IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 001029

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the death of Helen Maria BRYCE

Delivered on:	15 October 2015
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing dates:	24-28 February 2014 and 5 September 2014 (for submissions)
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr A. MUKHERJEE of Counsel, instructed by Ms G. Angelawitsch of Adviceline Injury Lawyers, appeared on behalf of the BRYCE family Mr S. MOLONEY of Counsel, instructed by Ms E. Dawes of K&L Gates, appeared on behalf of Austin Health
Assisting the Coroner:	Leading Senior Constable T. RAMSEY, Police Coronial Support Unit.

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of HELEN MARIA BRYCE

and having held an inquest in relation to this death between 24-28 February and 5 September 2014

in the Coroners Court of Victoria at Melbourne

find that the identity of the deceased was HELEN MARIA BRYCE

born on 27 August 1956

and that the death occurred on 20 March 2011

at 4 Landra Place, Greensborough, Victoria 3088

from:

I (a) HANGING

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES[1]

1. Mrs Bryce was a 54-year-old woman who had been married to her husband, Graeme, since 1981. In 1984, after their first child Nicholas was born, Mrs Bryce experienced a rapid onset of psychiatric symptoms, was diagnosed with puerperal psychosis and admitted to a psychiatric hospital. During an admission of some eight months, Mrs Bryce was treated with medication and electro convulsive therapy.

2. Mrs Bryce did not experience postnatal depression or psychosis after the births of her three other children, Claire, Hadyn and Anthony and her family reported no recurrence of mental ill-health in the 27 years since her 1984 episode of psychiatric care.[2]

3. From December 2010 and, particularly after mid-January 2011, Mrs Bryce's family observed significant changes in her demeanour and behaviour.[3] Mrs Bryce developed an uncharacteristically negative outlook,[4] expressed hopelessness[5] and dissatisfaction with her life[6] and disclosed financial concerns[7] that were baseless, according to Mr Bryce.[8] She had difficulty sleeping,[9] lost a lot of weight[10] and appeared agitated, pacing and rubbing her

[1] This section is a summary of facts that were uncontentious, and provide a context for those circumstances which were contentious and will be discussed in some detail below.

[2] Exhibit A.

[3] Exhibit F (2010 onset of behavioural changes) and Exhibits A, C, E, and G.

[4] Exhibit E.

[5] Exhibit G.

[6] Exhibits C, F and G.

[7] Exhibits F, G and D.

[8] Exhibit A.

[9] Exhibits A and C.

stomach distractedly for long periods.[11] Mrs Bryce's mood was labile[12] but she generally tended to appear anxious and was often tearful.[13] She sometimes appeared to have difficulty maintaining conversation,[14] was unable to complete simple tasks and gradually discontinued work and recreational activities that she had previously enjoyed.[15]

ACCESS TO MEDICAL/PSYCHIATRIC TREATMENT IN THE COMMUNITY

4. On 17 January 2011, Mrs Bryce consulted her general practitioner, Dr Roslyn Rayner of the Andrew Place Clinic, about insomnia and her depressive symptoms. She was prescribed temazepam (a benzodiazepine) that day and upon review two days later, a mental health assessment was completed and referrals made to a psychologist and to a psychiatrist Dr Rakesh Khanna.[16] Mrs Bryce was prescribed cipramil (an antidepressant) by Dr Rayner[17] and consulted psychologist Ms Chandler[18] on 27 January, and 3, 10 and 17 February 2011.[19]
5. On Friday 18 February 2011, Mrs Bryce attempted to overdose on temazepam. She was observed to remain in bed and be extremely drowsy, but rousable, throughout the weekend.[20] On the evening of 19 February 2011, Mr Bryant discovered empty medication packaging and telephoned the Poisons Hotline for advice.[21]
6. On Monday 21 February 2011, Mr Bryce informed Dr Rayner of his wife's attempted overdose and she, in turn, arranged for Mrs Bryce to be admitted to Northpark Private Hospital [NPH] for inpatient psychiatric treatment under the care of Dr Khanna.[22]

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[10] Exhibits E and F.

[11] Exhibits A and C.

[12] Exhibit G.

[13] Exhibits F, G, A and C.

[14] Exhibits G and A.

[15] Exhibits C, F and G.

[16] Coronial Brief of Evidence [Exhibit Y] page 48 (Statement of Dr R. Rayner) and, also, pages 54-56 (Mental Health Assessment).

[17] Ibid.

[18] Dr Rayner referred Mrs Bryce to psychologist, Tamara Evans, and attended an initial intake session with her on 22 January 2011. However, Mrs Bryce did not return to Ms Evans and consulted another psychologist, Ms Chandler, after seeking another referral from her general practitioner. See generally Exhibit Y pages 52, 58-60 (Statement and notes of Tamara Evans) and page 85 (Dr Rayner's referral to Ms Chandler).

[19] Exhibit Y, pages 61-83 (Statement and notes of Hilary Chandler).

[20] Exhibits A, B, C and E.

[21] Exhibit A.

[22] See Exhibit A and Exhibit Y page 48 (Statement of Dr R. Rayner) and 49-51 (Statement of Dr R. Khanna). Mr Bryce appeasrs to have first contacted Ms Chandler who recommended that he contact Dr Rayner. Ms Chandler contacted Dr Rayner herself to advise of her opinion that Mrs Bryce required an urgent psychiatric assessment.

7. Mrs Bryce was admitted to NPH on 23 February 2011 and was assessed by Dr Khanna that day. He noted that she was tense but articulate, presented with significant negative cognitions, and reported acute onset of high anxiety and low mood. Dr Khanna diagnosed a bipolar depression, commenced Mrs Bryce on zyprexa (an antipsychotic) 5mg at night and lexapro (an antidepressant) 10mg daily.[23]
8. In the absence of private health insurance, Mrs Bryce was concerned about the cost of her admission and could not be reassured about this by her husband. Dr Khanna observed that she 'tried to present herself as much better' the day after her admission, but was ultimately persuaded to remain at NPH as an inpatient.[24] She showed some improvement over subsequent days and was discharged on 1 March 2011, with an appointment to see Dr Khanna on 8 March 2011 and a plan to contact North-East Crisis Assessment and Treatment Team [CATT] in the event of an emergency.[25]
9. On Thursday 3 March 2011, Mrs Bryce attended an appointment with Ms Chandler who noted that she was agitated, guarded about her compliance with prescribed medications and thoughts of suicide, and expressing feelings of hopelessness.[26] Mrs Bryce reportedly 'did not see the point' of talking about her concerns.[27]
10. Ms Chandler was worried that Mrs Bryce's level of hopelessness and unwillingness to remain engaged in treatment while in an acute depressive episode increased the risk that she may impulsively attempt suicide. She considered that Mrs Bryce required prompt psychiatric attention and monitoring and that assessment by the CATT.[28] Ms Chandler, therefore, reported her concerns to Dr Rayner and Dr Khanna, Mr Bryce and the CATT. She also informed Mrs Bryce of her actions and that she should expect contact from CATT. Ms Chandler was later advised by the CATT that contact had been made and that Mrs Bryce was 'settled at home and did not want contact' with the mental health service.[29]

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[23] Exhibit Y pages 49-51 (Statement of Dr R. Khanna).

[24] Exhibit Y page 50 (Statement of Dr R. Khanna).

[25] Exhibit Y pages 49-51 (Statement of Dr R. Khanna).

[26] Exhibit Y pages 61-65 (Statement of Ms H. Chandler).

[27] Exhibit Y page 64 (Statement of Ms H. Chandler).

[28] Exhibit Y page 61-65 (Statement of Ms H. Chandler).

[29] Exhibit Y page 65 (Statement of Ms H. Chandler). Mrs Bryce's medical records show two contacts with CATT, the first consequent upon Ms Chandler's referral and the second following her "fall" in the shower. On both occasions a CATT representative spoke with Mrs Bryce and was reassured by her statements that she was compliant with medication, engaged with Dr Khanna, had no suicidal ideation or plan and identified her supportive family and religious beliefs as protective factors. It is also clear from these records that Mrs Bryce indicated heightened anxiety because of CATT involvement and her perception of a breach of privacy. And, that Mr Bryce considered his wife to be 'suicidal' and said as much to CATT on 3 March 2011; he was advised that he could call an ambulance for his wife if he was concerned [Exhibit Y pages 316-318 (Screening Register Detail)].

