FINDINGS, COMMENTS and RECOMMENDATIONS of Coroner Olivia McTaggart following the holding of an inquest under the *Coroners Act* 1995 into the death of:

JOSEPH AARON LATTIMER

Contents

Hearing Dates 3
Representation 3
Introduction 3
Scope of Inquest 4
The Evidence 5
Mr Lattimer's Background and Medical History 6
Mr Lattimer's Mental Health Issues and Treatment Before his Death 9
Circumstances Surrounding Death 11
Issues 15
Compliance with appropriate guidelines and principles relating to Mr Lattimer's triage and treatment in the Emergency Department 16
The connection between the failure to apply appropriate guidelines or best practice in the ED and Mr Lattimer's death 18
Any staffing deficits in the ED, whether mental health staff or otherwise, that may have contributed to Mr Lattimer's lack of treatment and supervision 20
Whether any staffing deficits in the ED are entrenched, such that the there is a risk of similar deaths 21
Availability of suitable space or beds in the ED for appropriate treatment of mental health admissions 22
Access block 22
Inadequate and unsuitable space in the ED for mental health patients 24
Whether the Tasmanian Government's current plans will demand adequately addressed staffing and space deficits in the ED of the RHH in respect of emergency mental health presentations . 25
The availability or use of other community treatment options and resources, including general practitioners, to reduce the number and severity of mental health presentations to the ED of the RHH 29
Findings required by s28(1) of the *Coroners Act* 1995: 29
Recommendations 30
Acknowledgements 30

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Olivia McTaggart, Coroner, having investigated the death of Joseph Aaron Lattimer, with an inquest held at Hobart in Tasmania, make the following findings.

Hearing Dates

28, 29 and 30 October 2019 and 12 February 2020
Final written submissions received by 6 March 2020

Representation

Counsel Assisting the Coroner: S Nicholson
Counsel for Tasmanian Health Service: J Rudolf
Counsel for the Employees of the Emergency Department of the Royal Hobart Hospital: A Mills

Introduction

1. Joseph Aaron Lattimer was born in Wollongong, New South Wales, on 17 November 1978 and was aged 37 years at the time of his death. He was single and unemployed. He is survived by his only child, a daughter, Cassie Lee Lattimer ("Cassie"). Mr Lattimer's parents are George Frederick Lattimer ("George Lattimer") and Julie Ann Lattimer ("Mrs Lattimer"). He has an older sister, Karen Lattimer.

2. For many years before his death, Mr Lattimer had suffered issues concerning his mental health, having been diagnosed with post-traumatic stress disorder, anxiety and depression. His poor mental health was exacerbated by incidents of sadness and trauma in his life, these including: the death of close family members, the relocation of his daughter to Queensland, his experience of violent incidents, involvement with authorities and court proceedings, and drug and alcohol abuse. For most of his life, he lived with his mother in Mornington.

3. On 10 July 2016, Mr Lattimer voluntarily attended the Emergency Department ("ED") at the Royal Hobart Hospital ("RHH"), suffering a severe mental health crisis with suicidal thoughts. Upon presentation, he was triaged by a triage nurse to fall within 'Category 3' of the Australasian Triage Scale, meaning that further assessment and treatment was urgent, and should occur within 30 minutes. Mr Lattimer then waited in the ED waiting room for 42 minutes without assessment or treatment, after which he entered a toilet cubicle in the ED

and took steps to end his life by using his shoelace to try and hang himself on the cross-bar of the cubicle. He was discovered, resuscitated and placed in a coma with life support. He was admitted to the Intensive Care Unit but, given the extent of his brain injury, his life support was withdrawn after family discussions and he passed away on 21 July 2016.

Scope of Inquest

4. My functions under section 28 of the *Coroners Act* 1995 are to make findings regarding the identity of Mr Lattimer, the cause of death and how it occurred, and the date and place of death. All of these findings can be made easily, with the exception of the question regarding "how death occurred". It is clear upon the evidence that Mr Lattimer's death came about as a result of him intentionally attempting to end his life by hanging. However, the circumstances leading to his death, including the question of how he was able to take such action in the ED after triage and whilst awaiting treatment, fall into the consideration of how death occurred.

5. Further, by section 28(2) a coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

6. By section 28(3) a coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

7. It was apparent from an early stage in the investigation that, when examining the circumstances of how Mr Lattimer's death occurred, the investigation should include any issues or deficits with his care, treatment and support in the ED. These matters may be found to be related or connected with his death as part of the circumstances and may be considered to be the subject of comments and recommendations with a view to preventing further similar deaths.

8. Therefore, the focus of the investigation and inquest was upon the following issues:

    a) The nature of Mr Lattimer's mental health issues generally, his state of mental health at the time of his presentation to the ED on 10 July 2016, and the sequence of events from his emergency call until his attempted suicide.

    b) The RHH's compliance with appropriate guidelines and principles relating to triage and treatment in the ED.

c) The connection between any failure to apply appropriate guidelines or best practice in the ED and Mr Lattimer's death.

d) Any staffing deficits in the ED, whether mental health staff or otherwise, that may have contributed to Mr Lattimer's lack of supervision.

e) Whether any staffing deficits in the ED are entrenched, such that there is a risk of similar deaths occurring.

f) The availability of suitable space for Mr Lattimer during and subsequent to his triage in the ED.

g) The availability of suitable space or beds in the ED for appropriate treatment of mental health admissions.

h) Whether the Tasmanian Government's current plans will adequately address any staffing and space deficits in the ED in respect of emergency mental health presentations.

i) The availability or use of other community treatment options and resources, including general practitioners, to reduce the number and severity of mental health presentations to the ED.

The Evidence

The evidence upon which I have based these findings is as follows:

- Police Report of Death to Coroner;
- RHH Report of Death of Coroner;
- Affidavits of life extinct and identification;
- An opinion of Dr Donald Ritchey, the forensic pathologist who conducted the autopsy;
- Toxicological evidence of the results of Mr Lattimer's ante-mortem blood sample;
- Audio recording of the 000 call to police made by Mr Lattimer on 10 July 2016;
- Medical records – Royal Hobart Hospital;
- Medical records – New Town Doctor's Surgery;
- Medical records – Salamanca Psychology;
- Medical records – Cambridge Park Medical Centre;
- CCTV footage of the ED waiting area;
- Report – Tasmania Ambulance Service;

- Affidavit and oral testimony of paramedic, Andrew Sculthorpe;
- Affidavit of paramedic, Kevin Gardner;
- Affidavits of five attending police officers and officers involved in the investigation into Mr Lattimer's death, and oral testimony of Constable Anna Seymour and Constable Matthew Streat;
- Affidavits and oral testimony of ED nurses, Emma Laning and Joan House;
- Affidavits and oral testimony of Dr Emma Huckerby, RHH Director of Emergency Medicine;
- Records and oral testimony of Josh Westland, psychologist;
- Affidavit and oral testimony of Dr Aaron Groves, Chief Civil Psychiatrist and Chief Forensic Psychiatrist;
- Oral testimony of Dr Stewart Gardner and Dr Sophia Ahmed, Mr Lattimer's general practitioners;
- Affidavits and oral testimony of Anglicare support workers, Vyvyan Alomes and Guy Lewis;
- Affidavit and oral testimony of Julie Lattimer, Mr Lattimer's mother;
- Affidavit of Cassie Lattimer, Mr Lattimer's daughter;
- Affidavit of George Lattimer, Mr Lattimer's father;
- Oral evidence of Dr Jorian Kippax, ED Medical Officer; and
- RHH ED Service Planning Requirements Summary document.

