharge follow-up services it was not practical to stay connected by an active engagement by the treating doctor unless it was mapped out in a planned and scheduled way.

214. Dr Hii did however confirm that if he had received Dr Jeans' letter which had been shown to him at the hearing and which had been placed on the file of Mr P he was confident that he would have contacted Dr Jeans to find out more information.

215. However, he had no recollection of either doing that or of reading or receiving the letter. Dr Hii struck me as a person who had sought to give Mr P the best assistance that he could in the provision of medical services but ultimately, Mr P was removed from his immediate care as a result of a haematoma requiring him to be transferred to another hospital.

216. I am satisfied Dr Hii provided appropriate medical services having regard to Mr P's complex array of health issues. It was appropriate for Dr Hii to hold the view that ultimately it is up to a patient to make choices concerning the provision of health services and what they might do about those services that are available. Dr Hii conceded that patients cannot be forced.

217. Dr Hii confirmed he was unable to provide any assistance in relation as to whether non-compliant anticoagulant therapy in the maintenance of Mr P's INR level following his mitral valve replacement had any relevant connection to Mr P having died from septicaemia secondary to renal infection.

218. Dr Hii did however confirm that Mr P's benefit from his prescribed medication of Warfarin could absolutely be affected by the consumption of alcohol.

219. Dr Hii said that he would have explained to Mr P the risk of infection through the mitral valve replacement surgery and the taking of antibiotics and the effects that other substances might have on his medication regime.

220. Dr Hii was satisfied that Mr P understood these issues and importantly, Dr Hii said Mr P gave the impression of being an intelligent man as observed from Dr Hii's engagements with Mr P. That is of course supported by the independent evidence of Mr Helson and others in their respective descriptions of Mr P, notwithstanding that in the last year of Mr P's life there was significant deterioration.

221. Dr Hii when concluding his evidence stated that from a physical perspective as reflected in the discharge summary Mr P was able to be discharged and that while

attempts were made to provide support services and to contact his family in order to facilitate discharge and ongoing support whether or not Mr P was prepared to accept that support was a matter for Mr P.

222. I am satisfied this was particularly evident in paragraph twenty of Dr Hii's statement. There Dr Hii sets out the actions of Registered Nurse Robinson and her notes concerning telephone contact with Mr P's wife and that it was Mrs P who conveyed to RN Robinson that while the family were willing and able to assist Mr P following his discharge that he declined all offers of assistance.

223. I am also satisfied there was an appropriate level of engagement between Dr Hii and associated medical staff when making the discharge summary for Mr P is discharge on 9 September 2014.

224. In his statement Dr Hii notes:

> *...As was the case previously, Mr P told Registered Nurse Robinson that he did not want any support service and he stated that he manages well at home. Registered Nurse Robinson formulated the following plan and documented it in the hospital records for Mr P to be reviewed by a complex case manager from Community.*

225. Dr Hii's evidence was that a complex case manager may be assigned to a particular patient following discharge and in such circumstances the complex case manager has the capacity to provide services interacting significantly in a patient's life such as doing their or supporting them in their shopping, managing medication or even organising the cleaning of a person's home.

226. Dr Hii stated this was more a matter to be secured from community nursing services and not from the hospital.

227. Dr Hii did concede that an important consideration for him on Mr P's discharge on the first occasion in particular was to have regard to the manner in which Mr P presented to hospital and the consideration of issues such as hygienic cleaning of his house and that these remained important considerations for him in the discharge summary for Mr P on that first occasion.

228. Importantly, at paragraph thirty of his statement, Dr Hii records that RN Robinson saw Mr P on 10 September 2014 and Mr P declined any referral to a social worker. The note further sets out that RN Robinson records Mr P agreed to discuss housecleaning with community options and that RN Robinson would attend to this referral prior to Mr P being discharged. There is of course no evidence of this being completed or if it ever in fact was referred.

Dr Chris Katsogiannis

229. Dr Chris Katsogiannis treated Mr P in the doctor's capacity as the staff specialist of rehabilitation medicine at the Canberra Hospital, National Capital Private Hospital and Canberra Private Hospital.