11. In the early hours of Saturday 5 March 2011, Mr Bryce was woken by a strange groaning sound emanating from the en suite bathroom. Upon investigation, he found his wife on the floor of the bathroom with a head laceration, and that her responses were delayed. As Mr Bryce moved his wife back to their bedroom he observed that a belt was hanging from the shower frame. Mr Bryce contacted the CATT, over his wife's objections, and was told that he could take Mrs Bryce to an emergency department.[30] Mr Bryce reported that he felt CATT was 'dismissive' of his concerns about his wife.[31] Over the course of the weekend Mrs Bryce's sister, Mrs Watts, and Mr Bryce secured an urgent appointment with Dr Khanna on Monday morning.[32]

12. On 7 March 2011, Dr Khanna assessed Mrs Bryce as very tense, acutely depressed and at serious risk of suicide. She was unwilling to trial an increased dose of medication, undergo further review or engage with the CATT.[33] Accordingly, Dr Khanna considered that Mrs Bryce met the *Mental Health Act* 1986 [MH Act] criteria for involuntary psychiatric treatment,[34] completed the recommendation forms,[35] facilitated her admission that day to Austin Health Acute Psychiatric Unit and provided her treatment team with a referral letter.[36]

ADMISSION TO THE AUSTIN'S ACUTE PSYCHIATRIC UNIT [APU] ON 7 MARCH 2011

13. Upon admission to APU on 7 March 2011, Mrs Bryce was assessed by psychiatry intern, Dr Kendrick Koo, and was subsequently nursed on half hourly visual observations.[37]

14. On 8 March 2011, Mrs Bryce was reviewed by consultant psychiatrist Dr Dilani Wijeratne and Dr Koo. They found her to be anxious, with reduced reactivity, restricted to the depressive range. Mrs Bryce's speech was slow and monotonous; she was vague when providing a history and avoided eye contact. Some psychomotor retardation was evident but

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[30] Exhibit Y pages 316-318 (Screening Register Detail).

[31] Exhibit A.

[32] Exhibits A and F.

[33] Exhibit Y pages 49-51 (Statement of Dr R. Khanna).

[34] The criteria for involuntary psychiatric treatment are contained in section 8(1) of the *Mental Health Act* 1986.

[35] Pursuant to section 9 of the MH Act, namely Exhibit Y pages 289-292 (MHASCH2 Forms).

[36] Exhibit Y pages 223-224 (Dr Khanna's letter of referral to APU).

[37] Referred to as "Level 3 Observations (Close Observation)" where the frequency of observation, day and night, is specified. Exhibit Y pages 296-313 (Admission Episode: Assessment completed by Dr K. Koo on 7/3/2011). Dr Koo noted, among other things, that Mrs Bryce's mood and affect were incongruent; she was guarded, evasive and vague when questioned, denied self-harm/suicidal ideation and demonstrated impaired judgement. Dr Koo noted that Mrs Bryce's risk of suicide was "unknown" despite her denying an intention to self-harm; she was at minimal risk of absconding and would be vulnerable on the ward. Mental Health Clinical Risk Assessment Screen completed by Nurse Fan on 7/3/11 assessed Mrs Bryce's risks of "suicide/self-harm" and "vulnerability" as "moderate but all other risk factors as "low" [Exhibit Y page 337].

there was no evidence or report of hallucinations, and no formal thought disorder. The content of Mrs Bryce's conversation revealed feelings of low self-esteem, inadequacy and preoccupation with financial concerns. The treating team considered the possibility of delusions of poverty. Although she acknowledged prior intermittent suicidal ideation and the suicide attempt, Mrs Bryce denied any current suicidal thoughts. Her insight into her mental illness was impaired and she had difficulty engaging with treatment.[38]

15. In light of her presentation, Dr Wijeratne confirmed Mrs Bryce's involuntary status under the MH Act.[39] The consultant's admission diagnosis was severe major depression with anxiety and possible psychotic symptoms.[40] Mrs Bryce was assessed as at moderate risk to herself by self-harm or suicide, and as moderately vulnerable on the ward.[41] Half-hourly observations continued and her daily citalopram and olanzapine doses were increased to 20mg and 10mg respectively.[42]

16. <u>On 9 March 2011</u>, Dr Koo reviewed Mrs Bryce and observed her presentation to be largely unchanged from the day before. He discussed the collateral history he had obtained from others including her husband, with her, and foreshadowed a meeting between the treatment team and her family.[43] Visual observations were reduced to hourly.[44] On this day, Dr Wijeratne approved short periods of escorted leave from the ward although no leave was actually taken.[45]

17. <u>On 10 March 2011</u>, there was a family meeting with the treating team attended by Mr Bryce and his son Nicholas. Notes of this meeting indicate that Mrs Bryce's pre-morbid history, the onset of the current psychiatric episode and a plan for short escorted leave were discussed.[46] Mr Bryce accompanied his wife off the ward for a short period that day without incident.[47]

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[38] Exhibit H and Exhibit Y pages 340- 345 (Austin Health Medical Records – Progress Notes dated 8/3/11).

[39] See Exhibit Y page 287 (MHA1 Form).

[40] Exhibit H.

[41] The first entry on the Mental Health Clinical Risk Assessment Tool (completed by Dr Koo) is not timed or dated; the only risk assessment completed for 8/3/1 is that by a Nurse at 0515. See Exhibit Y pages 331-335.

[42] Exhibit Y pages 340-345 (Austin Health Medical Records – Progress Notes dated 8/3/11).

[43] Exhibit Y pages 347-348 (Austin Health Medical Records – Progress Notes dated 9/3/11).

[44] Exhibit Y page 331 (Mental Health Clinical Risk Assessment Tool amended by Dr Koo).

[45] Exhibit Y page 284 (Austin Health Medical Records – Leave of Absence For an Involuntary Patient [MHA21 Form] dated 9/3/2011). Dr Wijeratne authorised "45min-1hr escorted leave [with] husband" for the period 9-12 March 2011. It appears that another person added "/family" to the leave form. No other information/conditions of leave were specified and the tick box indicating a discussion between clinician and patient about leave has occurred was not marked. It appears (see Nursing Note made by Nurse Dhlamini on 9/3/11 at page 346 of Exhibit Y) that Mrs Bryce was given a copy of the leave approval document during the morning shift.

[46] Exhibit Y pages 349-350 (Austin Health Medical Records – Progress Notes dated 10/3/11).

[47] Exhibit Y pages 351 (Austin Health Medical Records – Progress Notes (Nursing am) dated 10/3/11).

18. On 14 March 2011, Dr Wijeratne approved Mrs Bryce for three-to-four hours of escorted leave from the ward.[48] The following day, Dr Koo reviewed Mrs Bryce and found her mental state to be improving but noted that 'caution [was] required' given Mr Bryce's information that his wife 'puts up a brave face'.[49] Dr Koo assessed Mrs Bryce's self-harm/suicide risk to have reduced from moderate to low and so altered the frequency of visual observations to general observations.[50]

19. On 16 March 2011, Dr Wijeratne and Hospital Medical Officer, Dr Aileen Huang, reviewed Mrs Bryce and found her presentation improved. She was slightly fidgety but not agitated, continued to be anxious but her affect was not depressed, she maintained concentration and demonstrated reasonable insight into her illness.[51] Dr Wijeratne approved an increase of Mrs Bryce's escorted leave entitlement to between five and six hours.[52]

20. On 18 March 2011, Dr Huang contacted Mr Bryce, and at his request, Mrs Watts one of Mrs Bryce's sister), concerning a plan for overnight leave at home.[53] Dr Huang discussed the plan with Mrs Bryce, who was positive about it, and with the consultant psychiatrist.[54] Dr Wijeratne approved '2x overnight leaves escorted by family' for the period 18-21 March 2011, with further conditions that Mrs Bryce comply with medications at home and 'report back to APU if any concerns'.[55]

21. At about 3pm, Mrs Bryce was collected from APU by her son, Nicholas, at whose home they had dinner.[56] By prior arrangement, Mr Bryce met his son and wife in the Austin Health

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[48] Exhibit I, not replicated in the Austin Health medical records produced to the court, is a copy of a MHA21 Form (leave document) produced by Mrs Bryce's family who advised that it had been among documents provided to them by Austin Health sometime after Mrs Bryce's death [see Transcript pages 280-289]. Exhibit I is a MHA21 Form dated 14/3/2011. On that date, Dr Wijeratne authorised "3-4hrs of escorted leave [with] family" for the period 14-17 March 2011. No other information/conditions of leave were specified and the tick box indicating a discussion between clinician and patient about leave has occurred was not marked.

[49] Exhibit Y pages 359 (Austin Health Medical Records – Progress Notes dated 15/3/11 at 1725).