Mr Lattimer's Background and Medical History

9. Mrs Julie Lattimer, Mr Lattimer's mother, provided significant insight into her son's life and struggles with his mental health. Mrs Lattimer's love and concerns for him over many years was obvious in her evidence and in her thoughtful and respectful participation in the whole inquest process. The evidence of Mrs Lattimer and George Lattimer regarding their son's background and his issues leading up to his death went unchallenged and was corroborated by other witnesses and records tendered at inquest. The following narrative is derived from and comprises mostly evidence from Mr Lattimer's parents, whose evidence I accept.

10. As a young child, Mr Lattimer was happy and seemed to enjoy life. He attended play groups and pre-school when he was four years old. Mr Lattimer spent regular time at the beach and the swimming pool with his mother, sister and his close friends. Mrs Lattimer would take him and his sister, Karen, to church and Mr Lattimer loved attending Sunday school.

11. After moving into the family's first home, Mr Lattimer and his sister quickly made friends with the other children in the neighbourhood. Mr Lattimer told his mother that he recalled that this was an enjoyable period in his life. Shortly after moving into their family home, Mr Lattimer's grandmother fell ill with cancer. She had moved into the family home where Mrs Lattimer took care of her until she eventually passed away. In 1986, after Mr Lattimer's grandmother's passing, his mother and father separated. After the separation in 1986, his father moved to Tasmania where he saw very little of him for a number of years.

12. In 1993, when Mr Lattimer was 14 years old, he moved with his mother and his sister, Karen, from New South Wales to Tasmania so that both he and Karen could be closer to their father. Mrs Lattimer's own brother and sister had also moved to Tasmania and she believed that the children would benefit by having family close to them.

13. At the age of 14 years, and whilst attending high school in Tasmania, Mr Lattimer was given a quantity of marijuana by another person. He disclosed this fact to other school children who told him to bring it to school so they could buy it from him. Mrs Lattimer stated that this was a 'set-up' as the students told one of the teachers who waited for him the following day and caught him with the marijuana. The principal required Mr Lattimer to stand in front of the whole school and apologise. Mrs Lattimer was of the view that this event marked the commencement of her son's downward spiral of mental health issues that would affect his remaining life.

14. At the age of 15 years, Mr Lattimer no longer wanted to attend school. He would only attend one or two days a week before eventually refusing to attend school at all during year 9. Subsequently, he made poor choices in friends and started smoking cannabis on a regular basis. He said that cannabis made him feel better about himself, took away his anxiety and eased his pain. Mr Lattimer started to steal to finance his cannabis use.

15. In about 1995, at 17 years of age, Mr Lattimer met Belinda Eaton and formed a relationship with her. Their daughter, Cassie, was born in 1997. Cassie was only three months old when Ms Eaton and Mr Lattimer separated. After separating, Ms Eaton took Cassie to live with her in Queensland. This event took a significant toll on Mr Lattimer's mental health. Mr Lattimer's cannabis use continued to the point of addiction, with attempts to help himself being unsuccessful.

16. When Mr Lattimer was 26 years of age, his uncle passed away. His uncle's passing was devastating for Mr Lattimer as the two had been very close. Mr Lattimer continued his

cannabis use before starting to use methamphetamines. He gained employment in the hospitality industry and commenced drinking alcohol to excess.

17. Mrs Lattimer said that, during this period in Mr Lattimer's life, there was an occasion where he was taken into the bush and held captive with a gun. On a separate occasion, Mr Lattimer was held captive in a locked van and had a knife held at this throat for several hours. Mrs Lattimer believed that these events were connected with a large drug debt accumulated by her son. These traumatic events contributed to his ongoing mental health issues. With his mother's help, Mr Lattimer left Tasmania to stay with family friends in Cairns. He lived in Cairns for several months with their support before returning home, clean from methamphetamines but continuing his cannabis use.

18. In 2013, when Mr Lattimer was 34 years of age, he suffered an acquired brain injury after an old, wooden veranda collapsed upon his head. Mrs Lattimer said that, after this incident, her son became irrational and angry towards her. Later that year, he committed a home invasion in the company of another person, for which he was, in 2015, sentenced to a suspended prison sentence and ordered to perform community service orders. In this incident, he was hit in the head with a star picket. It seems that, from this time, Mr Lattimer's mental health, alcohol abuse and drug use were very serious issues for him. At this time, the evidence indicates that he attempted suicide by cutting his arms with a blunt knife.

19. Mr Lattimer had been a long-term, regular patient of general practitioner, Dr Stewart Gardner. However, it was not until 2013 that he consulted Dr Gardner in relation to anxiety and depression. He had some suicidal thoughts but Dr Gardner did not consider him high risk. Dr Gardner did not make referrals for Mr Lattimer to connect with any other services and treated him conservatively with medication.

20. At the end of 2013 Mr Lattimer voluntarily attended the Alcohol and Drug Services Inpatient Withdrawal Unit and spent four days attempting rehabilitation, stating that he wanted to get his life "back on track", wanted to get back to work, and wanted to be on good terms with his daughter. However, Mr Lattimer discharged himself before completion of his withdrawal.

21. In September 2015, Mr Lattimer was walking home, intoxicated, after visiting a friend in Mornington. At that time he was assaulted by a group of males and females from a nearby party and was kicked about the head and punched. Police officers and paramedics attended the incident and Mr Lattimer was taken to the RHH. He said to his mother that he was too frightened to defend himself as he was subject to a suspended sentence.

22. Mrs Lattimer said in evidence that, in 2015, she first became aware that her son struggled with suicidal thoughts but that he had assured her that he would never take his life. She described how, on one occasion in 2015, she called the police and an ambulance to take him to hospital as a safety measure.

23. Mr Lattimer received treatment and attended outpatient assessments to monitor the effects of the brain injury. It was noted by treating specialists that Mr Lattimer had a background of multiple head injuries and subsequent cognitive deficits. He was assessed as having a mild to moderate head injury. It was also noted that he suffered post-traumatic stress disorder, consumed alcohol excessively and suffered anxiety, disinhibition and aggressive behaviour. It appears that he still used methamphetamines, as well as prescription medication.

Mr Lattimer's Mental Health Issues and Treatment Before his Death

24. It was not until the beginning of 2016 that Mr Lattimer engaged in a co-ordinated manner with a range of services and health professionals who tried to assist him overcome his serious mental health issues and, in particular, his alcohol and drug abuse. His mother continued to provide him with a great deal of support and he had also started to reconnect with his father, George, through social media.

25. In December 2015, Mr Lattimer started receiving assistance from Mr Guy Lewis, a Community Services Worker with Anglicare Tasmania and this support continued for a period of seven months. Mr Lattimer wanted Mr Lewis to help him manage his anxiety and depression better and wanted help to cease his use of methamphetamines.

26. In the time that they worked together, Mr Lewis said that Mr Lattimer had had success in reducing his drug and alcohol intake. Specifically, in March 2016, Mr Lattimer was admitted to the Inpatient Withdrawal Unit for detoxification, staying for a period of three days.

