CORONER'S COURT

Inquest:	**Inquest into the death of DB**
File number:	1098/09
Hearing dates:	3, 4, 5 April 2012
Date of findings:	17 April 2012
Place of findings:	Coroner's Court, Glebe
Findings of:	Deputy State Coroner C. Forbes
Findings:	I find that DB died at Norton's Basins Road, Wallacia New South Wales, on 21 April 2009. The cause of his death was ligature strangulation and the manner was suicide.

NOTE: These findings and reasons are subject to a non-publication order pursuant to s 75 Coroners Act (2009). A report of these findings may be made only on condition that the pseudonym DB is used for the deceased and no material is published that identifies the deceased or his family

Representation:

Dr P Dwyer (Counsel Assisting) instructed by Ms C Berry (Crown Solicitor's Office)

Mr. Cavanagh representing the family of DB

Mr. Rooney, representing Nepean Blue Mountains Local Health District (Nepean Hospital and Pialla Unit)

Mr. Barnes representing Dr Noore

REASONS FOR FINDINGS

INTRODUCTION

On 21 April 2009 DB died at Norton's Basins Road, Wallacia, New South Wales.

The primary purpose of an Inquest is to make formal findings concerning the identity of the person who has died, when and where the death took place and the cause and the manner of the death.

The cause is the immediate physical cause. The manner refers to the surrounding circumstances of the death. It is not in dispute that DB committed suicide. This inquest is a close examination of the circumstances surrounding DB's suicide to see if there are any recommendations that can be made that might prevent a similar incident.

DB

DB turned 28 years of age on the day of his death. He was the youngest son of his parents and he had one older brother.

On the 31 March 2009 DB was admitted to the Emergency Department of Nepean Hospital after harming himself by cutting off his own testicle.

Dr Noore, the consultant psychiatrist at Nepean Hospital diagnosed that DB was suffering from a psychosis, probably related to drug use. DB was scheduled under the Mental Health Act. He was prescribed Olanzapine.

On the 3 April DB was transferred from the general hospital to the Pialla Mental Health Unit at Nepean Hospital. At the unit he came under the care of Dr Brakoulias, psychiatric consultant and Dr Thavakulasingam, psychiatric registrar.

On 9 April, DB went before a Mental Health Review Hearing. The Magistrate determined that he should remain in Hospital for at least a further fourteen days pursuant to the *Mental Health Act*.

After the hearing, a meeting was held between DB's family and Dr Brakoulias in the courtyard of the Pialla Unit. The family were informed that DB would now be given 3 hours of leave per day.

From 10th to 20th April DB left Pialla on 3 hours of leave with his family each day. On each of these 10 days DB was picked up and returned safely.

On 21 April, DB's leave was increased from 3 to 4 hours and his mother picked him up from Pialla at 10am.

Shortly after midday, DB appeared sleepy and was on the couch at home. It had started to rain and DB's mother left the lounge to collect the washing. DB got up and took the keys to both his car and his father's car. He went outside and started his father's car.

DB's father was under his caravan in the backyard doing some work and when he heard the car start he pulled his head out and called out to ask DB what he was doing. DB said he was just moving the cars so that he could give his car a wash.
DB did not clean the car, but drove down the road and disappeared.

Both of DB's parents were aware that Dr Thavakulasingam had told DB that he should not drive his car. DB didn't have his license.

DB's parents phoned his brother to let him know that DB had disappeared. At that point, DB's brother was so concerned that he looked through emails on his phone. DB's brother discovered that DB had sent himself an email to the effect that as soon as he had some money he would commit suicide.

DB's mother called Penrith police to report him missing. They were extremely worried, knowing that they had given DB a small sum of money some days earlier to cover his bills.

DB's mother called Pialla and told them that she had notified the police and she left a message on DB's phone pleading with him to come back. DB's father drove around Emu Plains looking for DB. DB's brother also left in his car to search for him.

DB phoned his mother and told her he was just driving around Emu Plains and would be home shortly. DB's mother asked him to come back, she reminded him that he didn't have his license and to be careful and she told him she would be waiting out the front for him.

DB attended Bunnings when he left home and at around 12.29pm bought two lengths of rope.

DB never came home. He drove to bush land in Norton's Basin and decapitated himself in the car using the rope he had purchased. At around 4.30pm, a passer by located his car and police were alerted.

THE ISSUES FOR THIS INQUEST

Two independent expert psychiatrists were given an opportunity to thoroughly review the material that related to DB's care and treatment; Dr Olav Nielssen, retained by the Crown Solicitors Office and Dr Enrico Parmegiani, retained by the Nepean Blue Mountains Local Health District.