[50] Referred to as "Standard Observation (Level 4)" see Exhibit Y page 334 (Mental Health Clinical Risk Assessment Tool amended by Dr Koo).

[51] Exhibit Y pages 360-361 (Austin Health Medical Records – Progress Notes dated 16/3/11 at 1025).

[52] Exhibit Y page 285 is a MHA21 Form dated 14/3/2011. Progress notes dated 16/3/11 suggest that on that date (not the 14th), Dr Wijeratne authorised an increase in Mrs Bryce's escorted leave entitlement from "3-4hrs" to "5-6 hrs of escorted day leave with family". This amendment was made by Dr Huang on the earlier MHA21 Form, already signed and dated by the consultant psychiatrist on 14/3/11 [see Transcript pages 268-9 & 377 (Dr Wijeratne) and page 431-433 (Dr Huang)]. Indeed, the MHA21 Form at page 285 of Exhibit Y shows that the leave entitlement approved on the earlier date to be crossed out in apparently different handwriting [at Transcript page 431, Dr Huang confirmed the amendment is in her handwriting].

[53] Exhibits L, A and F.

[54] Exhibit Y pages 364-364.1 (Austin Health Medical Records – Progress Notes dated 18/3/11).

[55] Exhibit Y page 286 is a MHA21 Form for the period 18-21/3/11, signed by Dr Wijeratne and dated 18/3/2011. The tick box indicating a discussion between clinician and patient about leave has occurred was not marked.

[56] Exhibit B.

grounds at about 7.30pm and then accompanied his wife back to APU to collect her medications.[57] Mr and Mrs Bryce departed the ward a short time later for overnight leave.[58]

CIRCUMSTANCES PROXIMATE TO DEATH

22. On Saturday 19 March 2011, Mr and Mrs Bryce watched their younger sons' football matches. Mr Bryce recalled that they all had a good, restful day together. The couple were alone at home when at about 9.45pm, Mrs Bryce said she would go to the shops to buy them some snacks. Mr Bryce gave her the car keys but became concerned when she had not returned after some 20 minutes. However, when he walked towards the front door he was surprised to see that his wife was playing a computer game and had not yet left the house.[59]

23. A short time later, Mrs Bryce left the house. Again, when she had not returned within 20 minutes, Mr Bryce became concerned. On going outside, he saw that their car had been driven out of the driveway and left in the street. There was no sign of Mrs Bryce and so Mr Bryce started looking for her, first on foot, and then in the car. After about 90 minutes, he went to Greensborough Police Station to report his wife was missing.[60]

24. After making a report and not long after Mr Bryce arrived home, a police canine unit came to assist in the search. Mrs Bryce then arrived home, saying that she had just gone for a walk because it was a pleasant night. A police patrol unit, advised that Mrs Bryce had been located, attended the Bryces' address whereupon Senior Constable Howard had a brief conversation with them and was reassured that no further police intervention was required.[61]

25. Mr Bryce was relieved that his wife had returned home and reported that she was 'upset that the police and everyone else knew what was going on'.[62]

26. Mr and Mrs Bryce went to bed. At about 6am on Sunday 20 March 2011, Mr Bryce realised that his wife was no longer in bed. He went looking for her, found her in the kitchen and then walked her back to bed. Mrs Bryce got into bed, still wearing her dressing gown, but then took it off and appeared to settle. Mr Bryce fell asleep.

27. At about 9.25am, Hadyn Bryce went to his parents' bedroom to wake his mother and ask her to accompany him to church. Mrs Bryce was not in the bedroom and so her son searched the

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[57] Exhibits A and B.

[58] Exhibit A.

[59] Exhibit A.

[60] Exhibit A.

[61] Exhibit Y pages 150-152 (Statement of L/S/C N. Rae).

[62] Exhibit A.

house.[63] Haydn discovered his mother in the backyard, hanging from a skipping rope tied to a swing set.[64] He alerted his father and called 000 and followed the operator's directions to perform cardiopulmonary resuscitation [CPR]. Attending paramedics arrived a short time later and continued CPR but were unable to revive Mrs Bryce. They in turn notified the police who attended and commenced the coronial investigation of Mrs Bryce's death.

INVESTIGATION – SOURCES OF EVIDENCE

28. This finding is based on the totality of the material the product of the coronial investigation of Mrs Bryce's death. That is the brief of evidence compiled by Constable Daniel Elliott from Greensborough Police, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[65] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

29. The purpose of a coronial investigation of a *reportable death*[66] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[67] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[68]

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[63] Exhibit E.

[64] Exhibit E.

[65] From the commencement of the *Coroners Act 2008* [the Act], that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[66] The *Coroners Act 2008,* like its predecessor the *Coroners Act 1985*, requires certain deaths to be reported to the Coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes deaths that appear *to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury* and the *death of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986".*

[67] Section 67(1) of the *Coroners Act 2008*. All references which follow are to the provisions of this Act, unless otherwise stipulated.

[68] This is the effect of the authorities – see for example *Harmsworth* v *The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

30. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[69]

31. Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[70] These are effectively the vehicles by which the prevention role may be advanced.[71]

FINDINGS AS TO UNCONTENTIOUS MATTERS

32. In relation to Mrs Bryce's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. Her identity and the date and place of death were not at issue. I find, as a matter of formality, that Helen Maria Bryce born on 27 August 1956, aged 54, late of 4 Landra Place in Greensborough, Victoria 3088, died at her home on 20 March 2011.

33. I find that at the time of her death Mrs Bryce was a "person placed in custody or care" as defined in section 3[72] of the *Coroners Act* 2008 because she was an involuntary patient at APU, albeit on approved overnight leave at the time.

34. The medical cause of Mrs Bryce's death was similarly uncontentious. On 21 March 2011, Dr Yeliena Baber from the Victorian Institute of Forensic Medicine [VIFM] conducted a preliminary examination of Mrs Bryce's body, reviewed the circumstances of the death as reported by police to the coroner and post-mortem CT scans of the whole body and provided a written report of her findings.

35. Dr Baber observed a linear parchmentised abrasion in a pattern consistent with ligature suspension and with the dimensions of a nylon skipping rope used as a ligature and seized at the scene. Dr Baber noted that toxicological analysis of post-mortem samples detected citalopram,

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[69] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[70] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[71] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[72] See section 3 of the Act, and in particular, subsection (i) of the definition relating to persons placed in custody or care.

diazepam and olanzapine, at levels consistent with normal therapteutic use. Dr Baber attributed the cause of Mrs Bryce's death to hanging.[73]

36. I find that Mrs Bryce's death was caused by hanging and that she intentionally took her own life, albeit while suffering from psychiatric illness.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

37. In common with many other coronial investigations, the primary focus of the coronial investigation and inquest into Mrs Bryce's death was on the circumstances in which she died. Specifically, the investigation and inquest examined the following issues and whether or not any or each of them had caused or contributed to Mrs Bryce's death:
    a. The process through which Mrs Bryce was granted overnight leave from APU, including:
        i. whether the process employed complied with any relevant legislative requirements or APU procedure;
        ii. whether the leave assessment was performed by an appropriately qualified clinician;

    b. The sufficiency of communications between Mrs Bryce's APU treatment team her overnight leave escort/primary carer, Mr Bryce, including:
        i. whether communications were sufficient to establish the nature and extent of the supervision she required; and
        ii. whether communications adequately informed Mr Bryce about the identification and management of any crises should one arise during leave.

These issues are inextricably linked but, to the extent possible, I will deal with the evidence in relation to each in turn.

APU LEAVE APPROVAL IN THEORY AND IN PRACTICE

38. The decision to allow Mrs Bryce to take leave from APU was a clinical one, governed by sections 40 and 41 of the MH Act and any guidelines, procedures or protocols in place at APU.
39. At the time, the relevant Austin Health procedure was entitled 'Patient Leave from Mental Health Inpatient Units' created in November 2010 [Leave Procedure].[74] Both the MH Act and

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[73] Exhibit Y pages 132-142 (Medical Examination Report of Dr Y. Baber).

the Leave Procedure required that an involuntary patient's leave be approved by an Authorised Psychiatrist[75] and be documented by completion of a MHA21 Form [MHA21] including the duration of leave and any conditions attached to it.[76] The MHA21 itself provided for information about action to be taken in the event of a crisis and the inclusion of 24-hour emergency contact telephone numbers.[77] The MHA21 is intended to be a communication to the patient. It is produced in triplicate, with one copy designated to be provided to the patient.[78]

40. The Leave Procedure provided general guidelines concerning day, overnight, weekend and 'accompanied' leave approvals, the timing, nature and purpose of communications between APU staff and a patient's family members and carers, and documentation of leave arrangements in the clinical file.[79]

41. Significantly, the Leave Procedure did not anticipate that leave of any kind would be approved for an involuntary patient on close, rather than general, observations; without prior discussion about leave arrangements with family/carers, including provision of a crisis plan; and without establishing the capacity and willingness of any escort to provide effective supervision at all times;[80] and/or in the absence of a signed MHA21.[81]

42. Furthermore, the Leave Procedure required that a Clinical Risk Assessment[82] be conducted at the point of departure and upon return to the APU, that patients and carers provide contact details for the duration of leave and receive those of the APU, and that the time of departure and anticipated duration of leave be documented in the patient's file.[83] Upon return, the Leave Procedure required staff to actively seek feedback from family/carers about the leave.[84]

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[74] Exhibit O, Attachment 2a [Leave Procedure].