27. Mr Lewis said that Mr Lattimer had expressed suicidal thoughts to him on a few occasions, but without specific plans or intentions - more, that he was finding life a struggle. Mr Lewis did not consider Mr Lattimer to be at high or moderate risk of suicide. Mr Lewis said that he referred Mr Lattimer to a sailing program, to which he dedicated himself with passion.

28. Mr Lattimer was referred to a number of additional support services, including experienced counsellor, Mr Vyvyan Alomes. Mr Alomes started supporting Mr Lattimer in June 2016. From that time, he made 23 home visits to Mr Lattimer with a total of 42 hours of contact. Mr Alomes also encouraged Mr Lattimer to foster his passion for yachts. During this time Mr

Lattimer purchased a 26 foot yacht which became a major focus and a catalyst for his recovery plan.

29. Mr Alomes said that, since buying the yacht, he had noticed a positive change in Mr Lattimer's mental health and a reduction in his addictive behaviours. He said that Mr Lattimer had withdrawn from drug use for approximately six weeks before his death, but still engaged in excessive alcohol binges on occasions, particularly when experiencing high levels of anxiety or depression. Mr Alomes said that, at the time of his death, Mr Lattimer was in the process of finalising mooring arrangements for his yacht before a period of planned inpatient detoxification and rehabilitation.

30. In mid-May 2016, Mr Lattimer saw a new general practitioner, Dr Sophia Ahmed, due to Dr Gardner's retirement. Dr Ahmed gave careful consideration to the prescription to Mr Lattimer of medication for his alcohol abuse and anxiety. I am satisfied upon the evidence that the prescribing was appropriate and diligent. She also prepared a mental health plan for Mr Lattimer, in consultation with either Mr Lewis or Mr Alomes, which involved a referral to a psychologist, Mr Josh Westland.

31. Mr Westland saw Mr Lattimer for his first appointment on 14 June 2016, noting that Mr Lattimer met the criteria for post-traumatic stress disorder and alcohol dependence. He said that Mr Lattimer told him that he had consumed close to a whole bottle of whiskey and taken Valium simply to be able to feel comfortable enough to attend the appointment. He presented to Mr Westland as highly avoidant and agitated, experiencing frequent intrusive memories, flashbacks, marked hypervigilance and was loathe to discuss any aspect of his traumatic experiences. Mr Lattimer reported using alcohol to self-medicate, drinking a bottle of whiskey every second night. Mr Lattimer told Mr Westland that he was experiencing daily suicidal ideation. He said that Mr Lattimer only refrained from carrying out any action by reason of wanting to be alive for his 19 year-old daughter, Cassie.

32. Mr Westland said that Mr Lattimer had good insight into his struggles and the way in which his suicidality fluctuated, and reported that he was content to call for assistance when he needed it. Mr Lattimer told him that he was quite happy to draw upon crisis supports, indicating that he would call the Crisis Assessment and Treatment Team or Police. Mr Alomes gave evidence of developing a 'contract' with Mr Lattimer when he felt at risk of suicide. Mr Alomes said that he spoke to Mr Lattimer continually about the contract. In evidence, Mr Alomes stated: *"We had an agreement between us, a contract. That if Joe was feeling really*

stressed, and at risk that he would ring the ambulance, or the police, and he would contact me, and I would respond as soon as I could".

33. Dr Ahmed last saw Mr Lattimer on 22 June 2016 when she noted that he was looking better in himself, had reduced his Valium intake, and was being helpfully supported by his Anglicare workers and Mr Westland.

34. Mr Lattimer saw Mr Westland for his second appointment on 27 June 2016, the last before his death. Mr Westland said that this session involved explaining to Mr Lattimer the psychological processes responsible for his post-traumatic stress disorder and low mood with a view to providing him with insight and a framework in which to understand his symptoms and begin trying to address them.

35. Upon all the evidence, Mr Lattimer did not, in the weeks before his death, present to his mother and supporting professionals as being at higher risk of suicide than at previous times. Mrs Lattimer did, however, say that Mr Lattimer had visited one of his friends in hospital for three consecutive days in the week before his death. He told his mother that he had introduced his friend to methamphetamines and she was in hospital with drug induced circulation issues that meant inevitable amputation of her fingers. He told Mrs Lattimer that he felt guilty for introducing her to methamphetamines.

Circumstances Surrounding Death

36. On 9 July 2016 Mr Lattimer and his father had a long conversation using Facebook messages, concluding their conversation at 11.23pm. The conversation chain focused upon proposed yachting adventures together and did not disclose that Mr Lattimer was in distress. George Lattimer, who was in Queensland at the time, said that he believed his son was in good spirits. It seems that this was the last communication by Mr Lattimer with anyone before he made a 000 call to emergency services early the following morning.

37. At 4.18am on Sunday 10 July 2016, Mr Lattimer called 000 requesting assistance due to having a "*high risk of self-harm*" (his actual words) and requiring assistance to be admitted to the RHH. This was in accordance with his plan developed with his support workers. Ambulance Tasmania paramedics and police officers were tasked to the home of Mr Lattimer in Mornington. Mr Lattimer then sent a message to Mr Alomes at 4.42am stating the following:

> *"Vyv, I'm sick of pretending I'm happy when I'm not. I have to admit myself to the psych ward. I need someone to support mum (0419574739). From the psych ward I hope to go to detox.*

Way too many bad thoughts go through my head too often. Getting shoes on and calling cops so I don't do nothing stupid. Ambulance on it's (sic) way. Chat soon. Joe"

38. Mr Lattimer sent the message to Mr Alomes' work phone and therefore Mr Alomes did not see that message until the following day, being Monday, 11 July. Mr Alomes had previously told Mr Lattimer that he could not contact him after-hours on his work phone. It may have been that Mr Lattimer simply wished to leave the message to inform Mr Alomes of his situation. The message was certainly in accordance with his prearranged agreement.

39. Paramedics and police officers arrived at the scene. Mr Lattimer had arranged in his call to meet the paramedics a little distance away from his house as he did not wish to wake his mother. The attending paramedics, Kevin Gardner and Andrew Sculthorpe, then met Mr Lattimer at the nominated point.

40. Whilst speaking with the paramedics, Mr Lattimer outlined that he wanted to go to the hospital and talk to someone. Mr Lattimer told Mr Sculthorpe that he had a history of depression, anxiety, traumatic brain injury, short term memory loss and alcoholism. Mr Lattimer also admitted to having consumed one bottle of scotch that day, which he said was not unusual for him. He said that he had only taken his prescription medication as prescribed and had not taken any illicit substances. Mr Lattimer also indicated that he had suffered suicidal thoughts in the past and had previously sought help from the hospital.

41. Whilst speaking to Mr Sculthorpe, Mr Lattimer indicated that his thoughts of suicide involved going to his yacht to hang himself or using a knife that he kept on-board.

42. Mr Sculthorpe indicated that even though Mr Lattimer had consumed a bottle of whiskey, there appeared to be no variations in his gait or speech, or even a prominent strong smell of alcohol. He also said that during the trip to the RHH Mr Lattimer was receptive and happy to engage in conversation, in particular about his newly-purchased yacht. Mr Lattimer also responded well to positive comments about him seeking assistance when feeling down and said that his daughter was a major motivator for this. Mr Sculthorpe did not feel as though Mr Lattimer was erratic, threatening or an immediate threat to himself or others.

