MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Robert Webster, Coroner, having investigated the death of Paul Stephen Scott

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that:

a) The identity of the deceased is Paul Stephen Scott (Mr Scott);

b) Mr Scott died as a result of hanging, which was action taken by him alone, with the intention of ending his own life;

c) Mr Scott's cause of death was asphyxial death due to hanging; and

d) Mr Scott died between 27 and 28 January 2018 at Smithton, Tasmania.

Introduction

In making the above findings, I have had regard to the evidence gained in the investigation into Mr Scott's death. The evidence includes:

- Police Report of Death for the Coroner;
- Affidavits establishing identity and life extinct;
- Affidavit of Dr Ruchira Fernando, forensic pathologist;
- Forensic Science Service Tasmania toxicological and analytical report;
- Medical records obtained from the Tasmanian Health Service (THS);
- Affidavit of Celia Smedley;

- Affidavit of Harold Scott;
- Affidavit of Daniel Eastwood (rank not stated) of Tasmania police;
- Affidavit of First-Class Constable Jessica Walshe;
- Affidavit of Senior Sergeant Mark Forteath and photographs;
- Letter of Dr Jennifer Ellix, consultant psychiatrist;
- Root cause analysis (RCA) report of THS;
- Written response to RCA by Dr Ellix;
- Affidavit of Sergeant Genevieve Hickman together with notes of a conversation with Celia Smedley and a letter from Ms Smedley to Sergeant Hickman; and
- Letter of Dr Ben Elijah, Medical Director Statewide and Mental Health Services (SWMHS).

Background

Mr Scott was born on 14 July 1956, he was 61 years of age, single and he resided with Celia Smedley (Ms Smedley) at the date of his death. Mr Scott was the middle child of 3 sons to his parents. He was previously married and had one daughter to that relationship. Mr Scott commenced painting when he was 14 years old and he painted during his lifetime. The evidence discloses he was a talented and successful artist.

His father, Mr Harold Scott, describes his son as having a restlessness in that he did not remain in one place for any length of time, except for when he lived in Margaret River, Western Australia for 6 years and in Bali, Indonesia for approximately 7 years.

In or about 1989, Mr Scott commenced a relationship with Ms Smedley. At that time they both resided in Smithton on the North West Coast of Tasmania. Mr Scott worked at the McCain's factory and as an artist focusing on painting and sculpture. After approximately 5 years, both Mr Scott and Ms Smedley left Tasmania in a converted bus and travelled around Australia. They travelled for a number of years with Mr Scott selling art work at local markets. Ms Smedley would on occasions need to work away from Mr Scott and this is when she says Mr Scott began to exhibit anxiety. Mr Scott spent a significant time living in Margaret River.

In 1998, they returned to Tasmania due to the failing health of Ms Smedley's mother and initially Mr Scott lived with Ms Smedley and her mother. As he could not paint at that house, he subsequently moved to Stanley where he painted but did not have much success in selling his artwork. After the death of Ms Smedley's mother in 2004, they returned to Perth and Mr Scott went to Margaret River where he rented a house. He continued to paint and sold many artworks. He told Ms Smedley there were times when he was increasingly anxious and that he said he had been prescribed diazepam which he had used carefully.

In 2010, Mr Scott moved to Bali, from where he was sending his artwork to a gallery in Margaret River and to a gallery in Singapore. Ms Smedley spent one month in Bali and then she lived there for a subsequent 3 month period but decided she could not work there or learn a new language so she returned to Australia. According to Ms Smedley, Mr Scott's move to Bali was a financial success for approximately 4 years. About 18 months before he returned to Australia, Mr Scott's artwork stopped selling. He lost trust in the galleries he dealt with and believed they were not telling him when his art work sold, or telling him months later and holding onto the proceeds in order to gain interest. When artwork did sell, he asked for receipts so he could see when a piece of artwork sold and for what price but those receipts were not forthcoming.

On one occasion, he went to the gallery in Singapore, without notice, and saw a piece of his art for sale for many thousands more than he expected. He had to trust the galleries to be honest in their dealings with him, but because of the difficulties he was experiencing with them he became more anxious. In addition, Ms Smedley says Mr Scott knew he should have been paying tax in Australia on his earnings but, because he did not receive receipts, his book keeping was poor and that also started to worry him. Because of his worsening financial situation, Mr Scott returned to Perth in September 2016 with the financial assistance of Ms Smedley. They both stayed with Ms Smedley's sister and then her brother in Western Australia. None of the galleries were doing well and Mr Scott had no success in attracting interest in his artwork so Ms Smedley and Mr Scott returned to Smithton. Although they had not been in a relationship for the last 10 years, Mr Scott was still Ms Smedley's friend and she wished to help him get his licence, obtain some assistance from Centrelink and find him work. He started painting again but became more dejected, he slept a lot during the day because he was not sleeping at night and he became more withdrawn.

In September 2017, Mr Scott attended the Smithton Medical Centre and was seen by a doctor. Immediately after that appointment Mr Scott was transported to the Spencer Clinic where he was admitted for psychiatric care. He remained an inpatient at that facility for approximately

2 weeks. He was referred to the Crisis Assessment Triage and Treatment (CATT) service which discharged him into the care of his general practitioner on 7 October 2017. On his return home he was a little better, however, he had difficulties filling out forms for Centrelink and using the computer and he was worried about not paying tax on his earnings. He feared he would be sent to prison. He was readmitted to the Spencer Clinic on 11 January 2018, went on escorted leave on 20 and 23 January 2018 before being granted leave from the clinic from Thursday, 25 January 2018 until Monday, 29 January 2018.