[75] Pursuant to sections 3 and 96 of the MH Act, an 'Authorised Psychiatrist' is a qualified psychiatrist appointed to be an authorised psychiatrist for an approved mental health service. Dr Wijeratne was an Authorised Psychiatrist at the relevant times.

[76] See generally the MH Act sections 40 and 41 and the Leave Procedure.

[77] See the MHA21 Form, for instance that appearing on page 286 of Exhibit Y.

[78] Ibid.

[79] Exhibit O. The Leave Procedure defines 'day leave' as that beginning and ending within the same calendar day and 'overnight leave' as that which extends overnight for one or more days. 'Accompanied leave' (referred to by staff most usually as 'escorted leave') is that where the patient is accompanied by one or more 'responsible persons ... through out their leave'.

[80] Implicit in this formulation is a requirement of communication with the proposed escort, provision of guidance about the nature and purpose of the role of escort and clarity as to the acceptance of those responsibilities by the escort.

[81] Leave Procedure.

[82] That is, a Mental Health Clinical Risk Assessment Tool must be completed before and after leave.

[83] See Leave Procedure.

[84] Ibid.

43. According to her progress notes, Mrs Bryce had day leave from APU on eight occasions during her admission.[85] Six leaves were taken between 10 and 15 March 2011 while Mrs Bryce was still on Level 3 Close Observations.[86] Mrs Bryce was required to be escorted on leave and was indeed escorted by Mr Bryce on four occasions (and briefly on two other occasions when he returned her from leave taken with others), by Mrs Watts on two occasions, and once by her son Nicholas Bryce.[87]

44. As an involuntary patient, Mrs Bryce's leave from the APU required a completed MHA21. There were three MHA21s in the clinical records, in respect of four different leave arrangements, including that for overnight leave. These were signed, if not all completed by Dr Wijeratne.[88] Both she and Dr Huang who *amended* the second MHA21 Form with the consultant psychiatrist's consent, extending leave from three-four hours to five-six hours,[89] conceded irregularities in the completion of leave documentation.[90]

45. Progress notes suggest that only the first MHA21 was provided to Mrs Bryce, and that no MHA 21s were ever provided to her family member/escorts.[91] It is unclear whether the MHA21 in place when Nicholas Bryce took his mother on day leave on 18 March 2011 was appropriate to authorise the leave.[92] I note that the day before, Nicholas Bryce made arrangements by

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[85] Leave recorded in the notes [see Exhibit Y pages 339-364.2 (Austin Health Medical Records – Progress Notes)]: 10 March 2011 – day leave with husband 'no incidents'; 11 March 2011 – (1) participation in a "Walking Group"; the occupational therapist noted Mrs Bryce had 'anxiety evident' but was 'able to manage'; (2) with her husband and Mrs Bryce commented that it was 'nice to get off ward'; (3) with her sister, to visit their mother post-operation, 'returned within given time frame without concerns'; 12 March 2011 – for dinner (pizza) with her husband, departing at 6.45pm and anticipating return before 8pm, not back until 8.15pm – the nurse had 'tried to call' Mr Bryce (but wasn't able to, he provided his mobile number upon return) – when 'both said leave went well', but incongruously, Mr Bryce told the nurse, 'It was difficult to get her back' because she didn't want to return; 14 March 2011 – collected by her sister and taken to the boathouse for lunch, then to her mother's from where Mr Bryce collected her and returned her to APU, she was allowed 3-4 hours (left at 1pm and so was due and did return at 5pm), it's noted that leave 'went well' (Mr Bryce was not present during the leave period and so what must be Mrs Bryce's account is incongruous in light of Mrs Watts' report to Dr Huang on 18/3/11 and what Dr Huang claims Mrs Bryce reported herself during review on 16/3/11 – in relation to which there is no relevant note); 16 March 2011 – leave with Mr Bruce between 1pm and 2.30pm, Mrs Bryce said she enjoyed her walk in the park and it was noted that she 'returned without incident'; 18 March 2011 – day leave with her son, Nicholas, departing at approximately 3pm and due to return at 7.30pm to collect medication, no feedback.

[86] See Exhibit V.

[87] Exhibit Y pages 339-364.2 (Austin Health Medical Records – Progress Notes).

[88] Exhibit Y pages 284-286 (Austin Health Medical Records – Progress Notes) and Exhibit I.

[89] Exhibit L.

[90] Transcript pages 215 & 269 (Dr Wijeratne) and 433 (Dr Huang).

[91] Exhibit Y page 346 (Austin Health Medical Records – Nursing (am) Notes 9/3/11). The family escorts all stated that they received no documentation about leave [see generally Exhibits A, B and F].

[92] The MHA21 signed on 18 March 2011 permits '2 x overnight leaves escorted by family' between 18 and 21 March 2011 only. Even though on its face it is impossible to determine when overnight leave(s) would begin and end, the Nursing Notes suggest, firstly, that the two leaves would be taken consecutively, and secondly, run between 730pm on 18 March until 8pm on 20 March 2011. Further, that the Nursing (am) Note on 17/3/11 [Exhibit Y page 362] states 'Need Leave of Absence Form Signed please' in relation to an outing planned for the following day.

telephone to take his mother out on day leave,[93] and that Dr Huang and nursing staff knew that Mrs Bryce anticipated day leave with her son on 18 March 2011.[94]

46. With the exception of her departure for overnight leave on the evening of 18 March 2011, Mental Health Clinical Risk Assessment Tool documents were completed before and after leave was taken, although some of these purport to reflect observations before *and* after in the same tool.[95]

47. At inquest, much was made of the degree to which Mrs Bryce was allowed graduated leave so that her tolerance for progressively longer periods of time off the ward could inform ongoing clinical management and, in particular, how her leave experiences were taken into account in the decision to grant two overnight leaves.[96] Against this background, it is instructive to observe that four of Mrs Bryce's seven periods of day leave taken with family were for periods of between 45 minutes and one hour, and that she returned from the last of these, on 12 March 2011, 30 minutes late because her husband had difficulty persuading her to return to APU at all.[97] The delay on that occasion prompted an attempt by nursing staff to contact Mr Bryce and for mixed or, more accurately, incongruous feedback about the leave to be documented in progress notes.[98]

48. <u>On 14 March 2011</u>, Mrs Bryce next went on leave, with her sister for four hours.[99] Mr Bryce, who had not spent the leave period with his wife, returned her to APU. Consequently, the arguably negative feedback from Mrs Watts was not available to clinicians until 18 March 2011.[100] Nonetheless, the PM Nursing Note reveals that following leave Mrs Bryce asked whether she would 'ever get well' prompting, appropriately, one-on-one time with the nurse to discuss 'depression and the plan to get her well'.[101]

49. Mrs Bryce had only one further period of <u>90 minutes leave with her husband on 16 March 2011</u>, prior to being allowed to take two overnight leaves.[102] The five-six hours of escorted day leave

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[93] Transcript page 89 and Exhibit B.

[94] Exhibit Y pages 364-364.1 (Austin Health Medical Records – Progress Notes for 18/3/11).

[95] Exhibit Y pages 331-335 (Austin Health Medical Records Mental Health Clinical Risk Assessment Tools, see in particular those completed on 11 & 12 (twice) March 2011.

[96] See generally the Transcript of the evidence provided by Drs Wijeratne [187-277 & 340-387] and Huang [pages 403-462] and the Transcript of Submissions by Counsel (Day 6).

[97] Exhibit Y page 355 (Austin Health Medical Records – Nursing (pm) Notes for 12/3/11).

[98] Exhibit Y page 355 (Austin Health Medical Records – Nursing (pm) Notes for 12/3/11).

[99] Exhibit Y page 357 (Austin Health Medical Records – Nursing (am & pm) Notes for 14/3/11).