43. The paramedics and Mr Lattimer entered the RHH through the main front doors, rather than the ambulance entrance at the side of the ED. When Mr Lattimer approached the doors he was hesitant and said to Mr Sculthorpe that he was always nervous when going to hospital. Mr Lattimer was given some further reassurance and, at 5.02am, he continued with the paramedics into the ED and seated himself near the door at the front, closest to the triage

nursing station. From this point, the CCTV in the ED waiting room captured the movements of Mr Lattimer.

44. Both paramedics then spoke with the triage nurse, Emma Laning, and advised her of the circumstances surrounding Mr Lattimer's distress and suicide plans. They indicated that Mr Lattimer was not in protective custody under the *Mental Health Act* 2013, that he was a voluntary admission, and was extremely compliant. The paramedics then left the ED and returned to other taskings, with Mr Lattimer remaining in the waiting room. Mr Lattimer had brought with him a book about the solo yachting voyage of Jessica Watson. Mr Lattimer had told Mr Sculthorpe that he intended to read it whilst he was waiting at hospital.

45. Mr Lattimer was triaged by Nurse Emma Laning. The triage process took about 5 minutes and concluded at 5.08am. Upon the evidence, I find that the duration of the triage was within standard guidelines. Based upon her communication with and assessment of Mr Lattimer, and upon the information she had received, Nurse Laning assessed him in accordance with the Australasian Triage Scale (ATS) as a 'Category 3', indicating that his case was urgent and required treatment within 30 minutes.

46. Following triage, Mr Lattimer was informed that the ED was fully occupied, there were no current available spaces to accommodate him and that he would therefore need to wait in the waiting room until there was something available. Mr Lattimer was apprehensive about this, but was happy that he could be seated near the main doors rather than having to go into the main waiting room where people could see him. There were also two other patients in the waiting room awaiting bed allocation at this time. It is apparent from the evidence that the process of waiting in a public area alone and without a support person would have been extremely difficult for Mr Lattimer, producing in him a high level of fear and anxiety.

47. No Psychiatric Emergency Nurse (PEN) was on duty at the time that Mr Lattimer was waiting in the ED and there was no support person or other staff member available who could sit with him to ensure his safety and provide reassurance.

48. Mr Lattimer, once triaged, stood in the waiting room, with the hood of his jacket covering his head, looking towards the automatic doors of the ED. He stood in that position for 42 minutes, appearing somewhat restless. Nurse Laning also thought that Mr Lattimer's behaviour was restless and slightly agitated during this time. She made regular assessments of him as she could, although other patients were also presenting and requiring triage.

49. At 5.27am a patient arrived by ambulance. Nurse Laning attended to that patient's triage. That patient, being non-ambulatory, was brought into the ED through the non-ambulatory corridor, requiring Nurse Laning to turn her back to the general ambulatory presentations waiting area where Mr Lattimer was waiting. Nurse Laning did not speak further to Mr Lattimer but, between her other duties, kept visual checks upon him at regular intervals.

50. The footage shows that at 5.50.50am Mr Lattimer finally sat down on a chair and bent over for approximately one minute, appearing to be playing with his right boot. At 5.51.45am he arose from the bent position to a sitting position and, 12 seconds later, arose from the chair and walked the short distance towards the male public toilets in the ED with his left hand in his jacket pocket. Mr Lattimer entered the toilets at 5.52.10am. Upon close examination of the footage it is possible to detect an increase in agitation on the part of Mr Lattimer. However, that is unlikely to have been apparent to staff members busy with other tasks.

51. At 5.54am Nurse Laning triaged a young female patient who came into the ED through the main entrance. She said that, at about this time, she noticed Mr Lattimer was no longer standing where he had been previously. Following her triage and assessment of the young female patient, Nurse Laning went into the waiting room through the triage assessment room to check whether Mr Lattimer had gone outside. The evidence indicates that it is not uncommon for patients waiting to go outside for a cigarette or fresh air. She looked at both sides of the building but could not see Mr Lattimer. On her return inside the ED she noticed Mr Lattimer's book on the front red chairs (where he had been sitting) and she waited another few minutes in case he returned from further outside the hospital grounds, expecting him to return shortly. She recorded in the nursing care record her observations and she planned to contact him by phone in case he had left the hospital. For this purpose, she approached the clerical staff to clarify his correct phone number.

52. At 6.12am a relative of another patient in the waiting room approached the clerical desk and said that she had seen a person she presumed to be Mr Lattimer go into the men's toilet. As a result of this information, Nurse Laning walked over to the toilet, knocked on the door and proceeded to open the door. She saw Mr Lattimer hanging from the toilet cubicle support bar, apparently by his shoelaces and cord from his jacket. Nurse Laning noticed that Mr Lattimer appeared lifeless and cyanosed. Mr Lattimer was at eye height of Nurse Laning (about 168cm) and his feet were on the ground. Nurse Laning then ran towards the triage nurse's station and raised the alarm. Additional emergency medical staff attended the waiting room toilets where Mr Lattimer was cut down from the support bar. He was in cardiac

arrest. CPR was commenced by the Clinical Co-ordinator Nurse, Joan House, inside the toilets.

53. Mr Lattimer was removed from the male toilets and taken into the ED resuscitation room, where prolonged resuscitation attempts resulted in an eventual return of his circulation. He was placed upon life support under the supervision of Dr Michelle Rogers, although the extent of any hypoxic brain injury due to the lack of oxygen whilst in cardiac arrest was unknown at that time. Dr Jorian Kippax, the on-call ED Medical Officer in charge, was telephoned and attended to assist with and oversee the medical treatment of Mr Lattimer. Mr Lattimer was placed into a medically-induced coma and then commenced radiological assessments of his neurological function.

54. Mrs Lattimer was contacted and told of the incident. She attended the RHH, where Dr Kippax advised her of the medical treatment that had been administered and indicated that prognosis was uncertain.

55. Before receiving the call from the hospital, Mrs Lattimer had woken earlier than usual for a Sunday morning and had noticed that Mr Lattimer was not in his bedroom. Concerned about his well-being, she sent him several messages but received no reply. The last message she sent was at 6.37am, most likely after Mr Lattimer had made the attempt to end his life.

56. Mr Lattimer was transferred to the Intensive Care Unit (ICU) later that morning. Testing of his neurological function by clinical, electroencephalographic and MRI criteria over the following days revealed that it was severely impaired with no chance of improvement. On 20 July 2016, there was a meeting between ICU doctors and family members where the decision was made to remove Mr Lattimer's life support mechanisms.

57. Mr Lattimer died at 5.20am on Thursday, 21 July 2016.

58. I find that, upon the evidence, Mr Lattimer entered into the toilet of the ED at the RHH with the intention of ending his life. I am satisfied that this action was taken by him deliberately and in sound mind as a result of the intolerable mental distress suffered by him at that time. He died as a result of hypoxic encephalopathy caused by his attempt at suicide by hanging.

Issues

59. I now address the remaining issues within the scope of this inquest.

Compliance with appropriate guidelines and principles relating to Mr Lattimer's triage and treatment in the Emergency Department

60. Nurse Laning, in her specialist role as the ED triage nurse, was required to assess patients as they came into the ED. This duty was undertaken by assigning patients a category from 1 to 5 according to urgency in line with the Australasian College for Emergency Medicine's Australasian Triage Scale ("ATS") which was in use at the time of Mr Lattimer's presentation. It had been in use since about 2009 and is still in use as the triage guide. In triaging generally, the tasks include physical assessment, communicating with the patient (or relevant others) and obtaining information regarding the reason for presentation. Where appropriate, vital signs may also be taken.