230. Dr Katsogiannis was involved in the treatment of Mr P on three occasions in 2014.

231. The first two admissions in which the doctor was involved were at National Capital Private Hospital in December 2013 to January 2014 and then 9 February 2014 to 22 February, following Mr P's discharge from Calvary Private.

232. The doctor's involvement in Mr P's third admission at the Canberra Hospital was from November to October 2014.

233. Dr Katsogiannis' evidence was that in the February 2014 admission period he saw Mr P approximately every two days. The doctor gave the following assessment during a period of Mr P's health. He described Mr P's condition as:

> *From a physical perspective he was making good progress. From a cognitive and affective component he was fine. ...both rehabilitation admissions at National Capital Private Hospital were uneventful. No red flags or alarms were raised that concerned the multidisciplinary team. ... I saw him approximately three times a week and we met as a multidisciplinary team at our case conference weekly where we discussed all our patients, Mr P being one of them.... his journey through the rehab episodes were uneventful. The only comment I can make was on the two occasions that he was under our care when the occupational therapist invited Mr P to undergo a home visit to assess his home situation, he declined. But throughout his episodes of care he was congenial, he was very engaging, he was very pleasant. There was never any distress or concerns. He participated and was an active participant in the program and his discharge was, as far as I can see, pretty smooth.*

234. Dr Katsogiannis recalled Mr P's past discharge summaries revealed a history of alcohol dependence and depression. He confirmed there were no issues concerning low mood and cognitive assessments and the application of Folstein's Mini Mental State Examination on Mr P revealed he scored 28 out of 30 in the first episode and 30 out of 30 in his second episode.

235. The doctor stated these results and day-to-day engagement and observations did not raise any concerns about Mr P's cognition or executive function and decision making that would warrant any intervention by them. The doctor indicated they only become concerned when scores are below 24/30 which indicates there might be some evidence of cognitive impairment.

236. It was on that basis the doctor confirmed that at no time did he consider it was necessary to make a formal psychiatric review of Mr P while he was at the National Capital Private Hospital because on the testing there was no basis to do so.

237. Dr Katsogiannis also confirmed he understood that mental health orders could be made under relevant legislation however in Mr P's case there was no need as Mr P was not displaying any cognitive impairment.

238. Dr Katsogiannis said that when he met up with Mr P in October 2014 having regard

to the time interval from when he last saw him on 22 February 2014 Dr Katsogiannis formed the view that Mr P was more frail than what he had been earlier in the year.

239. Dr Katsogiannis said Mr P appeared to have more acute medical needs including the possibility of pneumonia and unstable Warfarin INR levels and that Mr P appeared to be quite de-conditioned with a haematoma in his rectus sheath in his abdominal wall, that he was also oxygen dependent and had diarrhoea.

240. These observations are supported in a progress note made at about 11:30 AM on 9 October by Dr Usain Khan who had accompanied Dr Katsogiannis. Dr Khan records observations that Mr P was *suffering a retroperitoneal rectus sheath haematoma managed conservatively and a probable lower GI bleed, a gastrointestinal bleed, a lower respiratory tract infection, diarrhoea and he was on oxygen. He also had a significant inflammatory response on his blood work. His INR was supratherapeutic.* ...And further: *the rectal bleed was of about 400 mls*. Dr Khan had also indicated *bed mobility has worsened with one assist*.

241. Dr Katsogiannis said that based on that information, collectively the medical team formed the view that Mr P was not suitable for rehabilitation.

242. Dr Katsogiannis then referred to medical progress notes that revealed that while he was on leave a senior colleague Dr Venkata on 21 October saw Mr P for Dr Katsogiannis. The progress note reveals that Mr P's stool culture was negative, that Mr P denied any frank diarrhoea and had said that he had soft stools two to three times a day.