[100] Exhibits F & L.

[101] Exhibit Y page 357 (Austin Health Medical Records – Nursing (pm) Notes for 14/3/11).

[102] Exhibit Y page 361 (Austin Health Medical Records – Nursing (am) Notes for 16/3/11).

with family approved on 16 March 2011, by increasing from three-four hours the leave terms for the period 14-17 March 2011, was never availabed.[103]

50. Mrs Bryce remained in APU on 17 March 2011 and was visited by family and her close friend, Mrs Graham, who described her as being 'the worst she'd been at the Austin' – agitated, pacing and reclusive, and complaining of poor sleep.[104] Although the treating team did not receive any feedback directly from Mrs Graham, it is noteworthy that nursing notes for that day reflect Mrs Bryce's interrupted sleep,[105] and that she kept a 'low profile',[106] was 'glum and withdrawn' in her visitors' company and overall appeared 'less energetic and reactive'.[107]

51. On 18 March 2011, Mrs Bryce went on day leave with her son, Nicholas, at approximately 3pm[108] and returned to the APU at about 7.30pm with her husband, who had not been on leave with her, to collect medications for her overnight leave.[109] Mr Bryce estimated that they were at APU for a very short time before departing to commence overnight leave.[110] Progress notes do not contain any feedback about the period of day leave or observations concerning Mrs Bryce's presentation upon her return.[111] No Clinical Risk Assessment Tool was completed.[112]

GRANTING OVERNIGHT LEAVE/S BETWEEN 18 & 21 MARCH 2011

52. On Wednesday 16 March 2011, Drs Wijeratne and Huang reviewed Mrs Bryce and found her to be 'improving'.[113] They developed, and foreshadowed with Mrs Bryce, a plan for overnight leave at the weekend. The duration of day leave was increased on that day, in furtherance of Dr Wijeratne's test of Mrs Bryce's tolerance of progressively longer leave and maintenance of improvement prior to initiating discharge planning[114] and in consideration of Mrs Bryce's desire

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[103] Exhibit Y page 285 is a MHA21 Form dated 14/3/2011 and Progress Notes of/after 16/3/11.

[104] Exhibit G.

[105] Exhibit Y page 362 (Austin Health Medical Records – Nursing (nocte) Notes 16-17/3/11).

[106] Exhibit Y page 362 (Austin Health Medical Records – Nursing (am) Notes 17/3/11).

[107] Exhibit Y page 362 (Austin Health Medical Records – Occupational Therapy Notes 17/3/11). But compare to Exhibit Y page 363 (Austin Health Medical Records – Nursing (pm) Notes for 17/3/11).

[108] Exhibit K. "I believe I was the last person at the Hospital to have contact with Mrs Bryce...Mrs Bryce appeared happy to go on leave with her son."

[109] Exhibit Y page 364.1 (Austin Health Medical Records – Progress Notes for 18/3/11).

[110] Transcript page 34.

[111] Exhibit Y page 364.1 (Austin Health Medical Records – Progress Notes for 18/3/11).

[112] Exhibit Y page 335 (Austin Health Medical Records – Mental Health Clinical Risk Assessment Tool).

[113] Exhibit Y page 360-361 (Austin Health Medical Records – Progress Notes for 16/3/11).

[114] Transcript page 220.

or longer leave.[115] However, no decision about overnight leave as such was made at this time.[116]

53. Rather, the decision to grant overnight leave was made contingent upon four factors: Mrs Bryce's maintenance of subjective and objective improvement;[117] her progress on leave;[118] Mrs Bryce's views about overnight leave; and, her family's attitude to overnight leave and their concerns about leave, if any.[119] Dr Wijeratne delegated the assessment of these contingencies to Dr Huang, who had less than five months' psychiatric experience,[120] with an expectation shared by the junior doctor,[121] that any findings contrary to the overnight leave plan would be reported to her.[122]

54. From the available materials, it is difficult to determine precisely when the decision to grant overnight leave was made. However, it is tolerably clear that the MHA21 was signed on the morning of 18 March 2011.[123] That day, Dr Huang assessed Mrs Bryce in a common area of the ward,[124] recalling that Dr Wijeratne was not present for part of the assessment.[125] I note Dr

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[115] Exhibit Y page 361 (Austin Health Medical Records – Progress Notes for 16/3/11). I note A/Professor Harvey's evidence that leave is not a 'therapeutic intervention', rather, can be used to enhance the therapeutic relationship (encourage engagement, induce hope in the patient) and is a way of according greater freedom to a patient, particularly an involuntary one [Transcript pages 569-570].

[116] Transcript page 253.

[117] Transcript page 210.

[118] Transcript page 210.

[119] Transcript pages 353-354 & 361.

[120] Transcript page 430: Dr Huang had completed a ten or12 week psychiatry rotation while an intern and commenced at APU in February 2011. Dr Wijeratne stated that 'prioritisation' of patients on 18 March 2011 meant that she did not formally assess Mrs Bryce on that date [Transcript page 219].

[121] Transcript pages 422-423 and Exhibit L.

[122] Transcript page 363.

[123] Not a lot turns on when the decision was made/MHA21 Form was signed by Dr Wijeratne except in so far as it may tend to confirm the information available to the consultant when making the decision. Dr Wijeratne gave evidence that it was likely that the MHA21 Form was signed in the morning [Transcript page 355]. Mr Bryce recalls being informed by his wife that two nights' leave had been approved when he visited her at lunch time on 18/3/11 [Transcript page 34]. I note that in her statement [Exhibit L], Dr Huang reports the following chronology: an assessment of Mrs Bryce, discussion with Dr Wijeratne, telephone call to Mr Bryce to discuss leave, further review of Mrs Bryce (discussion about commencement of overnight leave, last leave taken, suicidality, techniques to manage anxiety, contact or return to the ward if concerned during leave), discussion with Mrs Watts. The Progress Notes written by Dr Huang are suggestive of a different chronology – one assessment of Mrs Bryce that occurred between Dr Huang's discussions with Mr Bryce and Dr Wijeratne [Exhibit Y page 364-364.1 (Austin Health Medical Records – Progress Notes for 18/3/11). Dr Wijeratne's statement [Exhibit H] would tend to confirm the chronology suggested by the progress notes in that she states after summarising the results of Dr Huang's mental state examination, "Following positive feedback from both her husband Graeme and daughter Claire to the ward medical officer, Mrs Bryce was granted weekend over night leave for two nights'.

[124] Transcript page 415.

[125] Exhibit L and Transcript page 416.

Wijeratne's evidence that she was *not* part of the review at all[126] but that she had observed Mrs Bryce in the common area and conversed with her very briefly.[127]

55. Dr Huang observed that Mrs Bryce was slightly withdrawn and anxious, demonstrated fluent speech with adequate content, and was able to maintain good concentration in conversation though her thoughts were still slightly delayed. She reported good sleep, no difficulties while on day leave and was positive about the plan for overnight leave. Mrs Bryce 'denied further suicidal/self-harm ideations, stating she has been able to "dismiss them" as much as possible'.[128] There were no signs of perceptual disturbance and Mrs Bryce showed reasonable insight into her illness. Dr Huang concluded that Mrs Bryce had not deteriorated and continued to show signs of improvement.[129]

56. Dr Huang spoke to Mr Bryce and his daughter by telephone to gauge their attitude to overnight leave. It was a short conversation[130] because Mr Bryce was driving at the time. Indeed, Claire Bryce testified that she relayed questions and responses between the doctor and her father.[131] Dr Huang could not recall whether she specified the duration of the proposed overnight leave as one or two nights.[132] Certainly, both Mr Bryce and his daughter believed that only one night's leave was contemplated.[133] Dr Huang noted that Mr Bryce reported no issues arising from day leave on 16 March 2011,[134] and that he was happy to have his wife home for overnight leave.[135] Mr Bryce gave evidence that he had been reassured by his wife's progress in the previous week and that he was encouraged that her clinicians believed that overnight leave was appropriate.[136]

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[126] Transcript page 210 (emphasis added).

[127] Transcript pages 209 & 360. The interaction between Dr Wijeratne and Mrs Bryce was, in the consultant psychiatrist's estimation, insufficient for her to rely on to make an assessment (independent of Dr Huang's) of Mrs Bryce's mental state. However, her impression was that Mrs Bryce's presentation was consistent with that observed during the formal consultation on 16/3/11.

[128] Exhibit Y pages 364-364.1 (Austin Health Medical Records – Progress Notes for 18/3/11).

[129] Exhibit Y pages 364-364.1 (Austin Health Medical Records – Progress Notes for 18/3/11).