Just prior to his readmission on 11 January 2018, Ms Smedley went out to his studio and found a rope coiled up on the rafter which she advised him she had seen. Mr Scott told her he did not really want to die, he did not want to hurt her and his family and he wondered if he had tried all his options. Ms Smedley then took him to Dr Edwards at the Smithton Medical Centre. Dr Edwards increased his medication, his symptoms worsened and this led to his readmission to the Spencer Clinic.

Circumstances Surrounding the Death

Ms Smedley says on his return home on Thursday, 25 January 2018, Mr Scott was happy but he did not want to go anywhere or do anything. On 26 January 2018, Ms Smedley attended an Australia Day event in Smithton with her family. Mr Scott stayed at home and rested. On Saturday, 27 January 2018, Ms Smedley says they had a quiet day around the house. However, Mr Scott told her he was terrified of going back to the Spencer Clinic. She told him *"they wouldn't make him stay there again, and that we would tell them everything is going okay, and we would talk to them about the review of his medication, and then we would go home again, and see the community mental health team."* They spoke about that issue again later that evening and she could see he was anxious. She gave him another lorazepam tablet, which had been prescribed and which she was looking after. She finished that conversation on a positive note and she went to bed around 11.00pm. Ms Smedley located Mr Scott hanging at about 8.00am on 28 January 2018 in the large shed on the property which was used by Mr Scott as his studio.

Post-Mortem Examination

On 30 January 2018, Dr Fernando performed a post-mortem examination on the body of Mr Scott. As a result of that examination, Dr Fernando says Mr Scott's death was asphyxia due to hanging. Toxicological analysis of samples taken at autopsy was unremarkable. A number of medications were detected which had been prescribed. The levels detected were either at a therapeutic or sub therapeutic range. No alcohol or illicit drugs were detected.

Investigation

Constable Eastwood was tasked to attend Ms Smedley's address. He arrived at the same time as paramedics who confirmed Mr Scott was deceased. Constable Eastwood requested Western forensics and Burnie CIB to attend. Inside the shed was a large open room and a doorway at the opposite end into another large room. The first room contained general items and miscellaneous property such as a bike, wheelbarrow, mattress and tools. The second room was Mr Scott's art studio and that contained an easel, paints and paintings. Mr Scott was hanging in the art studio by an electrical power cord tied to a rafter, and next to a ladder. There were no marks or injuries to Mr Scott's hands or body which suggested a struggle or assault. In the first room, under a window on shelving , a clothes iron was located. The electric power cord had been cut from the iron and above the iron, on another shelf, a pair of tin snips were located. Those tin snips had some fabric fibres on the inside of the blades which appeared to be similar to that of the outer sheath of the electic power cord of the iron. From the observations and examination of the scene by Senior Sergeant Forteath and First-Class Constable Walshe, they were of the view Mr Scott took his own life by hanging and that he had used a pair of tin snips in the shed to cut the cord off the iron and then use the cord as a ligature to hang himself from a rafter in the shed by stepping off the ladder. They did not believe any other person was directly involved in Mr Scott's death as there was no evidence to support such a theory.

Psychiatric Treatment Received by Mr Scott

Because Mr Scott's death occurred when he was on leave from the Spencer Clinic, it is necessary to critically examine the psychiatric treatment he received.

Mr Scott was first admitted to the Spencer Clinic by the emergency department of the North West Regional Hospital on 29 August 2017 following suicidal ideation and an 8 week history of depression. He was found to have low vitamin B12 levels while on the ward. That deficiency is mentioned in the discharge letter but B12 is not prescribed as a discharge medication. He was not given any treatment for it while an impatient because he did not want injections. He was discharged on 14 September 2017. He was referred to the CATT service on 14 September 2017 for follow-up after discharge. He was spoken to the next day at which time he had no self harm thoughts and he was taking his medication. He was to attend his GP on the following Monday, 18 September 2017 and then to contact the CATT service. Messages were left for Mr Scott to call on 19 and 21 September 2017, before a message was left with Ms Smedley on 21 September 2017. He was sent a letter on 22 September 2017 asking him

to contact the CATT service as soon as possible. He was spoken to on 29 September 2017 at which time he reported he was much improved and he denied suicidal ideation, plans or intent. Mr Scott did not think he required any further assistance and he was happy with general practitioner follow-up. His case was discussed at a multidisciplinary clinical review by the CATT service on 6 October 2017 and because of his reported ongoing improvement Mr Scott was discharged to the care of his general practitioner. This was confirmed in a letter to Mr Scott of the same date and by letter to his general practitioner the next day.