243. The note sets out that Mr P's haemoglobin remained at 8.3 and his INR was now within the targeted range. His CRP, which is an inflammatory marker, was 56. Mr P's bed mobility was independent in and out of bed with one assist into the bed. His sit to stand was with supervision with a forearm support frame and he was walking with a forearm support frame a distance of 30 metres. It was commented, "*Patient refused to allow for home visit by OT*," and then they've made a decision, "*We'll accept patient for rehab at 12B. Patient is willing, asking for private rehab. Team can do referral to private rehab*."

244. Dr Katsogiannis as a consequence stated that Mr P following his preference was transferred to a private rehabilitation service at Calvary John James Hospital.

245. Dr Katsogiannis was then referred to a two-page letter addressed to a Dr Lo from Dr Jeans. Dr Katsogiannis stated that he had not read that letter in the context of treating Mr P or shortly thereafter nor had Dr Jeans ever conveyed the content of the letter to Dr Katsogiannis either during Mr P's treatment or after.

246. Dr Katsogiannis responded as to whether not the contents of the letter would have been relevant in making a treatment decision for Mr P.The doctor said:

> *I don't believe so; mainly because he was a gentleman who always we felt had cognitive capacity and gave consent. He was, as far as - he was articulate, he understood what was going on, and certainly whenever we*

engaged with him everything went very well. Under a structured program, everything was fine. It would obviously - it looks that things were different in his domestic situation.

247. Dr Jeans had written in the letter that he did not believe that Mr P had a personality that would keep him sensible and compliant with his anticoagulation therapy.

248. Dr Katsogiannis stated such an opinion as expressed by Dr Jeans was not relevant to his decision-making as it was purely based on that particular doctor's assessment as to the cognitive capacity - that is to say the capacity to consent. In Dr Katsogiannis's view, Mr P was a patient who was always consenting and had capacity to make medical decisions.

249. An assessment as to a person's personality would be difficult to apply and as a consequence was not relevant to Dr Katsogiannis, although he said he was aware of personality disorders and that of course they have the potential to become pathological and actually form a mental illness.

250. Dr Katsogiannis did not agree that had Dr Jeans's observations been provided to Calvary John James rehabilitation providers a change in the support given to Mr P may have occurred. Dr Katsogiannis was firm in his response that it would not have changed Mr P's journey ultimately as they had held similar conversations during particular episodes of his care at National Capital and that their observations about providing structure and social support and follow on medical services at home were canvassed although politely declined by Mr P.

251. Moreover, what was being offered by Dr Jeans appeared to be a personal opinion and may not have been persuasively adopted by any medical service provider so as to alter the outcome of Mr P's post discharge medical support.

252. Dr Katsogiannis conceded Dr Jeans had felt seriously enough about these issues to write a formal letter and that that in itself was an indication of the seriousness of matters that should have been brought to the attention of Calvary John James. Importantly Mr P was transferred on 21 October and no discharge summary would have held the content of that letter as it was dated 23 October 2014 and further it was addressed to the Canberra Hospital medical records and Mr P's GP and not to any other ongoing medical facility.

253. Dr Katsogiannis did however reasonably conclude that the personal opinion of Dr Jeans is not something that would normally be entered into a discharge summary.

254. The discharge summary he explained essentially contains facts of clinical state, biochemical, haematological parameters and the plan of action for follow-up. Dr Katsogiannis set out that the eight page discharge summary on 21 October 2014 for Mr P was fairly comprehensive and communicated all the current issues which had occurred from the transfer to The Canberra Hospital from Calvary Hospital concerning Mr P's journey through The Canberra Hospital and ongoing follow-up.

255. Dr Katsogiannis concedes however that the documentation did not discuss Mr P's home living arrangements given this was a third incident in Mr P's history of home related events preceding hospital admission and readmission was likely to occur as suggested by Dr Jeans because of his observations about Mr P's personality.

256. Dr Katsogiannis conceded that having regard to that history it should have been information included in the discharge summary because of the recurrent admissions. Dr Katsogiannis stated he took Mr P at face value - there were repeated issues about his care outside of hospital support systems but that he had family and friends who could support him and that ultimately these were decisions for Mr P. Simply, Mr P did not consent to home visits.