[130] Transcript pages 428 [Dr Huang] & 107 [Claire Bryce].

[131] Transcript page 103.

[132] Transcript page 421. Dr Huang testified that at the time she telephoned Mr Bryce to discuss overnight leave, 'there had already been a decision by [her] consultant ... for Mrs Bryce to have two nights leave' [Transcript page 420] though it's impossible to determine whether the "decision" was merely the plan for two night's leave or whether the term indicates that the MHA21 Form had been completed and signed at that point. I note too that the chronology in the patient notes suggests that Dr Huang spoke to Mr Bryce prior to her assessment of Mrs Bryce and before she discussed "2x O/N leave over weekend' with Dr Wijeratne [Exhibit Y page 364-364.1 (Austin Health Medical Records – Progress Notes for 18/3/11)].

[133] Transcript pages 31, 53-54 and 64 [Mr Bryce] & 103 [Claire Bryce].

[134] Exhibit Y page 364-364.1 (Austin Health Medical Records – Progress Notes for 18/3/11).

[135] Transcript page 364 and Exhibit L.

[136] Transcript page 54.

57. Dr Huang contacted Mrs Watts further to Mr Bryce's request that her opinion be sought. Their accounts of this conversation were not entirely consistent but there is really only one important area of inconsistency. Dr Huang denied that Mrs Watts told her that she did not believe her sister was well enough to have two nights' leave.[137] Dr Huang testified that if Mrs Watts had said this, she would have clarified her particular concerns and relayed these to the consultant psychiatrist with a view to a reassessment of weekend leave.[138]

58. Mrs Watts testified that she told Dr Huang of concerns about her sister's demeanour towards the end of her leave on 14 March 2011, namely that she had been agitated, was crying on the floor and not wanting to return to the ward[139] and that she thought it was too soon in the admission to consider two nights' leave.[140] She asked Dr Huang who made the decision for two nights' leave and on what basis.[141] Dr Huang told her that the treating team considered that Mrs Bryce's mental state had improved,[142] that it was not uncommon for inpatients to be reluctant to return to the ward after leave,[143] and that leave at home would promote normal living.[144]

59. Although Mrs Watts does not recall the comment (and it appears nowhere in Mrs Bryce's clinical file), Dr Huang testified that she informed Mrs Watts that her sister had already told APU staff about her reluctance to return to the ward on 14 March. And that the treating team was reassured by her insight and ability to communicate her concerns to them.[145] Mrs Watts agreed that her sister's condition had improved overall, but reiterated her concern that it would be more difficult to encourage her to return to the ward after a longer period of leave.[146] She assumed that Dr Huang would convey her concerns to Mr Bryce and that they would be considered in decision-making about leave.[147]

60. Although not all aspects of Mrs Watts' and Dr Huang's recollection of their telephone call are congruent, it is tolerably clear that Mrs Watts' concerns about previous leave and their

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[137] Transcript pages 421-422.

[138] Transcript pages 422-423.

[139] Exhibit F and Transcript page 146. Dr Huang confirms that this was discussed [Transcript page 422].

[140] Transcript pages 147-148.

[141] Transcript page 165.

[142] Transcript page 165.

[143] Transcript page 157.

[144] Transcript page 165.

[145] Exhibit L & Transcript page 422 (Dr Huang) and page 157 (Mrs Watts).

[146] Transcript page 166.

[147] Transcript page 158. Mrs Watts did not speak to her brother-in-law about her concerns independently which, with hindsight, she considered 'unfortunate' [Transcript page 148].

implications for future/overnight, leave were not perceived as such by Dr Huang and so were not communicated to the consultant psychiatrist.

61. The upshot was that Dr Huang informed Dr Wijeratne that Mrs Bryce's family were happy with the plan for overnight leave.[148] Dr Wijeratne conceded that there was scope for miscommunication[149] in the conversations between Dr Huang and Mrs Bryce's family and, that had she been informed of Mrs Watts' concerns in terms,[150] or been cognisant of Mr Bryce's impression that he was agreeing to only one overnight leave,[151] the plan for two overnight leaves would have been[152] reconsidered.

62. In evidence at inquest, Dr Wijeratne stated that her decision to authorise overnight leave in the terms she did was based on the 'whole picture'[153] painted by Mrs Bryce's APU episode of care.[154] Dr Wijeratne enumerated the factors[155] she considered when deciding to allow overnight leave on 18 March 2011 - the improvement in Mrs Bryce's mental state, [156] her compliance with medication;[157] her engagement in ward activities (rather than remaining in her own room);[158] her tolerance of leave without major incident,[159] consistent denial of suicidal

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[148] Exhibit Y page 364-364.1 (Austin Health Medical Records – Progress Notes for 18/3/11).

[149] Transcript page 364.

[150] Transcript page 363.

[151] Transcript page 364.

[152] Transcript page 363.

[153] Transcript page 255. In the course of examination by Counsel for Mr Bryce, a number of other factors – particular parts of progress notes (eg, Dr Koo's "cautionary warning" of 15/3/1 and the Occupational Therapist's note of 17/3/11), specific collateral information (eg Mr Bryce's "brave face" comment and the contents of Dr Khanna's referral letter), etc – were put to Dr Wijeratne: she indicated that each had been taken into account.

[154] The sources of information used by Dr Wijeratne included: her own assessments conducted on 8, 10 and 16 March 2011, those conducted by her junior colleagues including Dr Huang's assessment on 18/3/11, progress/nursing notes in the clinical file and feedback about previous periods of leave and any information handed over [Transcript pages 221].

[155] Transcript page 220.

[156] I note that lay, medical and nursing witnesses agreed that Mrs Bryce's condition had improved since her admission on 7 March 2011. Mrs Bryce's family members observed that she wasn't "back to normal" and, clearly, Dr Wijeratne did not consider that she no longer met the MH Act criteria for involuntary treatment, or that Mrs Bryce was well enough to have unaccompanied leave.

[157] Dr Wijeratne indicated that Mrs Bryce had been compliant with the recommended maximum therapeutic dose of her antidepressant and antipsychotic medications for 11 days and noted that the time taken to achieve the desired effect varied between patients – from between one and eight weeks [Transcript page 198].

[158] The extent to which Mrs Bryce was participating in ward activities is unclear from the clinical record: there are three occupational therapy entries only (referring to a walking group, [missing] CBT group, stress management group); the muffin making activity, though it appears in many statements, is not evident in the file. The notes suggest that Mrs Bryce did spend much of her time in her room and if she emerged she would infrequently interact with co-patients or staff: see generally Exhibit Y pages 339-364.1 (Austin Health Medical Records – Progress Notes).

[159] See above regarding the length and frequency of day leaves and the extent of feedback obtained: I also note Dr Wijeratne's concession that APU could have obtained more/better feedback about leave periods from escorts.

ideation and no observation of suicidal behaviour;[160] that her risk was assessed as low;[161] her preference to be managed in the community; and that when on leave she would go to a supportive family environment. Dr Wijeratne also referenced the least restrictive care framework established by the MH Act in this context.[162]

63. Dr Wijeratne steadfastly defended her clinical judgement[163] that it was appropriate for Mrs Bryce to take two overnight leaves notwithstanding her concession that it was a decision ostensibly made 'on the papers',[164] and in the absence of her own clinical assessment of Mrs Bryce on 18 March 2011.[165] Although she acknowledged that overnight leave was crucially[166] different to day leave, because Mrs Bryce's escorts would be asleep at some point, she had no concerns about authorising overnight leave.[167]

64. Associate Professor Richard Harvey, Clinical Director, Mental Health, Drugs and Alcohol Services, Barwon Health, provided an independent expert opinion concerning the adequacy of APU's leave processes and communication with Mrs Bryce's family,[168] and gave evidence at inquest. He identified a number of flaws in the clinical assessment process culminating in Mrs Bryce's period of overnight leave. In particular, the apparent lack of effort by the treating team to engage Mrs Bryce,[169] Dr Wijeratne's reliance on junior staff,[170] a concern that a change of

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[160] Dr Wijeratne was examined closely on this point and stated that Mrs Bryce consistently denied suicidal ideation or plan [Exhibit H and Transcript page 247 (for example)]. She explained that this conclusion was, essentially, an accurate reflection of the fact that each time she was directly asked whether she was experiencing suicidal thought/plans – by a psychiatrist, doctor or nurse at APU – Mrs Bryce denied it. I note too [and this was not put to Dr Wijeratne] Dr Huang's note from her assessment on 18/3/11 that Mrs Bryce denied suicidal ideation/plan but also recorded her statement that she 'dismisses' such thoughts as much as possible. Certainly Mrs Bryce's denial of suicidality at the time of assessment and self-reported dismissal of suicidal thoughts provides some grounds for reassurance, however, the documented comment confirms an implicit admission that she continued to experience suicidal thoughts – albeit intermittently – on the day overnight leave was granted.