The CATT service next had contact with Mr Scott on 8 January 2018 via the mental health helpline. He was triaged as a category 3 patient and a home visit was booked the same day. An assessment on that day found him to have made a noose a few days earlier which he was planning to use to suicide. He did not carry through with this attempt due to protective factors being a close family and a friend, namely Ms Smedley. An appointment with his general practitioner was already booked for the next day, being 9 January 2018. He was offered an appointment with a psychiatrist which took place on 11 January 2018 at which time he was found by Dr Telang to be at risk of suicide with intent and plan. The history of admission to the Spencer Clinic in August/September 2017 was noted, as was the fact that that admission was the only psychiatric history which Mr Scott had. The doctor's clinical impression was Mr Scott had major depression and an anxiety disorder with a past episode of hypomania He was sent to the emergency department where he was medically cleared and he was then admitted to the Spencer Clinic. The plan was to conduct different medication trials including a trial of ceasing olanzapine.

The notes of the Spencer Clinic indicate Mr Scott was seen by the pyschiatrist, Dr Ellix, on 11 January 2018 where he was identified as a category 3 risk. Mr Scott described an in depth attempt to hang himself. He felt worse in the morning, was alienated from society, feels guilty, hopeless and helpless but he had no formal thought disorder. He denied active thoughts of suicide. He was advised to tell staff if this changed. He was prescribed venlafaxine 75mg mane together with mirtazapine 45mg, olanzapine 7.5mg nocte and diazepam PRN. He was medically reviewed by Dr Gunarathna on 15 January 2018 at which time it was noted the medication was effective, he was sleeping okay and had a reasonable appetite. He continued to be a voluntary admission. He was euthymic and had some disorganised thinking and fleeting suicidal ideation but with no plan or intent. His insight was reasonable. He said he only had *"X amount of time."* He was reviewed by Dr Ellix on 17 January 2018 at which time he had continuing thoughts of self harm, feeling anxious and agitated in the mornings, no self-esteem, no future plans. He was not to leave the ward if he felt unsafe and staff were to carry out a risk assessment before he left the ward. Venlafaxine was increased to 150mg mane and olanzapine

to 10 mg nocte. At a multidisciplinary team meeting, a change in diagnosis to schizophrenia was made, and it was noted that Mr Scott was slowly improving and case management was requested. On 19 January 2018, Mr Scott requested a medical review at which time he was seen by Dr Gunarathna. He had a racing thoughts, self harm thoughts, poor appetite and there was some evidence of thought block and disorganised thinking with perplexed affect. Venlafaxine was reduced to 75mg mane. He is again advised not to leave the ward if he was feeling unsafe and he was permitted escorted leave with staff or a friend. On 20 January 2018, the nursing notes reveal Mr Scott went on escorted leave which *"went bad."* A meeting was requested with the doctors as Ms Smedley believed this was the worst she had seen him. Mr Scott was worrying about going to jail because of unpaid taxes and that he would be in the clinic forever as he could not cope off the ward. PRN 1mg lorazepam was given with good effect and a therapeutic assessment grid (TAG) risk assessment was completed. The nursing notes for 22 January 2018 indicate Mr Scott believed patients on the ward were dealing drugs, he was suspicious about a staff member, he was worried about visitors and he believed workmen had come onto the ward to remove drugs from faeces in the toilet. He was settled later in the day. TAG was completed and category 3 observations were maintained.

On 23 January 2018, the notes of a meeting with Ms Smedley are recorded. It was noted she had been in a romantic relationship with Mr Scott but they were now friends. She described him as being paranoid 6 weeks prior to leaving Bali but since his return he had been scared for his own safety and going to jail for not paying tax. He has always been grandiose, creative and eccentric with a history of suffering panic attacks. She described his progress as very slow with some decline since admission. He also went on escorted leave which was successful and a request was made for overnight leave over the coming weekend. His mood was described as *"hopeful,"* he denied self harm ideation but remained guarded and suspicious. On 24 January 2018, he was reviewed by Dr Ellix who noted he was a poor historian, he had poor insight but that he denied active suicidal thoughts. He had some paranoia, his energy levels were okay, his sleep was poor but he described feeling 10% better. The doctor requested a mini mental state examination and a Montréal cognitive assessment be done by a psychologist. He was advised to inform staff if he was feeling unsafe. He was given unescorted leave from Thursday, 25 January to Sunday, 28 January 2018. TAG was completed and a discharge prescription was also completed. There was a plan for possible discharge during the next week. A subsequent note of Dr Ellix of 24 January 2018 confirmed the leave was to be with Ms Smedley. Mr Scott was found by Ms Smedley on the morning of 28 January 2018.

Dr Ellix provided a comprehensive report as to her involvement with Mr Scott on 10 January 2019. She has worked as a consultant psychiatrist in the public sector predominantly in