257. I am satisfied that Dr Katsogiannis was thoughtful and helpful in his consideration of Mr P and his treatment in matters that were presented to him in the course of hearing to which he gave consideration and made observations.

258. Dr Katsogiannis conceded there could have been clearer or more information about the nonclinical aspects of Mr P's social circumstances but again this was difficult in that he engaged and presented well in full clinical discussions on life threatening issues and there was no context to accept at least in part what could have changed from their medical input as to Mr P's lifestyle. I am satisfied as to the standard of care delivered by the doctor and no criticisms could be made of his professional involvement in the treatment of Mr P.

Dr Anna Berger

259. Dr Anna Berger, a liaison psychiatrist and senior staff specialist employed by ACT Government Mental Health, Justice Health, and Alcohol and Drug Service was also called to give evidence having engaged with Mr P during the relevant period prior to his death.

260. On the morning of 27 May 2014 Dr Berger recalled being requested by Dr Hii to undertake a cognitive assessment of Mr P addressing two areas of concern.

261. Dr Berger recalled the first was to determine if possible, whether or not Mr P was doing anything to his medication to lengthen the time Mr P remained in hospital and secondly, if in fact he was feigning his illness so as to receive hospital treatment and/or care.

262. Dr Berger stated she was not requested to consider whether or not Mr P was depressed or psychotic, or to make a comment about anything other than determine if he was in her words: *fiddling with his Warfarin to make his INR go up, and if so is that because he wants to stay in hospital longer*.

263. Dr Berger however added that in the course of undertaking her assessments she would answer the question and look for a range of other things, and if the she held concerns or if there were red flags, she would investigate further.

264. Dr Berger recalls meeting with Mr P and that he was happy to be interviewed by her. Dr Berger recalled this was not the case in 2012 when she been assigned to undertake an assessment of Mr P where he refused to engage stating to her at the time that he was offended that Mental Health had become involved.

265. Dr Berger said she explained to Mr P in 2014 that Dr Hii wanted her to ask him specifically about why he was in hospital and about his Warfarin and associated matters. She made the observation that Mr P was quite cooperative and friendly, which surprised her, given her 2012 experience with Mr P.

266. Dr Berger, having read Mr P's file, conducted a follow-up assessment given the history of alcohol misuse and undertook quite detailed cognitive testing.

267. Dr Berger indicated prior to doing so she also read Mr P's mental health records and contacted his pharmacist and his former wife, his daughter and Mr P's GP to obtain more detail about Mr P.

268. Dr Berger explained the difference between a cognitive assessment and a capacity assessment, indicating that the latter concentrated mainly on the person's capacity to make decisions and the former being more about understanding what the person's memory is, what their knowledge base is, how they go about using their mind in order to, for example identify an object, or the way they speak or their ability to organise themselves.

269. Dr Berger indicated the assessment went for approximately half an hour and that Mr P had freely provided contact numbers in relation to his GP, pharmacists and Mrs P.

270. Dr Berger conducted the assessment using a tool which she identified as ACE, a screening tool used to measure cognitive ability in hospital patients. She said that cognitive impairment would exist with a score of 82 or below and that Mr P had scored 93. From that she concluded that there were no concerns whatsoever about his cognitive impairment.

271. In specifically taking Mr P through questions raised by Dr Hii, Dr Berger recorded that Mr P had relayed to her that he was not taking his medication incorrectly nor was he taking excess amounts in order to stay in hospital.

272. Mr P did indicate however to Dr Berger that Mr P believed his wife thought that Mr P subconsciously wanted to be in hospital and liked to be cared for. Dr Berger said Mr P was not presenting with infections that seem quite odd. The inference being had he had done, so may have put her or hospital staff on notice that something else was going on. Dr Berger added that when looking back over his history he was not making multiple presentations where he was requesting hospitalisation.

273. Dr Berger's evidence was that this was completely to the contrary on the history stating that Mr P did not usually come the hospital until things were quite serious or that he was quite unwell. From this, she formed the view that he was not misusing his medication. This was a reason for undertaking the cognitive assessment to make

sure that he was not suffering memory impairment as to the amount of Warfarin he was consuming on a daily basis.