[161] See Mental Health Clinical Risk Assessment Tools. I note that no risk document was completed on 18/3/11 until at/after Mrs Bryce's departure on day leave at 3pm.

[162] Transcript page 224.

[163] For example, Transcript pages 276-277, 355, and 359-360.

[164] Transcript page 210; but included Dr Huang's communications and information handed over at the start of the morning shift [Transcript page 351].

[165] Dr Wijeratne stated that she saw Mrs Bryce in the common area interacting with co-patients but that her contact with her was an insufficient basis for a formal assessment to be made [Transcript page 351]. Dr Wijeratne relied on Dr Huang's assessment of Mrs Bryce's mental state [Transcript page 255]. I also note also A/Prof Harvey's comment about the inappropriateness of practicing psychiatry by 'popping in' on patients [Transcript page 574].

[166] Transcript page 259.

[167] Transcript page 219.

[168] Exhibit V.

[169] Transcript pages (generally) 557 and 561 (in relation to exploring with Mrs Bryce the meaning of her recent suicide attempts).

[170] Exhibit V.

personnel meant that Dr Koo's cautionary note had not been handed over[171] and non-compliance with some MH Act and Leave Procedure requirements.[172]

65. A/Professor Harvey acknowledged that a coronial investigation had a uniquely broad view of a range of potentially clinically relevant information not typically available to clinicians who must essentially start from scratch with each episode of care.[173] Nonetheless, he observed that there were clues[174] in the material available to APU staff pointing to the potential seriousness of Mrs Bryce's presentation.

66. A/Professor Harvey concluded that the decision to allow Mrs Bryce to take weekend leave was made by a junior member of staff, incorporating the biased opinion of the patient, and disconnected opinions from family members. The decision was ratified by a consultant psychiatrist, based on third party information, with there was a failure to adequately communicate the decision and conditions to Mrs Bryce and her family.[175] A/Professor Harvey observed that such practices were not uncommon in Victoria's public mental health system and were born of limited staffing resources and the MH Act's least restrictive care framework.[176]

COMMUNICATION ABOUT MRS BRYCE'S LEAVE

67. Dr Wijeratne testified that she had no direct contact with Mrs Bryce's family except during family meeting of 10 March 2011.[177] Although there was a notation at the foot of the entry about this meeting that 'Plan: escorted leave with family, initially short period', it is not clear whether, or to what extent, leave was discussed with the family.[178] Neither Mr Bryce[179] nor Nicholas Bryce[180] recalled a discussion about leave arrangements at the meeting.

68. There were no other family meetings during Mrs Bryce's admission, and while on 14 March 2011 it is evident Mr Bryce complained to the Nurse Shift Manager about not being adequately

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[171] Transcript page 568; c/f Dr Wijeratne stated that Dr Koo's note was taken into account when she made her leave decision, Transcript page 357-357.

[172] Exhibit V.

[173] Transcript page 562.

[174] Transcript page 563 (the 'clues' A/Professor identified included: the gravity of Mrs Bryce's previous psychiatric history and the extent of treatment needed to address it, the contents of Dr Khanna's referral letter, the two recent suicide attempts and Mrs Bryce's propensity to minimize her symptoms).

[175] Exhibit V. I note Dr Wijeratne's comment that A/Prof Harvey only critized the process by which the decision to grant overnight leave was made rather than the decision itself and did not explicitly state that Dr Wiheratne's decision to allow overnight leave was unsound.

[176] Exhibit V.

[177] Transcript page 213.

[178] Exhibit Y page 350. (Austin Health Medical Records – Progress Notes dated 10/3/11).

[179] Transcript page 26-27.

[180] Transcript page 84.

informed about his wife's treatment, with particular reference to leave arrangements, it does not appear that any action was taken to remedy the situation.[181]

69. It is plain from Dr Wijeratne's and Dr Huang's evidence that it was general practice at APU to provide family members with information about leave and that there was an expectation or assumption,[182] particularly given their proximity to patient departures and returns, that nursing staff were the main conduit of such information between the treating team and a patient's family.[183]

70. Perhaps unsurprisingly given the effluxion of time and the contents of her clinical file, no-one on Mrs Bryce's treatment team could say for certain that comprehensive information about leave arrangements was communicated to her family, or more pertinently, to Mr Bryce.[184]

71. None of Mrs Bryce's escorts were provided paperwork regarding the conditions of her leave, information about the degree of supervision she required, or how to identify and respond to any deterioration in Mrs Bryce's mental health or any other crisis.[185] None were asked to identify themselves to staff, provide their contact details during leave, or so that feedback could be obtained after leave, or the destination or activity to be undertaken on leave.[186] None were provided with the APU telephone number though, obviously, some of the escorts had this information.[187] Each escort was told to return within a specified period.[188]

72. Prior to departing for overnight leave, Mrs Bryce appears to have been told that she could return to the ward early if she wished or if she was not coping with leave, and that she could telephone the ward for advice if she was concerned.[189] Mrs Watts also received this information from Dr Huang.[190] Despite APU staff knowing that Mr Bryce was his wife's primary carer, there is no evidence that this information was ever given directly to him.

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[181] Exhibit Y pages 358 (Austin Health Medical Records – Progress Notes (Nursing pm) dated 14/3/11). Though, I note that Mr Bryce is told, on 16/3/11, that his wife's leave entitlement was increased to 5-6 hours.

[182] See, for example, Dr Huang's comments at Transcript page 425.

[183] Transcript pages 207 and 215-216.

[184] Transcript pages 215-216; but see generally the transcript of all APU witnesses who, when giving evidence, relied on their general clinical practice rather than any specific recollection of Mrs Bryce's admission.

[185] Transcript pages 26, 30, 57 and 64 (Graeme Bryce), 78-80 (Nicholas Bryce) and 44-46 (Mrs Watts).

[186] Transcript pages 44-46.

[187] Transcript page 89.

[188] Mr Bryce appears to have been the only escort to have not consistently been provided information about the duration of leave. He stated that his wife, not APU, provided him with information about leave [Transcript pages 26 & 30]. However, he was reported of an extension of leave to 5-6 hours on 16/3/11.

[189] Exhibit Y pages 364 (Austin Health Medical Records – Progress Notes dated 18/3/11).

[190] Exhibits F and L.

73. Indeed, Nurse Dhalamini from whom Mrs Bryce collected her medications on the evening of 18 March 2011, could not recall the content of any of interaction with her or Mr Bryce,[191] or even if she had given either of them a copy of the MHA21.[192] She commented that she would not have provided specific information about leave arrangements unless asked.[193] And, although she could not remember whether or not she had done so, Nurse Dhlamini testified that it was standard practice to say to a patient 'You still need to come back and if there are any concerns, come back'.[194]

74. Notably, all APU staff giving evidence at inquest reported that it was usual practice to inform escorts/family to call the ward with 'any concerns'.[195] Only one witness suggested that *what* may constitute a concern, risks, changes in presentation or particular types of behaviour, for instance,[196] would ordinarily be communicated to family members.[197] Generally, however, APU staff were of the view that family members did not require specific information about concerns because they could or would be able to 'pick up cues' that the patient is unwell, one even suggesting that even the patient's greengrocer could do so if they had known them for a long time.[198]

75. Dr Wijeratne made a number of concessions regarding suboptimal communications between APU staff and Mrs Bryce and her family. She conceded that APU staff neglected to get more extensive information from the family about Mrs Bryce's progress on day leave.[199] She acknowledged that Mrs Bryce's family had not been told that overnight leave was a test of her functional ability at home with a view to discharge in the following week.[200] She volunteered

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[191] Transcript page 393.

[192] Transcript page 400.

[193] Transcript page 392.

[194] Transcript page 392. I note that the Coronial Investigator, L/S/C David Kennelly gave evidence that during the conversation he had with ANUM Deegan on 20/3/11 to inform APU of Mrs Bryce's death, Nurse Deegan referred to "bed shortages" and "pressure to clear beds" giving rise to a concern that there was some connection between that and the decision to grant overnight leaves [Transcript page 584]. Nurse Deegan could not recall making any such comment and, if he had, it would have been a general remark unrelated to Mrs Bryce's management. Nurse Deegan stated that the beds of patient's on leave remain their own until discharge [Transcript pages 473-474].