They both agreed that DB was diagnosed, medicated and supervised appropriately by the Nepean Hospital. They also agreed that the decision for DB to be given leave was appropriate.

The real issues that have arisen in this inquest are;

1. Whether the risk assessments upon DB were carried out and recorded appropriately, and

2. Whether the family were given adequate and appropriate psycho education.

1. RISK ASSESSMENT

It is in not in dispute that risk assessment is an essential part of a psychiatric patient's treatment and that in the hospital setting it occurs daily.

During DBs admission at the Pialla Unit there were two weekly interdisciplinary meetings. At those meetings the teams were required to record a risk assessment that is overseen by the psychiatric consultant. In DBs medical records there are two Mental Health Review Forms that were completed at these meetings. At the first meeting on the 7th April the form was completed by the social worker who had never met DB. She completed the risk assessment and concluded his overall level of risk was high. (see tab 53). Dr Brakoulias was at that meeting and he gave evidence in this inquest that the level of risk was not high. That DBs risk was being assessed daily in the unit. The weekly meeting recorded an assessment that was incorrect and completed without his knowledge. At the next meeting on the 14 April the risk assessment part of the form was not filled in. The rest of that form was completed by another Social Worker.

These facts highlighted the paucity of the risk assessments that were conducted at the interdisciplinary meetings and the lack of proper recording of those assessments. I am informed by Clinical Director of the Mental Health Network for Nepean Blue Mountains Local Health District that from now on the psychiatric consultant will be the only person who signs off the record of the weekly interdisciplinary meeting. I am also informed that there will be teaching sessions to educate mental health clinicians on how to complete forms. There is no criticism of the daily risk assessment that took place in relation to DB at the Pialla unit.

2. THE ADEQUACY OF PSYCHO EDUCATION

The medical records on 6 April and 7 April include the words "psycho education given to family". (Tab 62 pp 266, 267). There is no record of what the family were told.

Evidence has been given that on 9 April when 3 hours leave was granted to DB there was a discussion between Dr Brakoulias with the family about leave. This discussion

took place in the Pialla Unit Courtyard with other families in the vicinity and DB nearby. The risk that DB might further self-harm was not discussed.

The family had never been involved in Mental Health before. They were suffering from the shock of DBs self mutilation and admission. They were now being included in his treatment and needed a lot of information about his diagnosis, prognosis and treatment to feel confident to take DB home.

It is agreed that the information content and manner it was given was not optimal. This was DB's first psychotic episode and his first period of hospitalization. His risk of suicide was higher than for other patients.

The Director of the Mental Health and Drug and Alcohol Unit, NSW Government has informed this inquest that a new policy is being prepared for the standards and requirements for in patient leave. That policy relates to all mental health patients.

This case highlights the particular circumstances of the early stages of treatment of first episode psychosis patients. In these cases there is heightened risk of self-harm combined with the very likely circumstances that the family or carer given responsibility of the patient would have no previous experience. The two independent Psyhchiatrists are of the view that some form of informed consent on behalf of the family/carer would be beneficial. This form should include;

1. The diagnosis,
2. The treatment,
3. An explanation that experience shows patients with first episode psychosis are at an increased risk of self-harm. That this is particularly so during the early stages of treatment. That the decision to grant leave does not mean that the patient has fully recovered or there is no risk of self-harm.
4. Supervision requirements
    - **a.** the supervisor is required to accompany the patient whilst on leave
    - **b.** the patient is not to drink any alcohol or take any illicit or non-prescription medication
    - **c.** the patient is not to drive

d. the supervisor is required to inform the hospital of any worrying behaviour while the patient is on leave

e. If the patient absconds or becomes unwell during the leave period the supervisor should immediately contact the hospital on the following numbers or call their local police.

A draft form has been formulated with the input of the Nepean Blue Mountains Local Health District, the two independent experts, the family and other mental health workers involved in DBs care. A copy of that form is attached. (Annexure A)

CONCLUSION

DB's case exposed the need for a more thorough and careful inclusion of the family/carer in a patient's treatment especially when the patient is sent home. There is a new NSW Health policy being formulated that addresses these issues. I note that the Nepean Blue Mountains Local Health District has written a letter to this court confirming the strategies that will be implemented to ensure the policy is complied with. I attach a copy of that letter dated 13 April 2012. (Annexure B) I note that the Area Clinical Director has assured that she will send this court an updating report in six months on the matters raised in her letter.

RECOMMENDATIONS

I recommend:

To the New South Wales Minister for Health

1. That consideration is given to the introduction of a leave form for involuntary patients with first episode psychosis. The attached form should be considered as an example of one that might be adapted for that purpose.

2. That consideration is given to the creation and distribution of an information package for patients and their families/carers relating to first episode psychosis.