274. Interestingly, Dr Berger specifically put to Mr P questions dealing with depression, alcohol use, hoarding and clutter because these issues had been issues before - which I infer means 2012.

275. Dr Berger also sought to obtain confirmation as to things Mr P had told her from Mrs P as Dr Berger understood she had previously been involved in his care notwithstanding he was divorced from her. However, Dr Berger said her attempts to make contact with Mrs P were unsuccessful.

276. Dr Berger stated however she was successful in contacting Mr P's daughter, however the daughter was very clear that she did not want to be involved under any circumstances in the provision of any information regarding her father.

277. Dr Berger further stated she left a message for the GP to contact her however no contact was made by the GP to Dr Berger.

278. Dr Berger recalled speaking to the pharmacist who confirmed that that Mr P was not having his Warfarin dispensed for some time and that this concerned to her given that she understood Mr P's INR was high. The pharmacist also confirmed that other medications which had been prescribed on discharge from hospital were also not brought in for dispensing to Mr P.

279. Dr Berger confirmed that her review of the ACT Mental Health MHAGIC records indicated that Mrs P had been in contact with ACT Mental Health raising concerns about Mr P.

280. Dr Berger stated her reason for not pursuing that issue further with Mrs P was that it was not relevant to the questions which had been put to her by Dr Hii which she had already answered: namely, that she did not find that Mr P was attempting to deliberately alter his Warfarin or was a malingerer.

281. Dr Berger conceded that while the ACT Mental Health MHAGIC system was a universal system across ACT Mental Health, it did not provide any access of information as to records held at National Capital Private Hospital or John James Hospital.

282. To be precise, there was no cross-referencing of any other medical issue confronting Mr P other than mental health it seems.

283. Dr Berger was asked in the course of the hearing the following:

> Did you feel you had enough information to make the assessment that you did?---*To answer the specific question about whether he was misusing his Warfarin on purpose to remain in hospital, yes. I was not asked to do anything more than that, but I did try to do quite a lot more than that.*

284. It was put to Dr Berger that if Dr Hii had raised concerns about Mr P's hygiene standards and concerns about his house would that have required or warranted some other form of assessment. Interestingly Dr Berger said the following:

> *So I would have needed to do what I did, which was to ask Mr P about his house, to say that I have read the MHAGIC file and that I have seen over a number of occasions that there were concerns from his ex-wife about hoarding. I did ask him about that. He said, "Yes, I know they're concerned. I'm a bit of a mess." He said, "Look around. I do have a lot of things around my bed here. This is what I do." In fact, he had train sets and things that he'd ordered from the Internet that were actually in the hospital. That's quite unusual. People don't generally - well, I should say he's the first person I'd ever met that the friends had brought in packages from the post office for him for model trains. So I did ask him about his house specifically because I had read the MHAGIC file. He said that yes his wife had been concerned, but that it all had been cleaned up now, and I said, "Well, do you mind if I ring your wife to ask her about that and whether she has any other concerns," and he didn't have any hesitation. So I wouldn't - if he'd asked that, I wouldn't have done anything differently.*

285. Dr Berger went on to say that from her experience she had seen a number of people at Calvary Hospital who hoard, and one of the things that she would do prior to the person being discharged is to conduct a home visit.

286. Dr Berger added however that the person would need to consent to the home visit and that she had been apprised of the records held on Mr P's file that he did not want people to come to his house. She in fact made the clear statement that Mr P was embarrassed by how much he had in his house. Accordingly she said she would not undertake any other assessment of Mr P other than the assessment that she did.

287. Dr Berger did not rule out providing appropriate psychiatric assessment or input where the patient was hers, but as she was not in charge of the patient she just provided her opinion as she was required to do.

288. Dr Berger stated that she is able to provide advice to treating teams who have requested her opinion as to what they should do. Her observation was whether or not they chose to follow that opinion however was a matter for them - again for the reasons she expressed earlier, namely that she is not in control of the patient management.