61. In the ATS triaging categories, a patient assessed as falling within Category 1 requires immediate treatment; a Category 2 patient requires emergency treatment within 10 minutes; a Category 3 patient requires urgent treatment within 30 minutes; a Category 4 patient requires semi-urgent treatment within 60 minutes; and a Category 5 patient requires non-urgent treatment within 120 minutes.

62. The ATS provides specific guidance for triaging ED mental health presentations. The guidelines envisage, for instance, that a Category 3 patient presenting with a mental health issue or in crisis will exhibit a moderate behaviour disturbance and will be in severe distress. It also envisages that the patient will be in a situational crisis and may be agitated or withdrawn. Further, the patient's presentation is likely to include suicidal ideation, thought disorders, severe symptoms of depression, be withdrawn or uncommunicative, and the patient may not be likely to wait for treatment.

63. The supervision of a Category 3 patient required by the guidelines is "close observation" at regular intervals of a maximum of 10 minutes, and the patient is not to be left in the waiting room without a support person. There are also requirements to alert the mental health triage section, ensure a safe environment for the patient and others, re-triage if there is evidence of increasing behavioural disturbance such as agitation or distress, and inform security that the patient is in the ED. There is also a requirement to consider whether the patient is intoxicated by drugs and/or alcohol, which may cause an escalation in the patient's behaviour that requires management.

64. In her affidavit, Nurse Laning explained the process of triaging Mr Lattimer and the reasons for assigning him as an urgent Category 3 patient requiring treatment within 30 minutes. She explained that she believed him to be a potential danger to himself, because of his reported

suicidal ideation and plans, in addition to his observed behaviour. She was also aware that he was likely to have consumed a bottle of whiskey before his arrival.

65. I am satisfied upon the evidence that Nurse Laning triaged Mr Lattimer into the correct category, adhering to the criteria specified in the ATS and guidelines. This conclusion was not disputed by any interested parties. I am also satisfied that Nurse Laning, despite being required to attend other duties, did make the required 10-minute checks of Mr Lattimer whilst he was waiting. However, necessarily, these were made briefly and between her other pressing tasks in an extremely busy ED. She was diligent and professional, and her actions cannot be criticised. For the reasons set out below, this is not a case where Nurse Laning could have done any more to assist Mr Lattimer. I acknowledge her understandable distress upon discovering him.

66. I find that, contrary to the guidelines applicable to a Category 3 triage:

(a) Mr Lattimer was not placed in a safe environment, namely, in his own bed or private space within the main ED immediately after being triaged. It is clear that this was due to all suitable spaces and beds already being occupied.

(b) Mr Lattimer was not seen for further assessment or treatment by an ED doctor, PEN or other nurse within 30 minutes of triage or at any time during his 42 minutes in the ED waiting room before his suicide attempt. This was due to the unavailability of such a suitably qualified person.

(c) Mr Lattimer was left in the waiting room without a support person after triage. Upon the evidence, no such person was available to fulfil this role.

67. Relevantly, Mr Lattimer was not seen by a PEN after triage as should have been the case.

68. Upon the evidence, PENs play a critical role within the ED for mental health patients. They are specialist psychiatric nurses trained to assess and commence management of patients presenting with mental illness. Apart from mental health assessments, the PEN plays a crucial role in the ED in de-escalating the distress of mental health patients. Due to the large number of mental health presentations to the ED, a PEN is rostered on duty at all times, including throughout the night. As will be further discussed, a high proportion of the PEN rostered shifts are unable to be filled due to a nationwide shortage of PENs. At the time of Mr Lattimer's suicide attempt, a PEN had been rostered for duty but the shift was unable to be filled.

69. It is also appropriate to observe that in the absence of a PEN (or perhaps in addition to a PEN), Mr Lattimer could have been assisted and supported after triage by the Clinical Initiatives Nurse ("CIN") on duty. The CIN is a senior ED nurse whose duties in the ED are: to ensure that patients, including mental health presentations, are able to be placed in an assessment area of the ED and to have appropriate care initiated whilst waiting; to provide ongoing review of waiting room patients; to facilitate a safe clinical environment; and to detect changes in a patient's clinical urgency. If available, a CIN could have provided support to Mr Lattimer and liaised with ED doctors about his presentation for the purpose of commencing his assessment and treatment in a timely manner.

70. Although a CIN was on duty in the ED at the time of Mr Lattimer's presentation, that nurse was fully occupied with three patients in the resuscitation area and unable to attend to patients in the waiting room.

The connection between the failure to apply appropriate guidelines or best practice in the ED and Mr Lattimer's death

71. Dr Emma Huckerby, Director of Emergency Medicine at the RHH, provided evidence that if Mr Lattimer had gone directly into a bed space or other allocated space appropriate for him, then this would not only have provided more opportunity for direct observation of him by other ED nursing staff but may have resulted in him feeling reassured. She said that, once allocated an appropriate space, he may also have been offered oral medications to reduce his distress.

72. In relation to the inability to allocate Mr Lattimer an appropriate space, Dr Huckerby stated in her affidavit as follows:

> *"At the time of Mr Lattimer's arrival, the ED was very busy and congested. There were 27 patients in the ED, with 3 patients in the resuscitation area and 14 admitted/awaiting inpatient bed (sic). The only empty cubicle available to place Mr Lattimer was in the Nell Williams area of the Emergency Department. This area is separate to the main department and patients in that area cannot be visualised by staff in the main area. The triage nurse asked Mr Lattimer to wait in the waiting room and advised him that there would be a wait until he was seen."*

73. I accept the evidence of Dr Huckerby that the ED at this time was very busy, a situation encountered very regularly. This situation resulted in a lack of support, assessment, treatment, comfort and privacy for Mr Lattimer.

74. I also accept the evidence of Mr Lewis that Mr Lattimer was able to reduce his distress by connecting and talking to people who would listen to him. He gave evidence as follows:

> *"…if I could comment on what the conditions – what the optimal conditions would have been for Joe was for somebody to say, 'So you're feeling unsafe. You've said that you're feeling at suicidal risk. Would you like to come into a private room, and we'll have a conversation,' and for Joe to have been validated with what he was saying, and expressing, and to have a longer conversation about what he was actually thinking, and feeling at the time. So I think in an ideal world that would have been…"*

75. Mr Lewis further stated:

> *"…so initially to hear, to listen to Joe, and hear what he was experiencing. To listen to what he was saying, and to reflect that back to him so that Joe knew that I could hear what he was saying, and so that Joe felt that I understood what he was experiencing. So that's pretty standard suicide intervention, or standard counselling…"*

76. It was submitted by counsel for the THS, Ms Rudolf, that Mr Lattimer's attempt to hang himself was unexpected, as suicide often is, as he did not appear to be at immediate risk. She submitted that if he was at immediate risk, he would have been triaged accordingly and the ambulance officers could have stayed with him, as was their practice in some such situations. She submitted that the lack of timely support, assessment, treatment and bed space could not be found to be contributing factors in Mr Lattimer's decision to end his life.