inpatient settings since 1990. Prior to this, she was as a medical officer and then as a psychiatric registrar in the public sector, again, mostly in inpatient settings from 1983. She confirmed she reviewed Mr Scott on 11 January 2018 with the treating team which consisted of herself, the medical officer, Dr Gunarathna, the contact nurse who was rostered to look after Mr Scott on that shift and his case manager, Mr Price. The team also includes the staff who attend handover in the morning, the discharge coordinator and the psychologist who is only at some handovers. She sets out a detailed history and refers to the previous psychiatric admission to the Spencer Clinic where Mr Scott had been diagnosed with a major depressive disorder and schizotypal personality disorder and she notes what occurred after discharge. There was no recent history of substance abuse or of recent alcohol abuse or of any family history or psychiatric illness. His medications and dosage on admission are noted namely mirtazapine 45 mg nocte, increased by his GP on 7 January 2018 from 30mg, and olanzapine 7.5mg nocte, increased by his GP from 5mg on 5 January 2018. The impression of the team she says was Mr Scott was experiencing a worsening of a mood disturbance in the context of having issues with Centrelink. Venlafaxine XR 75mg mane was added. He was nursed in the low dependency unit on category 3 observations and a 3 month medical certificate for Centrelink was provided. She reviewed investigations including a head CT scan from the earlier admission and no abnormalities were identified. A low B12 was missed but she says it was the medical officers responsibility to check these investigations and to manage physical issues such as low B12 and replacement. She says the medical officer also organises investigations. In any event, her view is the B12 level was only minimally lowered and unlikely to have had any impact on Mr Scott's presentation, his illness or his response to treatment or the treatment required. She says over the next few days he settled well into the unit and was not recorded as reporting suicidal ideation on 11, 12, 13 or 14 January 2018. He tended to isolate in his room and reported that he disliked being around people. He was observed wearing earplugs on one occasion. On 15 January 2018, he had fleeting suicidal ideation but no plan or intent. His main concern was his interaction with Centrelink and he was happy for an application to be made for a disability support pension. No suicidal ideation was expressed on 16 January 2018. She then reports on her review of him on 17 January 2018 as summarised above and given his presentation in the unit since admission it was thought it was likely he had a primary diagnosis of acute psychotic episode, possibly schizophrenia with an acute exacerbation. He may have had a schizotypal personality disorder with a brief reactive psychosis. He appeared to have experienced an associated catastrophic reaction to a significant stressor, namely his Centrelink certificate running out. Venlafaxine XR was increased to 150mg mane, olanzapine was increased to 10mg nocte and mirtazapine was continued and 45mg nocte. She notes on 18 January 2018, he is described as interacting with co-patients, having good self-care and sleeping well. He was observed to be perplexed and vague and tangential in conversation. No suicidal ideation was expressed and he was supported to fill out the appropriate Centrelink forms. On 19 January

2018, he requested to see the medical officer as set out above at which time the dose of venlafaxine was reduced and he returned to his previous improved state. She then reports on the meeting with Ms Smedley on 23 January 2018.

On 24 January 2018, he was reviewed by Dr Ellix at which time he denied suicidal ideation or intent. Olanzapine was increased to 10mg given his ongoing psychotic symptoms, while the other medications continued unchanged. The tests to be conducted by a psychologist were organised as was an MRI. She says Mr Scott sought discharge and that he was relieved his application for the disability support pension and that his taxation issues were being addressed. He was happy to undergo an MRI to exclude organic pathology such as early dementia. He agreed to a referral for psychological testing to assess cognitive decline. He was focussing on the future given he sought a dental referral and was organising to have his eyes tested and he planned to sort out his mobile telephone difficulties with Telstra. He agreed to taking medication and to having a follow-up consultation with adult community mental health services. He was assessed as having the capacity to make decisions about his psychiatric treatment and therefore Dr Ellix concluded there were no grounds to place him on an assessment order under the *Mental Health Act* 2013. She says he was persuaded to accept leave rather than be fully discharged and he agreed to take his medication and return to the unit for psychological testing, review and formal discharge if appropriate. Mr Scott was expected to return to the Spencer Clinic on 28 January 2018.

As to the rationale for leave, Dr Ellix said the diagnosis was unclear. Mr Scott did not fulfil the criteria for major depressive disorder as he did not describe persistently depressed mood or lack of enjoyment in activities. He did not have significant sleep disorder or appetite disturbance. His increase in suicidal ideation was in the context of a major stressor. He was not observed to have psycho motor abnormality and his self-care was generally good. Sleep was reasonable and he ate most meals. Mr Scott expressed suicidal ideation at times without plan or intent. There was no self harm incident during the admission. He appeared to have been psychotic at times in his life and during this admission. He had disorganised thinking, persecutory ideation and abnormality of affect with perplexity and inappropriateness. It is possible he experienced auditory hallucinations when he was observed walking in the unit with earphones in for no apparent reason. He denied experiencing voices but his interaction with staff was noted to be odd at times. He reported that while in Bali he was regarded as *"crazy"* by the locals and advised to seek treatment. It is possible his persecutory ideation was of delusional intensity at times and for example led to him leaving Bali. It was thought he may have had a long-term schizophrenic illness and it was possible he fulfilled the criteria for schizotypal personality disorder with an acute deterioration in functioning in the context of

stress. It was felt the diagnosis of schizophrenia would best support an application for a disability support pension but, regardless of diagnosis, he was not able to work in paid employment at that time or in the foreseeable future. The doses of medication which were used to treat Mr Scott were therapeutic for treatment of depression and treatment of psychosis. Leave was negotiated for the reasons set out in the last paragraph.

Dr Ellix did not impose the usual restrictions on Mr Scott's leave such as not using illicit substances or abusing alcohol as they were not issues in his presentation. The other type of restriction is where the leave is and both Mr Scott and Ms Smedley agreed that he remain with Ms Smedley who she notes was previously a registered nurse. Dr Ellix understood the medical officer, contact nurse and case manager would have provided Mr Scott with information about the bed being held and the invitation to contact the Spencer Unit or the CATT team. He could have returned from leave early as the bed was held for him.