289. Dr Berger also gave evidence that her understanding of the new *Mental Health Act* in the ACT was that every person has capacity, that is mental capacity, unless proven otherwise. It was her position that patients have autonomy and they have the right to choose what they want to do. Dr Berger indicated that this was a very difficult issue sometimes.

290. Dr Berger formed the view that Mr P's refusal to have people enter his home to provide ongoing treatment did not amount to a mental illness or a mental

dysfunction.She formed the view that it might be assessed as a wrong decision or a poor decision that did not mean he lacked capacity from a mental health perspective.

291. Dr Berger accepted a question from the P family about Mr P's co morbidities and as to whether not having regard to them might of itself indicate that he was mentally unwell.

292. The co morbidities that were identified were that Mr P lived in squalor, he was a hoarder, and he had obsessive-compulsive aspects to that hoarding. He would soil himself in his own home and had continence issues in hospital. There were multiple hospital admissions and the family claim Mr P was making decisions against his own interest and they were contrary to his own health which included his adherence to the Warfarin medication program and his INR levels.

293. Dr Berger responded that by definition, that did not paint a picture of someone who might be mentally unwell. Dr Berger referred to the *Mental Health (Treatment and Care) Act 1994* which was available when she last saw Mr P and noted that the Act contains a very clear definition of mental illness.

294. Dr Berger was clear that Mr P did not meet the criteria set out within that piece of legislation.

295. Dr Berger was clear in her evidence that Mr P did not have delusions, he did not have a hallucinations, he did not have a disorder of thought form and he did not have a serious evidence of depressed mood.

296. Dr Berger conceded Mr P had episodes of when he was depressed but he did not have a severe major depressive illness.

297. Accordingly, Dr Berger expressed that by definition Mr P did not have a mental illness. Dr Berger succinctly expressed it as it being very difficult to not think someone may be mentally unwell when somebody makes decisions that you believe aren't in their best interests.

298. Dr Berger was taken to the dictionary section of the ACT Mental *Health (Treatment and Care) Act 1994* and specifically to the definition of mental illness and in particular subparagraph (e) that talks about sustained or repeated behaviour indicating the presence of the symptoms referred to in either of the above paragraphs.

299. Dr Berger responded that although Mr P chose to hoard and chose to use alcohol in a way that was not beneficial to his health, he did not in that way demonstrate that he had delusions, hallucinations, disorder of thought form. In Dr Berger's opinion, for subparagraph (e) to apply Mr P had to behave in such a way that he must have one of those other four things, being the delusions, hallucinations, disorder of thought or evidence of depressed mood. None of these were present following the assessment of Dr Berger.

300. Disorder of thought form is a very specific psychiatric terminology usually indicating that a person has disorganised thought, in that a person is not logical in the way they think. Dr Berger said that the fact that Mr P chose to spend his money on trains or to drink at the expense of his health or without looking after his health until reaching the point of requiring hospitalisation was not disorder of thought form. However, that is why she sought to pursue the matter to undergo more complete testing in the cognitive assessment of Mr P.

301. Importantly, Dr Berger went on to explain in her words the following:

> *So it can be that they have a cognitive deficit which means they don't see that that's what they're doing, that they don't recognise it or they don't choose to do anything about it because it doesn't bother them. So alcohol can affect the frontal lobe and the frontal lobe is important for organisation, planning, sequencing, thinking ahead, putting things in place in case something happens, recognising that your self-care is poor. Alcohol is notorious for doing that, which is one of the reasons I did the more detailed cognitive assessment because I felt if this man is drinking heavily, that may be why his Warfarin use is not reliable and may be why he's not looking after himself, why his wife has these concerns and he's not concerned. But that doesn't mean that he has a mental illness. Mental illness can make you do that, but it's not by definition the only cause of such difficulties. Mr P indicated to me that he was demoralised by being in hospital, that he was frustrated, that he wanted to be at home where he could do his own thing. He showed me his model trains and told me he had numerous trains at home and wanted to go home to be with his own things. So he valued his independence. And I wonder whether he was cooperative in hospital so that he could be discharged sooner. If he was a heavy drinker, you're not able to drink in hospital ..., so he may have been cooperative because he wanted to go home and drink. And that's not something you can force someone to change. So I think it's very tempting to say, well, he must be mentally ill* ...