77. The fact remains, however, that Mr Lattimer had recognised his high level of suicidality and had taken the step (a most difficult one for him), of presenting to the ED by ambulance in order to save his own life. This strategy had been prearranged by himself and his counsellors in an agreed "contract". His high level of distress and his suicidal ideation was recognised correctly at his triage. From that time, he required continuous support to be provided by an appropriate person. He required a private, or at least suitable, space with his support person (optimally an on-duty PEN) to commence the process of reducing his suicidal distress. At this time, he would quite likely have been offered medication of assistance. He then required professional assessment and treatment within 30 minutes in accordance with his assessed triage category. None of these required steps occurred and, predictably, Mr Lattimer's distress and anxiety increased considerably in the environment in which he waited without support. He then took the very action that he wished to prevent by seeking treatment at the ED.

78. I accept the submission of Ms Rudolf that there must be clear evidence for a finding to be made that these deficits were contributing factors in his death. I am particularly cognisant of the standard required by *Briginshaw v Briginshaw* (1938) 60 CLR 336, which is applicable in this situation. Applying that requirement, I am nevertheless satisfied that Mr Lattimer's death would not have occurred at that time had the appropriate guidelines and procedures been able to be followed. It is particularly clear on the evidence that Mr Lattimer wished to prevent his own suicide and that he responded well to the provision of one-on-one support. Unfortunately, his mental condition deteriorated markedly whilst he was waiting for treatment.

79. It is, of course, always possible to say that he may have taken such action during a visit to the toilet, even if he was with a doctor, nurse or support person in a private and comfortable space in the ED. However, if he had been afforded the correct level of care, protection and treatment, I very much doubt that he would have done so. In this sense, the deficits to which I have referred contributed to his decision to end his life.

80. I should add that this conclusion does not imply criticism of any staff member working in the ED at the relevant time. Upon the evidence, those staff members performed their roles diligently and efficiently. The issues affecting Mr Lattimer's situation were caused by insufficient staff to attend to him and insufficient, appropriate space to accommodate him.

Any staffing deficits in the ED, whether mental health staff or otherwise, that may have contributed to Mr Lattimer's lack of treatment and supervision

81. Upon the evidence, the only significant shortfall in the rostered staff on the morning of Mr Lattimer's presentation was the absence of a PEN - the very role required by Mr Lattimer for prompt support, assessment and treatment. Although rostered, a PEN was not available for the shift, as was a common situation.

82. Dr Huckerby stated in evidence:

> "*The most stark staffing deficit is the lack of a PEN nurse on that shift. Someone to be able to take patients from the mental health queue, patients that come through our emergency department and prioritise seeing them whilst the medical doctors are trying to see all the patients that are coming through the department.*"

83. The inquest explored whether the rostered staff were able to adequately cope with the number and complexity of ED presentations at the time of Mr Lattimer's death. I am satisfied that there were insufficient rostered staff for the workload at that time. It is likely, for

example, that if extra CINs or doctors had been rostered and were working, Mr Lattimer would have received appropriate care and treatment. The details of the insufficiency of rostered ED staff at that time is a complex matter and cannot be resolved in this finding. The issue more clearly and immediately connected to Mr Lattimer's death was the absence of the rostered PEN.

Whether any staffing deficits in the ED are entrenched, such that the there is a risk of similar deaths

84. Dr Huckerby gave evidence that, since 2016, there have been significant increases to both medical and nursing staffing in the ED to try and accommodate the increased number of presentations as well as care provided to patients who are admitted to the RHH but who cannot be transferred out of the ED to a ward due to bed shortages. Clearly, these increases have been necessary. There was evidence that, due to dramatic increases in ED presentations, the staffing levels are still inadequate to satisfy demand. However, as discussed, it is not part of the scope of the inquest to embark upon analysis of the adequacy of the current levels of staffing in the ED in the wider sense.

85. Given the more immediate connection with Mr Lattimer's death, I deal under this heading with the lack of available PENs to fulfil the allocated shifts.

86. Dr Huckerby identified recruitment as the barrier to PEN nurses being on duty. She said in evidence that this problem is Australia-wide and caused by a shortage of mental health nurses. She said that, at the time of giving her evidence to the inquest, there were less night shifts covered by PENs than in 2016 and the ED was "extremely under-recruited" in this regard. Dr Huckerby said that, for example, in the four months before swearing her affidavit in October 2019, 60% of PEN night shifts were unable to be covered. She said that difficulties with the environment in the ED for mental health presentations made it a less attractive position than working in other mental health care settings. She said that a number of PENs had left the ED for other areas where they felt able to provide better quality care. In his evidence, Dr Aaron Groves, Chief Civil Psychiatrist and Chief Forensic Psychiatrist for Tasmania, agreed that there is a national and international shortage of mental health nurses, attributing this partly to particular issues with the nature of university training. He commented that such a position is challenging and agreed that this is particularly the case in the environment of the RHH for the reasons given by Dr Huckerby.

87. Dr Jorian Kippax, Emergency Specialist at the ED at the time of Mr Lattimer's presentation, gave helpful, informative evidence at inquest. His role at the time included co-ordinating the

care of all presenting patients (including mental health patients), overseeing and supervising the registrar and junior medical staff, and being directly involved with more complicated cases. As stated above, Dr Kippax was the on-call specialist at the time and received a call in respect of Mr Lattimer at 6.08am, arriving at the RHH at 6.40am to assist in resuscitating and treating Mr Lattimer.

88. Dr Kippax, in his evidence, emphasised the crucial role of the PEN in mental health presentations. He gave evidence that there should be a PEN nurse on duty most of the time and was of the view that there would be enough work for two PEN nurses in the ED. He stated that it was "absolutely critical" in mental health presentations, for staff to have knowledge of the patient's history and pre-hospital care to inform assessment and treatment. He gave evidence that a very important role of the PEN is to obtain such information for the purpose of proper treatment and integration of care. Quite obviously, there would need to be sufficient PEN resourcing available at any one time to be able to obtain and properly utilise this crucial information.

89. Therefore, I can safely conclude upon the evidence that PEN deficiency is an on-going issue affecting the care and safety of persons presenting to the ED in crisis or with mental health issues. No immediate solution to this problem was apparent from the evidence.

Availability of suitable space or beds in the ED for appropriate treatment of mental health admissions

90. Mr Lattimer was unable to be allocated a suitable space in the ED for two reasons: firstly, that the ED was experiencing heavy access block and, secondly, that the environment, size and layout of the ED space is unsatisfactory for mental health presentations. I deal with these issues below.

Access block

91. "Access block" is the term used to indicate reduced availability of suitable space for patients (such as Mr Lattimer) after triage. In her affidavit, Dr Huckerby said that access block occurs as a result of admitted patients being unable to move out of the ED into a ward bed due to shortages of ward beds. As a result, these admitted patients occupy ED bed spaces for prolonged periods (in excess of ED guidelines), preventing new ED patients moving from the waiting room into an ED bed space.

92. Dr Huckerby gave clear, frank evidence and was an impressive witness in all respects. She also provided a great deal of assistance regarding the operation of the ED prior to inquest. She

said that access block played a major part in a bed not being available to Mr Lattimer. She said that when Mr Lattimer presented to the ED there was significant access block, with 14 admitted patients occupying ED bed spaces. The access block was, she said, so bad that there were two admitted patients in the Fast Track area of the ED.