Finally, Dr Ellix says she understood a Root Cause Analysis (RCA) was completed by the Tasmanian Health Service, that she had a conversation with Dr Elijah about this case but she did not think her opinion was taken into account and nor was she invited to provide a written submission. She thought it was simplistic to say the diagnosis was wrong because a lot of thought went into making a formulation for Mr Scott in an attempt to explain how he came to be presenting as he was. Dr Ellix was not suggesting Mr Scott had suddenly developed schizophrenia and, in her view, he did not have features to support a diagnosis of major depressive disorder. The medication he received was at therapeutic doses for treating both a psychotic disorder and a depressive disorder.

The RCA was signed off by Dr Elijah, Acting Statewide Medical Director of SWMHS and Nicola Dymond, the Chief Operating Officer of the THS. The RCA indicates the panel had concerns regarding aspects of Mr Scott's care but were unable to confirm this due to the time which had passed since the incident and the fact that the treating doctor was a locum *"and unable to be interviewed to discuss the care of the patient."* This is at odds with the comments made by Dr Ellix in her report of 10 January 2019 that she spoke to Dr Elijah about this case but was not invited to provide a written submission to the panel conducting the RCA. There is no evidence Dr Ellix was unavailable for interview. However the concerns included:

- The diagnosis was likely to be incorrect. The more likely diagnosis was considered to be psychotic depression and, if that diagnosis was made, treatment would have included the use of an antipsychotic medication;

- Without any discernible reason, the diagnosis was changed from depression to schizophrenia which would be unusual for a man of Mr Scott's age to suddenly develop this condition and, if that was so, his presentation would have reflected this. There was no change in treatment to reflect the changing diagnosis;

- There were changes to medication which included the reduction in the dose of venlafaxine which did not reflect the clinical picture and would likely have affected Mr Scott's presentation;

- Little weight was placed on the reports of deterioration by both the patient and Ms Smedley with no change made to treatment to account for the deterioration in mental state;

- There seemed to be high importance placed upon giving Mr Scott leave despite the reported deterioration which appeared to take precedence over listening to him and Ms Smedley and of the obvious risk which Mr Scott presented;

- It is well documented that suicidal risk can increase once an antidepressant response commences with increased energy and a risk of acting as yet unresolved suicidal ideation and intent. In this case, 12 days after commencing venlafaxine, he was sent on 4 days leave. This would coincide with when that medication began to have an effect on him.

In addition, the RCA found the following contributing factors:

- Mr Scott was granted overnight leave from Thursday to Sunday without a full and comprehensive risk assessment being completed, and despite both he and Ms Smedley telling staff he was not getting any better and that he continued to have suicidal ideation;

- There was no leave plan for the granted leave, including; no discussion with either the patient or Ms Smedley about what to do if he became unwell, how to observe his behaviour for signs of increased risk, there was no safety plan for either Mr Scott or Ms Smedley, no PRN medication given for the leave period despite Mr Scott using it regularly on the ward and no contact details were given so that help could be obtained if required. The leave was also granted over the Australia Day

public holiday weekend when no medical staff would have been available on the ward.

The RCA found there were *"other contributing factors which were related to the incident,"* but which were not a root cause and they were as follows:

- Poor documentation from medical and nursing staff;
- Lack of risk assessment being completed as per policy;
- Poor communication including medical staff and nursing staff, especially with regard to the GP, Ms Smedley and CATT team;
- No evidence was found of a care plan, leave plan or safety plan; and
- No evidence was found there was any monitoring of Mr Scott's physical health. This is relevant as he had previously been diagnosed with low levels of vitamin B12. A deficiency in B12 can cause depression, psychotic symptoms including paranoia and cognitive problems so it could have contributed to or even caused some or all of Mr Scott's mental health symptoms. There is no evidence any treatment for this deficiency was provided or that there was any follow-up blood tests and there is no documentation on whether B12 was taken orally while at home.

In order to ensure procedural fairness to Dr Ellix, my office provided her with a copy of the RCA and she responded on 1 February 2019. In a very thorough response which provides detailed reasons supporting her position, she said the following with respect to the concerns identified in the RCA:

- Diagnosis: Mr Scott did not fulfil the criteria for a diagnosis of major depressive disorder with psychotic features (psychotic depression). He was psychotic with persecutory delusions and possible auditory hallucinations. There was a past history of psychosis. He fulfilled the diagnostic criteria for schizophrenia which was not thought to be a new presentation but an acute exacerbation related to stress in the context of a longer standing previously undiagnosed and untreated schizophrenia. The major stressor was the lapsing of his Centrelink sickness

certificate and that he seek paid employment to fulfil his Newstart obligations so that he could continue to receive Centrelink benefits. He had no other income. He had previously been diagnosed with a schizotypal personality disorder in the previous admission to the Spencer Clinic. This diagnosis was considered but it was thought his presentation was better explained by the diagnosis of schizophrenia. Dr Ellix says there was much discussion between herself and the medical officer about Mr Scott's presentation and diagnosis and he was reviewed on a number of occasions by both of them. He was discussed every weekday morning at the multidisciplinary team meeting. Twice-weekly this meeting included representatives of adult community mental health services. All members of the team agreed with the diagnosis and that the management plan was appropriate. He was treated with antidepressant and antipsychotic medication in therapeutic doses so it is incorrect to say he was not treated with an antipsychotic - he was prescribed olanzapine.