302. Perhaps more importantly Dr Berger's observation where she says in her evidence:

> *I was wondering whether that's what the family are concerned, that he had an untreated mental illness and therefore if he had been treated, this wouldn't have happened.*

303. Dr Berger was taken then to the family's concern as to whether not it would have been appropriate to have taken action under the *Mental Health (Treatment and Care Act* to coerce Mr P into treatment. Dr Berger's response was to query what possible treatment could have been given had he been coerced.

304. Dr Berger's evidence was that Mr P did not have a mental illness, and if you do not have a mental illness you cannot be forced to have treatment. As to the hoarding issue, she was of the view that you cannot have a treatment order put in place to have someone's house cleaned or to remove or sell their possessions.

305. Dr Berger went on to say that hoarding is a particularly difficult area to work with and there has to be clear evidence that the person's safety is at risk or there is a risk to other people.

306. Dr Berger indicated there was not any area of concern concerning this aspect of Mr P's personal safety or his life. It was Dr Berger's observation Mr P was enjoying his life: he did not see anything wrong with it.

307. Dr Berger indicated Mr P had told her he enjoyed drinking alcohol, that he got great pleasure in purchasing the items that he purchased and was using. He had relayed to her that this was frustrating his wife.

308. Dr Berger indicated that Mr P was not making mortgage payments instead he was using the money to purchase military equipment, trains and other memorabilia, and that Mr P told her this was why his wife had left the marriage.

309. Dr Berger said that in the absence of Mr P being immensely unwell there was very limited capacity to do anything other than to make suggestions about what might be available for a person to access or utilise should they elect to do so.

310. It was Dr Berger's assessment that alcohol abuse, hoarding, living in squalor, soiling and issues with incontinence, obsessive compulsive aspects, multiple hospital admissions and decisions and display of judgment that is against interest and/or health, fell within their own mental illness classifications as set out within DSM-4 and DSM-5.

311. The Doctor stated presentations such as Obsessive Compulsive Disorder (OCD) have their own particular criteria. The doctor said there was often an overlap between obsessive compulsive disorder and hoarding, as people may hoard because they believe, for instance, that they need a particular number of trains and they have to get that number because if they don't they have an intrusive thought saying they haven't got enough.

312. The doctor went on to say the relationship between hoarding and OCD is complex. Dr Berger further referred to the DSM 4 and the DSM 5 which set out a range of mental health conditions symptoms and treatments. Dr Berger indicated that while hoarding was listed in the DSM 5 at the time Mr P was being assessed, hoarding (under the DSM 5) was not incorporated into Australia's psychiatric practices by the Australian College of Psychiatrists until October 2015.

313. It was put specifically to Dr Berger that, in light of the DSM 5 now recognising hoarding as a mental illness, would Mr P fall within the classification of having a mental illness, Dr Berger responded that Mr P would have been classed as having a mental illness under the DSM 5.

314. However, Dr Berger did indicate clearly, that while Mr P would fit the criterion for mental illness, that would not necessarily mean that a coercive order would or could be made, as an order is made to enforce treatment and it was her observations or

reasonable belief that there was not any forcible treatment for hoarding and as a consequence, Mr P would have to consent to treatment for hoarding.

315. There is certainly evidence within the material provided to me that a recommendation from Belconnen Mental Health on 2 September 2014 was that a geriatrician be involved and that guardianship be considered. However, nothing seems to have developed from that - at least not from the family perspective or the Mental Health service.

316. It is evident from the material before me that Peter Shiels, a mental health worker, spoke to the referring clinician, which was the complex care nurse, and informed her of those things. The material goes on to state: "*Spoke with the community nurses. Client has been readmitted to private hospital for physical health issues*," and that was the last contact, in that once he had been admitted into private hospital, Mental Health appear to have closed their file.