FINDINGS

Pursuant to s 81 of the Coroners Act 2009, I find that DB died at Norton's Basins Road, Wallacia New South Wales, on 21 April 2009. The cause of his death was ligature strangulation and the manner was suicide.

Magistrate C Forbes

Deputy State Coroner

17 April 2012

LEAVE FOR INVOLUNTARY FIRST EPISODE PSYCHOSIS PATIENTS

Name:…………………………………

Diagnosis / provisional diagnosis…………………………………………………………..

Treatment…………………………………………………………………………………..

…………………………………………………………………………………………………

What leave is granted…………………………………………………………………

Experience shows patients with first episode psychosis are at an increased risk of self-harm. This is particularly so during the early stages of treatment. The decision to grant leave does not mean that the patient has fully recovered or there is no risk of self-harm.

Supervision requirements

- the supervisor is required to accompany the patient whilst on leave
- the patient is not to drink any alcohol or take any illicit or non-prescription medication
- the patient is not to drive
- the supervisor is required to inform the hospital of any worrying behaviour while the patient is on leave
- If the patient absconds or becomes unwell during the leave period the supervisor should immediately contact the hospital on the following numbers or call their local police.

Contact Numbers:………………………………………………………………………

Signed: …………………………
Consultant Psychiatrist

Signed; …………………………
Patient’s Supervisor

13 April 2012

Dear Deputy Coroner Forbes,

RE: INQUEST INTO THE DEATH OF DB

Please find below the information requested from Nepean Blue Mountains Local Health District ("NBMLHD") on 5 April 2012:

1. **What education will be provided by NBMLHD to mental health clinicians regarding the Mental Health Act provisions concerning information being provided to nominated carers and how that balances with concepts of patient privacy in a mental health context.**

Information will be disseminated to NBMLHD's senior mental health managers who will provide education to their team members regarding this issue.

This information will summarise the requirements of the *Mental Health Act 2007* relating to information to be provided to primary carers and what strategies are to be employed if a patient has concerns about the release of information to primary carers.

2. **How will education be provided to NBMLHD mental health clinicians when the statewide draft Transfer of Policy ("the Draft Policy") takes effect and any adaptations at a local level?**

The NBMLHD recognises that any major new policy requires considerable work in local health districts to develop suitable protocols and forms to comply with the policy.

At this stage, it is difficult to know exactly what education will be required to be provided by the NBMLHD and what local level adaptations will be required as the Draft Policy has not yet been finalised.

It is likely that an education package will be developed concerning the Draft Policy (once finalised) to reach all NBMLHD mental health staff and to provide an ongoing resource as new staff join the teams.

The NBMLHD also intends to employ the following measures once the Draft Policy has been finalised:

(a) Education will commence by involving many members of the NBMLHD's multidisciplinary teams in the design of the new local protocols and forms to comply with the policy;

(b) Staff will be provided with a copy of the final policy and copies of the policy will be kept on the ward and/or electronically available on the NBMLHD's health intranet;

(c) Senior staff members will be alerted with memos and management forums regarding the new policy; and

(d) Each team leader will be responsible for education of the individual members of each team.

Further to the above and as a matter of general practice, the implementation and education of any new policy is monitored by local regular monitoring and clinical audits. This includes annual reporting to the Ministry of Health, the measurement of relevant key performance indicators, the oversight and checking of the Official Visitors, reviews during Root Cause Analysis (RCA) and other sentinel event investigations and audit and review during accreditation processes such as the Clinical Excellence Commission accreditation.

3. Which mental health forms will be reviewed by NBMLHD?

As required with new state policies, once the Draft Policy is finalised, the NBMLHD will review all relevant forms and local policies to ensure that they comply with the state policy.

4. What education will be provided to mental health clinicians at NBMLHD regarding the use of forms and how they should be properly completed?

Once new forms are created by the NBMLHD to conform with the requirements of the Draft Policy (once finalised), teaching sessions will take place to educate NBMLHD mental health clinicians regarding how to use and complete these forms.

5. How will NBMLHD review the adequate recording of family reports regarding a patient's mental state in the case notes? What arrangements will NBMLHD make to arrange for mental health clinicians to meet and "debrief" with families/ carers following a patients first session of accompanied leave?

In addition to regular clinical audits that are completed, emphasis will be provided to NBMLHD mental health clinicians regarding talking to family/ carers upon an inpatients return from leave.

Further, in accordance with any general principles adopted in the Draft Policy (once finalised), the NBMLHD mental health clinicians will be required to follow any requirements for documentation of post leave feedback from patients and carers.

Yours Faithfully

Dr Marcia Fogarty
Area Clinical Director, Mental Health Network