- Change in diagnosis: Dr Ellix says the file does not reflect the amount of discussion that occurred with respect to Mr Scott's presentation and diagnosis. There is nothing unusual in that. With further review and observation by Dr Ellix and her team it became clear that the diagnosis made by Dr Telang was not correct. His antipsychotic medication was increased because it was believed he had a primary psychotic disorder rather than an affective one.

- Medications: Venlafaxine was reduced because his symptoms deteriorated when the dose was increased. Mr Scott sought out Dr Gunarathna, the medical officer, to inform her of this as he was distressed. Increasing the dose of this medication can lead to agitation and dysphoria which may include experiencing racing thoughts. This was the reason this medication was reduced to its previous dose which he had tolerated without reporting any adverse effects and is consistent with the view he did not have a major depressive disorder.

- Reported deterioration: The clinical notes report some fluctuation in presentation which was addressed with support and extra medication as required. Although a fluctuation in his symptoms was expected, he appeared to be improving and was more optimistic for the future. The overall plan was to continue the antidepressant medication, increase the antipsychotic medication, address his psychosocial issues and transition him to community case management. In addition, leave had gone well on 23 January 2018, Mr Scott was

future focused and Ms Smedley was supportive of him living with her and providing him with assistance. On the return from day leave, Ms Smedley requested leave over the coming weekend.

- Leave: Mr Scott sought discharge from the unit on 24 January 2018 which Ms Smedley supported. He could not be detained as an involuntary patient. Dr Ellix says there was no push from her or the unit for him to go on leave and she did not want to discharge him because she felt he was not ready. He remained symptomatic and his medication was still being adjusted. The application for the disability support pension had been lodged but not yet accepted. The Centrelink certificate had been lodged and there was no requirement that he look for work to be eligible for benefits and so the offer was made that he go on leave as an alternative to discharge so that he would continue to have the support of the Spencer Clinic if his condition deteriorated. Dr Ellix did not anticipate Mr Scott would suicide as he was future focused, had not reported suicidal ideation at review and had managed leave from the unit. Her preference was for him to remain as an inpatient for a longer period but she could not compel him to do so.

- Medication Effects: Dr Ellix agrees that some patients can experience an increased risk of suicide after antidepressant medication has commenced because they can experience an increase in energy before the depressed mood has improved. The increased risk of suicide occurs because the patient has an ongoing lowered mood but with more energy to act on the depressed thoughts. She did not think this was the case with Mr Scott because he did not complain of a lack of energy and did not display a lack of energy. She did not think his primary diagnosis was major depression and antidepressant medication will not lead to someone without a depressive illness developing the energy to suicide. He felt better once the dose of venlafaxine was reduced.

As to the factors which the RCA described as contributing, Dr Ellix says:

- Mr Scott was reviewed by herself and Dr Gunarantha on 24 January 2018 andat which time he informed her he wished to be discharged rather than have leave. She performed a mental state examination and a risk assessment at that review and formed the opinion Mr Scott had capacity to make the decision to discharge himself and could not be held as an involuntary patient.

- He wished to discharge himself and could not be persuaded to remain in hospital. He and Ms Smedley were aware a bed was held for him, that he was having leave and he was not being discharged. It was her routine practice to discuss with patients what to do in the event symptoms deteriorated when she reviews them prior to them taking leave. He agreed to return on 28 January 2018 and it was unfortunate it was the Australia day long weekend and the first day of leave was a public holiday.

As to the remaining factors which the RCA described as contributing but not a root cause, Dr Ellix says:

- Documentation: Her usual practice is to complete the documentation in the clinical file but this was not standard practice in the Spencer Clinic where the medical officer writes in the file. As a locum, she followed the standard practice of the clinic. If she had followed her usual practice, the documentation would have been clearer and of a higher standard.

- Risk assessments: It is her practice to perform a risk assessment at every patient review which she did in this case.

- Communication: There was a meeting with the treating team which consisted of herself, Dr Gunarathna, the nurse rostered to look after Mr Scott for that shift, his case manager, Mr Price, and Ms Smedley on 23 January 2018.

- Plans: A more comprehensive leave plan should have been documented.

- Mr Scott's physical health: Dr Ellix requested that the investigations were reviewed by the medical officer as organising and checking those investigations is a medical officer's responsibility as would be management of a deficiency in vitamin B12. There is a note in the file that investigations were normal but this is an error as Mr Scott had a low B12 level. It would be unusual practice to repeat a routine admission investigation such as a B12 test in the January if they were normal in August of the previous year. Usual practice is to repeat routine investigations on a yearly basis. There is nothing in Mr Scott's presentation to suggest the low B12 level contributed to his presentation. Low B12 can result in abnormalities in full blood examination which is a marker of low B12 causing

harm. His full blood examination in August 2017 was normal. The B12 level should have been repeated though because it was abnormal and good care dictates that an abnormality is followed up.