317. Dr Berger was specifically asked as to whether or not she formed the view that Mr P suffered a mental dysfunction which is defined under the legislation as meaning: a disturbance or defect to a substantially disabling degree of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion.

318. Dr Berger's cognitive assessment indicated that Mr P did not have memory impairment and that he could manipulate information on quite a detailed test in order to get a surprisingly high score for someone who has a long history of drinking alcohol.

319. Dr Berger's evidence was that notwithstanding all the behaviours concerning Mr P, which had earlier been identified as co morbidities, they still did not necessarily bring Mr P within the definition and application of the coercive powers under the legislation.

320. Dr Berger confirmed that were a patient admitted to hospital for a physical illness for instance, there is no connection between any existing mental health file and the physical health file that might generate or create some form of real liaison or referral being made. It is dependent on the treating team to make determinations as to whether not some form of underlying psychological or psychiatric issue needs addressing and to call in their liaison psychiatrist.

321. It was Dr Berger's understanding that the mental health system is separate to the hospital for confidentiality reasons. Usually a referral is triggered by somebody's concern, like Dr Hii's concern.

322. Dr Berger went on to explain that general hospital staff do not have access to the ACT Mental Health Services MHAGIC system. You have to be employed by Mental Health in order to get a password and access these file. Accordingly, at the time Mr P was treated by Dr Hii, Dr Hii would not have known that there was an active mental health file in place concerning his patient.

Dr Jeans

323. Dr Phillip Jeans having provided a statement also gave evidence in relation to the matter by telephone. Dr Jeans recalled writing the letter to Dr Lo dated 23 October 2014 on the basis that he believed that Mr P was going to the rehabilitation ward at The Canberra Hospital. It wasn't until after that that he had learnt that Mr P had in fact gone to Calvary John James Rehabilitation Ward.

324. Dr Jeans confirmed his usual practice to write letters of this nature where a patient has been discharged from hospital to inform the GP of what had taken place. He further added, that he had CC'd the letter to a number of people including Dr Hii as he understood that doctor to have been Mr P's cardiologist and particularly given that Mr P was having a problem with managing his anticoagulation through the prescription of Warfarin.

325. Dr Jeans stated he was unaware that Mr P was no longer being seen by the GP or anyone in the GP's medical practice centre.

326. I am satisfied Dr Jeans forwarded the content of his letter of 23 October to those relevant people who he considered were involved in the care of Mr P. It was clearly not Dr Jeans' mistake or error that it wasn't forwarded to Calvary John James, as Dr Jeans had no knowledge that Mr P had in fact been transferred to that facility.

327. Dr Jeans confirmed that in relation to Mr P's habit of defecating while in bed that this was a choice that Mr P had made and that he was not experiencing faecal incontinence. Dr Jeans reached this conclusion having discussions with community workers and social workers investigating it from a medical perspective.

328. Dr Jeans's evidence was that he was direct with Mr P that Mr P should use a toilet because he was creating unnecessary work for the nursing staff and further he was in a four-bedroom ward and it was unfair on other patients.

329. Dr Jeans's evidence was that following three days of faecal incontinence from when Mr P was first brought into the hospital he questioned Mr P's mental state in that he appeared to obviously demonstrate an inability to adequately care for himself and that he had been informed by social workers that this in fact was an ongoing issue concerning Mr P.

330. Dr Jeans stated that following further discussion amongst the social workers, psychiatric assessment was formerly undertaken in relation to these underlying issues.

331. Dr Jeans stated how the system might be improved in regard specifically to Mr P's issues and treatment. The doctor indicated that he made a recommendation that community nurses should call every day so that history was being supervised or through the attendance of the social worker. Of course, having regard to Mr P's rejection of such services, it is readily apparent as to why that recommendation was not successful because ultimately Dr Jeans held the view that the issues surrounding

Mr P were insoluble.

332. Dr Jeans noted that Mr P was exercising his rights as to how he chose to live and as to what services he wanted provided or that he would accept. Unless Mr P was assessed to be, from a psychiatric viewpoint, incompetent, he was entitled to exercise his rights in the manner that he did.

(end)