93. She said that access block in the ED has worsened in the years since Mr Lattimer's death. As such, there is a higher chance of a patient spending longer in the waiting room waiting for a bed in the ED. She said that the degree of access block at the RHH is disproportionately greater than that occurring in the rest of Australia. Dr Huckerby also referred to the fact that with regards to four major Melbourne hospitals, each of those see more patients than the RHH but those hospitals only had two patients spend over 24 hours in the ED whereas at the RHH there were 1800 stays of more than 24 hours.

94. Dr Kippax also confirmed that access block had increased since Mr Lattimer's presentation and that the overall number of patient presentations had increased, with an increase overall in the number and complexity of mental health presentations. Dr Huckerby illustrated the dramatic increase in mental health presentations by comparing the numbers admitted in the same 6-week period in both 2017 and 2019.

95. A consequence of access block for mental health patients includes the inability to have an appropriate space to conduct an assessment or an appropriate space to undertake treatment. The consequences of this problem can have a dire impact upon the patient as was the case for Mr Lattimer.

96. One other consequence of access block and lack of staff in the ED is the increase in the occurrence of ambulance ramping. Mr Sculthorpe stated in evidence that, since the death of Mr Lattimer, paramedics do not now leave a mental health patient unaccompanied in the waiting room but stay with the patient, and assist them, until they can be treated in their own space. Mr Sculthorpe gave evidence, which I accept, that remaining with such patients improves their safety and allows a rapport to be built at a critical time.

97. Dr Huckerby confirmed that the directive since Mr Lattimer's death is that any patient brought to the ED by ambulance with a mental health presentation must be triaged in the ambulance ramp and, if there is a risk of suicidality, the patient is not to be unramped until a nurse and appropriate clinical space are available. Unfortunately, this practice also has the effect of removing an ambulance and paramedics from other taskings for extended periods. Mr Sculthorpe said that, as a paramedic, he has been "ramped" on hundreds of occasions and

he said that there is always one or two emergency mental health patients transported on each shift he works which may require prolonged ambulance attendance at the RHH.

98. Dr Huckerby testified that although there were genuine attempts to deal with the issue of access block, these efforts are being made without proper resourcing, effectively from "the side of the desk" of doctors and others who had other full-time duties. Dr Huckerby stated that there was also a need to change the culture at the RHH to improve access block, and that this would involve a team of people working strategically to implement change within the institution.

Inadequate and unsuitable space in the ED for mental health patients

99. On the day of Mr Lattimer's incident, several hours after it had occurred, Dr Kippax and Staff Specialist in Emergency Medicine, Professor Simon Brown, expressed some concerns in an email which was forwarded to a number of administrative and medical personnel within the Tasmanian Health Service. In that email, Professor Brown included the following statement:

> *Jo (Dr Kippax) and I would also like to flag for consideration that we don't have a very good physical setup for psychiatric presentations to match the psychiatric workload we have as a department. There is an expectation that psychiatric presentation (sic) mix throughout the department including both streams ("Mountain" and "River") which makes it potentially difficult to ensure a safe physical environment for patients who are at risk for self-harm."*

100. Dr Huckerby stated that the ED has limited suitable space or beds for the short term assessment and treatment of admitted mental health patients. She further stated in her affidavit:

> *"There is a single seclusion room in the RHH ED for patients who are acutely severely distressed. The room is not appropriate for patients who do not require seclusion as it has limited furniture and is designed for containment and close observation.*
>
> *These acute bed spaces have to be shared between the admitted surgical, medical and mental health patients requiring close observation as well as the new ED patients who require these treatment spaces.*
>
> *When these bed spaces are available, they are suitable for assessment and short-term treatment of mental health patients.*

However, longer periods of time in these bed spaces are poorly tolerated due to the noise, bright lights and constant traffic of patients, relatives and staff.

In addition, the ED is not a closed ward so absconding is a risk and it is not possible to make it risk-free for mental health patients by removing hanging points or freestanding objects."

101. In his evidence at inquest, Dr Kippax expanded on his concerns regarding the ED physical environment being "extremely sub-optimal" for mental health presentations. He said:

"Look firstly, I would say that for the vast majority of mental health patients - the overall structure of the emergency department, with the front loading if you will of a large number of senior medical staff, and senior nursing staff. The imaging availability. The surgical availability. All of these things add very little to the care of many psychiatric patients, except if they have a toxidrome resulting from a drug overdose for instance, or from self-harm. So for many patients we add very little. Conversely, I would say that as an environment it's an extremely stimulating environment. At any time of day it's brightly lit. There can be literally many hundreds of people in a confined space. It's very noisy. The sounds of screaming; vomiting. There's smells. There's other agitated patients, so it's an extremely stimulating environment. For a group of patients who in most cases need a quiet, supportive, calm environment, and I think – and again my opinion is that the result of this is an unnecessary number of instances of violence towards staff, and episodes where patients need to be sedated with consequent risks. Sorry, third point would be safety. It's not optimally set up, and there's a large number of people into, and out, of the emergency department, and so therefore it's very hard to secure the place. If people are determined to get out of the emergency department, and particularly if they know their way around, it's very hard to prevent that happening."

102. Dr Groves, like Dr Huckerby and Dr Kippax, expressed concerns about the serious deficiencies in the environment of the ED for adequate treatment of patients presenting with mental health issues. I fully accept the evidence of those three doctors and find that the ED at the RHH is an unsuitable environment for effective assessment and treatment of mental health patients.

Whether the Tasmanian Government's current plans will demand adequately addressed staffing and space deficits in the ED of the RHH in respect of emergency mental health presentations

103. Dr Groves, in the position of Chief Psychiatrist, is responsible for providing high-level specialist advice in relation to mental health policy and clinical practice to the Tasmanian

Health Service and other bodies in relation to mental health policy, clinical practice and legislation that regulates mental health care and treatment. He stated that the provision of this advice is *"with the aim of promoting continuous quality improvement and supporting the delivery of safe, effective and high quality integrated mental health care and treatment".*

104. Dr Groves gave a comprehensive affidavit and oral evidence about the Tasmanian Government's plans and commitments for both the improvement of treatment in ED mental health presentations at the RHH and the proposed reform of mental health services generally.

105. In relation to improvements to the ED, Dr Groves indicated that "Stage 2" of the RHH re-development included a redesign of the ED to deal with the vastly increased demand. He gave evidence that government had committed to its implementation. He said that it is intended that a dedicated mental health assessment area within the ED be established. He described the particular need, within the design of such an area, to cater for the various categories of mental health presentations which require quite different treatment environments. He said, for example, that a patient presenting in suicidal distress requires a private and comforting area, whereas requirements for a patient presenting with psychosis or intoxication are considerably different.

106. Dr Huckerby is also involved in the planning requirements for the new ED. She also gave evidence that it is particularly important to incorporate into it a separate mental health assessment unit. She referred to the tendered document entitled *"RHH Emergency Department Planning Requirements Summary October 2018"*, which outlines the urgent need for a rebuild of the ED and includes a proposed plan for a mental health assessment unit modelled upon that of the Canberra Hospital.

107. Dr Huckerby acknowledged that, at the time of giving her evidence, seven extra acute mental health beds were proposed to become available in 2020. She expressed concerns, however, that staffing these beds may be difficult (partly due to lack of PENs) and, in any event, this measure is not likely to relieve access block to any significant degree.