In addition, Dr Ellix says she was not provided with any documentation which outlined the THS's policies regarding patient leave. If they had been provided, she would have reviewed them. She would have preferred to complete her own documentation in the clinical file but that was not the practice in the Spencer Clinic. If she had completed her own documentation, then it would have been more comprehensive and of a higher standard. She asked about previous physical investigations and was informed they were normal. It was not her responsibility to check the results of investigations only to know they had been done and were either normal or being managed appropriately. She says his low B12 level did not contribute to Mr Scott's presentation, progress or his death. The RCA noted the current risk assessment tool was poor and underutilised and as to this Dr Ellix says she would have been happy to use paperwork as directed. She confirmed she routinely performed a risk assessment at every patient review, however, she concedes the risk assessments were poorly documented.

By letter on 4 May 2021 my predecessor, Coroner Andrew McKee, wrote to Dr Elijah and asked him to respond to the responses of Dr Ellix. Dr Elijah responded on 16 July 2021. He notes he was not privy to the deliberations of the panel and the reasons or circumstances why Dr Ellix was not interviewed. He says RCA panels are constituted by clinicians who do not have direct involvement with the patient or the relevant service arm. The panel's job is to consider system gaps or shortcomings that may have caused or contributed to the event under investigation. Recommendations based upon the panel's analysis are then provided for service response and improvement. In my view, it would be very difficult to accurately identify system gaps or shortcomings without interviewing and/or inviting those treating the patient which led to the event under investigation to make a written submission to the panel. He then responds as follows:

- Diagnosis: Dr Elijah acknowledges diagnosis in psychiatry can be difficult as it relies significantly on self-disclosure by individuals who are unwell and who may be unable or unwilling to share material which is of diagnostic significance. As such it is an iterative process of interviewing, observation and review of history obtained from significant others about current and past presentations before a definitive diagnosis is arrived at. He says diagnoses can also change over time. He notes the RCA panel was of the view the diagnosis was a psychotic depression and he notes the treating team in this case considered the diagnosis of schizotypal

personality which was considered to be the diagnosis in 2017. For the reasons set out in his response, he does not consider that diagnosis can be sustained. He says consideration should have been given to psychotic depression or schizophrenia with depressive features but that the *"medications being prescribed were, contrary to the panels observation, appropriate to amelioration of symptoms in either condition or had likely already partially done so."*

- Diagnostic change: Dr Elijah says it is not unusual to revise a diagnosis as the clinical picture in response to treatment unfolds. He says psychotic phenomena did become the primary presentation as acute depressive features receded during this admission to the Spencer Clinic.

- Medication change: Dr Elijah says Dr Ellix has provided an appropriate reason for reducing the dose of the antidepressant venlafaxine when Mr Scott complained of agitation and rapidity of thoughts.

- Reported clinical deterioration: Dr Elijah appears to agree with the assessment of Dr Ellix that the clinical entries suggest a slow improvement with a reduction in the early depressive symptoms and disclosure of psychotic phenomena. He agrees fluctuation in presentation is not unusual and the focus would be on the primary symptoms of concern. He notes the positive experience on leave on Mr Scott's return on 23 January 2018.

- Emergent antidepressant response and suicidal risk: As to this point, Dr Elijah agrees with Dr Ellix that it is unlikely that the anti-depressants contributed to the sad and adverse outcome. He says it is also unlikely that the necessary reduction in dose of the antidepressant, due to the reported side effects, contributed.

As to what Dr Elijah describes as contributing factors, he makes the following further comments:

- Documentation: He is aware use of a scribe has become part of inpatient clinical approaches in some interstate services most likely due to time pressures. He notes the Spencer Clinic has a single consultant but it would be more appropriately staffed if it had 2 consultants as is the case in the similarly sized Northside Clinic at the Launceston General Hospital. If scribes are to be used,

he says it is prudent for a consultant psychiatrist to check the notes, add to them as necessary and countersign them as accurate and representative of the discussions that have occurred. Dr Elijah says it is accepted good clinical practice for a consultant psychiatrist to enter, at a minimum, in the clinical notes the initial diagnostic assessment and treatment plan, including the management plan for identified risk issues after interviewing a new patient or summarising relevant clinical facts when taking over the care of a patient.

- Risk assessment: This is an iterative and dynamic process which continues throughout a patient's admission and is an inherent part of the mental state examination and codified processes, including the TAG. He notes Mr Scott was assessed as appropriate for overnight leave with Ms Smedley and, contrary to what the RCA panel reported, the TAG had been maintained from the time of admission to the day of leave and that the risk of intentional and unintentional harm had been rated as mild from at least 19 January 2018.

- Care planning: The clinical record demonstrates thought had been given to progressive leave with day leave being successfully negotiated, followed by the plan for overnight leave after feedback from the patient and Ms Smedley. Psychosocial and health aspects were addressed as tasks for him to undertake during his last leave period following a letter of support being provided by Dr Ellix for an application for the disability support pension on 22 January 2018. In response to the panel's suggestion there be contact with the local crisis team for support during the period of leave Dr Elijah says that would not be routine unless there were specific issues identified around risk or medication adherence.

- Physical health: Dr Elijah agrees with Dr Ellix that junior medical staff are primarily engaged in review of the medical status both past and current, follow-up of results and discussion with the treating consultant who has oversight especially in respect of conditions that may contribute to or complicate psychiatric conditions; here he is referring to the vitamin B12 deficiency. He agrees with Dr Ellix and says the level of the vitamin B12 deficiency in this case did not contribute to Mr Scott's clinical presentation. He says what occurred, that is the failure to follow up a medical test, is indicative of there being an absence of an appropriate electronic medical record.

- Changes and current practice: Dr Elijah says SWMHS continue to improve the RCA process by including consideration of written documentation being provided by clinical staff after a critical event, interviewing of relevant staff and the choice of panel members. The THS has also commenced a process around commissioning a statewide electronic medical record. In addition, SWMHS has implemented a staff training program to assist with the management of suicidal crisis and risk which has been endorsed by the chief civil and forensic psychiatrist, Dr Groves. A voluntary patient's conditions of leave form is now to be used and a SWMHS care planning protocol now guides treatment approaches with patients. In addition an orientation document is now available to medical staff assigned to SWMHS in the northwest but it is open to further development. It seems all of these documents and processes came into existence after Mr Scott's untimely passing.

Some notes made by Sergeant Hickman of a discussion between Sergeant Hickman of the Coroner's office on 7 May 2021 and Ms Smedley indicate it was Ms Smedley's idea to have weekend leave and she was aware that over the long weekend there were no doctors present on the Unit. It was thought it would be best to have him home. She says Mr Scott seemed keen and therefore she asked the doctor. She was aware Mr Scott was required back in the unit after his leave ended but if things went well it was a possibility his care would be transferred back to a community service. She says she picked Mr Scott up, she thinks she picked up his medications and was given a phone number if his condition deteriorated. She took him home. She says during the time Mr Scott was at home his behaviour was in her view normal and there was no acute episode. She didn't need to telephone anybody, I assume for assistance, because there was no reason to. She does not recall a discharge or release plan being given to her and she knew Mr Scott had a bed in the unit which would be available for him if he needed to return.

Sergeant Hickman sent her notes to Ms Smedley via email and on 13 May 2021 Ms Smedley responded by email saying the summary was incorrect in so many ways and that she had written and signed a more coherent note and that she would send it if Sergeant Hickman could supply an address and guaranteed it would not get lost. Sergeant Hickman contacted Ms Smedley again and asked her to correct the notes to ensure they were accurate after which the Magistrates Court received, on 31 May 2021, a letter from Ms Smedley to Sergeant Hickman dated 9 May 2021. That letter notes it was a distressing time for Ms Smedley after Mr Scott's death and it was difficult to revisit it. She indicates in reading her original affidavit she is confused in that document in so far as the 2 admissions to the Spencer Clinic are

concerned. She confirmed, on the subject of leave, Mr Scott wanted to come home on leave for the weekend and was granted leave to return on a later date. The letter does not point out or highlight any errors in Sergeant Hickman's notes.

Comments and Recommendations

I have decided not to hold a public inquest into this death because the investigation has been sufficient to disclose the identity of the deceased, the date, place, cause of death and relevant circumstances concerning how his death occurred. I do not consider that the holding of a public inquest would elicit any significant information further to that disclosed by the investigation.

Given Dr Elijah's response to the 2 written responses of Dr Ellix as set out above there is little difference between the respective positions of SWMHS which is a part of the THS and Dr Ellix. Dr Ellix was not wrong to diagnose a different psychiatric condition for the reasons expressed by Dr Elijah. In my view she was better placed than the panel to diagnose Mr Scott's psychiatric condition because she had the benefit of speaking to and observing Mr Scott and the benefit of discussions with the treating team who had also observed and spoken to Mr Scott during his admission to the Spencer Clinic. In any event the medications which were prescribed were appropriate to treat the psychiatric condition diagnosed by Dr Ellix and the psychiatric condition diagnosed by the panel. In addition there is no criticism of Dr Ellix for changing the diagnosis and an appropriate rationale is provided for changing the medication which was prescribed for Mr Scott. There is also agreement there was slow improvement in Mr Scott's overall condition and that leave on 23 January 2018 had been a positive experience. There is agreement that the use of antidepressants and the B12 deficiency did not contribute to Mr Scott's presentation and his subsequent passing. Dr Elijah does not criticise Dr Ellix's assessment that Mr Scott should be permitted to take leave from the unit commencing on 25 January 2018.

In essence Dr Ellix was confronted with a patient whose presentation was complex. She notes Mr Scott was a voluntary patient and at no time did she consider he could be detained under the provisions of the *Mental Health Act* 2013. She did not push for him to have leave from the Spencer Unit and she did not wish to discharge him. She says, and I accept, leave was a compromise as Mr Scott did not wish to remain in the Unit. Dr Ellix says, and I accept, she did her best to provide good inpatient psychiatric treatment and care in a way that was respectful of Mr Scott and which was provided to him in the least restrictive manner. As she could not detain him involuntarily she took, in my view, the reasonable step of negotiating

accompanied leave which Ms Smedley agreed to. I accept Dr Ellix did not anticipate Mr Scott would suicide while on leave and she of course regrets this tragic outcome.

The changes to practice and processes canvassed by Dr Elijah, which are set out above, are in my view appropriate responses to what occurred in this case and they should be finalised and implemented in full if that has not occurred already.

The circumstances of Mr Scott's death do not require me to make any further comment or to make any recommendations pursuant to s28 of the *Coroners Act* 1995.

I convey my sincere condolences to Mr Scott's family and loved ones.

Dated: 24 February 2022 at Hobart in the State of Tasmania.

Robert Webster
Coroner