108. Dr Groves provided evidence about his involvement in advising the Tasmanian Government as Chair of the Mental Health Integration Taskforce ("the Taskforce"). The Taskforce was established in July 2018 to provide recommendations on the integration of mental health services in southern Tasmania. The government had previously committed to developing an integrated mental health service as part of a plan entitled *Rethink Mental Health – Better Mental Health and Well-being – A Long Term Plan for Mental Health in Tasmania 2015-25("Rethink").* However, the Taskforce noted slow progress in the government achieving its commitments

within *Rethink* and considered how best it could meet the objective of reforming mental health services in Southern Tasmania in a timely manner.

109. In April 2019 the Taskforce produced its report, providing the Secretary of the Department of Health with recommendations on the integration of mental health services in Southern Tasmania. In July 2019 the government responded to the report and recommendations, accepting all 21 recommendations of the Taskforce and maintaining its commitment to the reforms in *Rethink*. The government response provided specific timelines for the implementation of those reforms over the following three years.

110. Relevantly, the Taskforce found that due to poor integration of services and lack of alignment of the processes between inpatient services and community services, the mental health system had become "hospital-centric", meaning that the hospital was prioritised above both the needs of the consumer and of community services. As a result, there was a major disconnection between in-patient services and community based services. The Taskforce noted that, generally, the services for mental health patients were not sufficiently connected and were difficult for users of those services to navigate.

111. The Taskforce findings and recommendations emphasise that a balanced approach to mental health services includes both appropriate hospital services and comprehensive community services as well as relying on good primary care, community residential care, assertive community treatment, early intervention, and alternatives to acute inpatient care to achieve the best service delivery and patient outcomes.

112. In *Rethink* the government committed to a "Hospital Avoidance Program", designed to reduce ED presentations, reduce hospital admissions from the ED, reduce the average length of stay for people in hospital, reduce the re-admission of complex patients and reduce the need for ambulance transfers. Dr Groves gave evidence that the implementation of the services involved in this program is likely to significantly lessen the numbers of ED presentations, reduce access block and provide a better outcome for those requiring the services. He stated in evidence at inquest:

> *"Generally in Australia about three quarters of people who come to emergency departments with mental health presentations probably don't need admission to hospital and possibly might not have even needed to come to the emergency department if there was suitable other alternatives available for them. Tasmania is no exception from the mainland states in that we don't have the full range of comprehensive mental health services that would help somebody who is in distress or in need not to go to an emergency department but to go somewhere else. So the whole intent of*

the Hospital Avoidance Program is to try and ensure that there are pathways for those people not to go to an emergency department if that's possible."

113. Dr Groves gave evidence that the Hospital Avoidance Program included the establishment of the Hospital in the Home which is designed to provide the necessary level of care in the patient's own home as an alternative to hospital presentation. It is proposed that this program will be supported by the establishment of two "Integration Hubs". These Integration Hubs, to be established at the Peacock Centre and at St John's Park, are community service centres which bring together information and advice from practitioners across a range of services. It is proposed that these facilities will also have a number of short stay beds for individuals who require a short period of management of their illness followed by support from a community team upon discharge. As part of this Program it is intended that there will be a total of 27 beds for mental health patients in the community. He also gave evidence of the proposed establishment of a post and after care suicide response which takes into account that many persons experiencing suicidal distress do not have a mental illness but nevertheless require ongoing assistance.

114. Dr Groves emphasised the importance of general practitioners in an integrated mental health system and said that there needed to be better funding for general practitioners to successfully treat mental health patients, as consultations may be complex and take additional time and expertise. I note that the Hospital Avoidance Program involves establishing strong links with general practitioners and other health care providers to enable more effective and comprehensive management of patients. He also noted the need for expansion of the Crisis Assessment and Treatment Teams, which currently work limited hours and, compared with interstate counterparts, and have less staff in each team.

115. Dr Groves also emphasised that the proposed reforms in the community will require significant recruitment of mental health nurses and staff for its successful operation.

116. Importantly, the government has committed funding for the purpose of managing the whole project of reform to ensure accountability and reporting at regular intervals. I do not have evidence as at the date of this finding as to whether the reforms are being implemented within the stated time frames.

The availability or use of other community treatment options and resources, including general practitioners, to reduce the number and severity of mental health presentations to the ED of the RHH

117. Under the previous heading, I have dealt with this issue so far as is relevant to the issues connected with Mr Lattimer's death. The evidence at inquest indicated the government's commencement of and commitment to wide-scale reform. The issue is complex and I am not equipped with sufficient evidence to make comment on many aspects of the reform. Suffice it to say that the reforms are designed to provide increased access to quality mental health services in accordance with the growing demand and to find long-term solutions which reduce the need for ED presentations and hospital admissions. Dr Groves was of the view that the community-based service models, in conjunction with a mental health unit in the new ED, will create the optimal environment to deliver care and treatment for those in need. Patients such as Mr Lattimer could well have been assisted by enhanced and integrated community services, which may have avoided the need for his ED presentation.

118. Dr Huckerby endorsed the government's reform plans. She was of the view that the community reforms, if implemented as is proposed, will assist with the issue of access block. It is fair to say that she held reservations about the extent of any relief in access block. At the time of giving her evidence, the operating Hospital in the Home program allowed for up to 10 patients to be managed in their home, which Dr Huckerby indicated had made no appreciable impact upon access block in the ED.

119. I endorse the government's commitment to much-needed reform of mental health services, including its commitment to the Hospital Avoidance Program. This reform ought to be completed without delay.

Findings required by s28(1) of the *Coroners Act* 1995:

(a) The identity of the deceased is Joseph Aaron Lattimer;
(b) Mr Lattimer died as a result of the consequences of asphyxia due to hanging himself in the ED of the RHH on 10 July 2016 in the circumstances set out in this finding, such action taken with the specific intention of ending his own life;
(c) The cause of death is hypoxic encephalopathy; and
(d) Mr Lattimer died on 21 July 2016 at the RHH, Hobart in Tasmania.

Recommendations

I **recommend** that the government assess the current requirements for Psychiatric Emergency Nurses ("PENs") in the Emergency Department of the Royal Hobart Hospital and take all possible steps to recruit sufficient PENs to enable proper triage, assessment and treatment of ED mental health presentations; and, in the absence of the availability of sufficient PENs, take steps to recruit other qualified health professionals for this purpose.

I **recommend** that the government consider recruiting appropriately trained persons to provide support to patients presenting to the ED with mental health issues and who are not otherwise adequately supported whilst awaiting assessment and treatment.

I **recommend** that the government progress with priority its *Rethink* mental health services reforms, including implementation of the recommendations of the Mental Health Integration Taskforce and completion of the Hospital Avoidance Program.

I **recommend** that in the redesign of the Emergency Department, there is included a dedicated Mental Health Assessment Unit in accordance with contemporary standards.

Acknowledgements

I am grateful to Counsel Assisting, Mr Nicholson, and the other counsel involved in this inquest. I am also appreciative of the assistance provided by the Associates and staff of the Coroner's Office.

I extend my appreciation to Senior Constable Timothy Champion, investigating officer, for his thorough investigation and report.

I offer my condolences to Mr Lattimer's family and trust that the conclusion of the investigation and inquest process may bring them some closure.

Dated: 5 February 2021 at Hobart in the State of Tasmania

Olivia McTaggart
Coroner