[195] Transcript pages 215-216 (Dr Wijeratne), 326 (Nurse Argyropoulos), 392 (Nurse Dhlamini), 426 (Dr Huang) and 478 (Nurse Deegan).

[196] Transcript page 327.

[197] Transcript page 330 (Nurse Argyropoulos) as part of the ongoing exchange of information c/f Dr Huang's [Transcript page 425] expectation that leave information would be communicated on the first occasion leave was taken by a patient.

[198] Transcript page 299 (Nurse Argyropoulos) and 426 (Dr Huang).

[199] Transcript page 208.

[200] Transcript page 245.

that Mrs Bryce did not have a crisis plan while on leave[201] and that it was a gap in her treatment that her family was not provided with written leave plans containing information about crisis management while she was in their care.[202]

76. Dr Wijeratne acknowledged that since Mrs Bryce's death she now explicitly included a number of conditions as standard when completing the MHA21 to authorise escorted leave, including stipulating supervision 'at all times', prohibiting driving and the use alcohol or drugs, directing compliance with prescription medication, and including APU's telephone number and a direction to return from leave if there are any concerns.[203]

77. A/Professor Harvey noted that it was unclear from the medical records whether or not Mrs Bryce or her husband (and other escorts) had been provided with written leave instructions at any point.[204] And, on its face, the MHA21 relevant to overnight leave was ambiguous as to its duration.[205] He noted APU staff's disconnected attempts to provide a crisis plan to Mrs Bryce and Mrs Watts prior to overnight leave, and that none had been given to Mr Bryce.[206]

78. He opined that given the events of the night of 19 March 2011, when Mr Bryce contacted the police, a written or more clearly communicated leave safety plan might have prompted him to contact APU. However, as Mrs Bryce downplayed the significance of this event, it is unclear whether this would have resulted in the cancellation of her leave, even if staff had been notified.[207]

79. A/Professor Harvey observed that the statements of the police members who spoke to Mrs Bryce after she had returned home after midnight on 20 March 2011, indicate that they assessed her as not being a risk to herself, and so declined to exercise their coercive powers under the MH Act.[208]

80. A/Professor Harvey noted that on the basis of all of the available material, Mrs Bryce's suicide was either highly impulsive, or that she very deliberately failed to disclose her suicidal intent. He testified that if a competent patient outside of a closely supervised inpatient environment is intent on taking her life, and repeatedly denies having intent, it is extremely difficult to prevent

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[201] Transcript page 272.

[202] Transcript page 240.

[203] Transcript page 261.

[204] Exhibit V.

[205] Transcript page 568.

[206] Exhibit V.

[207] Exhibit V.

[208] Exhibit V.

the patient from succeeding when the choice of mean is one of high lethality.[209] A/Professor Harvey concluded that it was difficult to see how any form of education or communication could have altered the outcome in this case.[210]

CONCLUSIONS

81. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[211] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction, that they departed materially from the standards of their profession/s and in so doing caused or contributed to the death.

82. It is axiomatic that the assessment of any departure from norms or standards must be judged strictly without the benefit of hindsight. The trajectory of a suicide may well be obvious after the event. Patterns or causal connections that can be traced from the privileged position of knowing the tragic outcome, may not have been obvious or even appreciable before the outcome. This is particularly so with people at intermittent risk of suicide, and/or whose impulsivity puts them at risk.

83. Having applied the applicable standard to the available evidence I find that –

    a. Mrs Bryce experienced rapid onset of significant psychiatric symptoms in early 2011 that, to her family, were reminiscent of those she had suffered 27 years earlier. Her family proactively sought the assistance of professionals.

    b. General practitioner Dr Rayner, psychologist Ms Chandler and psychiatrist Dr Khanna intervened promptly and appropriately. As a result of their joint efforts, Mrs Bryce was provided with timely and appropriate treatment, initially in the community and briefly as a voluntary psychiatric inpatient. And, when Mrs Bryce was no longer willing or able to comply, they arranged her involuntary admission to APU, in the context of deteriorating mental health and two suicide attempts, one on 18 February and another on 5 March 2011.

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[209] Exhibit V.

[210] Exhibit V.

[211] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"

c. At APU, Mrs Bryce was under the care of consultant psychiatrist, Dr Wijeratne, who confirmed her involuntary status and commenced treatment with a working diagnosis of severe major depression with anxiety and possible psychotic symptoms.

d. Mrs Bryce was reviewed seven times between 7 and 18 March 2011. Of these, only three were formal consultations undertaken by Dr Wijeratne, the latest on 16 March 2011. Dr Wijeratne was the only qualified, experienced and MH Act authorised psychiatrist on Mrs Bryce's treatment team. The significance of formal psychiatric review to a patient's clinical management, though not necessarily paramount, cannot be understated.

e. Periods of escorted day leave of progressively greater length formed part of Mrs Bryce's clinical management at APU. While this approach to leave is reasonable and appropriate, I find that irregularities in the completion of MHA21s relating to day leave, the absence of APU emergency contact telephone numbers from all such forms and the inconsistent provision of a copy of MHA21 to Mrs Bryce, were suboptimal practices.

f. Generally, communications about *leave arrangements* between APU staff and Mrs Bryce's family, particularly her leave escorts, did not comply with the requirements of the relevant Leave Procedure.

g. Contrary to the Leave Procedure, APU staff failed to proactively and consistently obtain *feedback* about Mrs Bryce's progress on leave from her escorts. This resulted in the loss of clinically relevant information, potentially skewed that feedback which was recorded, and represented a missed opportunity for discussions with escorts about the identification of clinically relevant and other concerns, and their role and responsibilities as escorts during leave.

h. Notwithstanding the pressures on the Victorian public mental health system, and the balancing act undertaken by clinicians making decisions in the least restrictive care framework established by the MH Act, I accept and endorse A/Professor Harvey's opinion that the process by which Mrs Bryce's '2x overnight leaves' was authorised, was deficient.

i. Dr Wijeratne ratified the decision to allow weekend leave made by her junior colleague, Dr Huang, using Mrs Bryce's biased opinion and the disconnected, and arguably misinterpreted, opinions of her family members. The evidence supports a finding that this process, with its undue reliance on Dr Huang and evaluation of the

patient 'on the papers' was flawed and resulted in the loss of information that Dr Wijeratne would have considered clinically relevant to the decision to allow overnight leave.

j. Once reduced to writing on the MHA21, the decision to allow '2x overnight leaves' and the conditions attached to it were inadequately communicated to Mrs Bryce and her leave escort(s).

k. Communications between a APU staff and all leave escorts, but most pertinently Mr Bryce in relation to the '2x overnight leaves' granted on 18 March 2011, were not sufficient to establish:

    i. the nature and purpose of escorted leave;
    ii. the necessity for and extent to which patient supervision was required;
    iii. the conditions attached to the leave period and the implications of non-compliance (if any);
    iv. information about Mrs Bryce's illness trajectory including early warning signs of deterioration of her mental health, identification of risk factors or other behaviours in relation to which APU advice should be sought; or
    v. a crisis strategy, including clear directions about actions to be taken and how to contact APU.

l. As such, communication about leave fell short of the standards of good clinical practice and, frankly, defy common sense. It is self-evident that if, for all practical purposes, a mental health service hands over the care of an involuntary psychiatric patient to a family member or other carer, that person should understand their responsibilities, and be armed with the tools or information necessary to safeguard the patient and promote their recovery. This was not the case with respect to Mrs Bryce's two overnight leaves commencing on the evening of 18 March 2011.

m. That said, I am unable to determine whether Mrs Bryce's suicide was a highly impulsive act or one that was premeditated and deliberately concealed from the treating team and her family. It follows that the evidence does not support a finding that optimal decision-making around leave from APU would have prevented Mrs Bryce's death, or that there was any want of clinical management and care on the part of the medical and nursing staff of APU, that caused or contributed to her death.

COMMENTS

Pursuant to section 67(3) of the Coroners Act 2008, I make the following comments connected to the death:

1. Mrs Bryce's death was the subject of a Root Cause Analysis [RCA] conducted by Austin Health. The RCA recommended the development and implementation of a standardised and structured leave process with standard tools and processes for:
   - gathering and documenting risk information about the patient and his/her interpersonal relationships, the burden of care and a carer's capacity to provide care to the patient and leave event documentation;
   - provision of information to the patient and the supervising carer about the level of required supervision, administration of medication, information about illness trajectory/early warning signs, contact number and escalation response processes for carers, and delineation of organisational accountabilities for escalation in the event of crisis;
   - implementation of active communication between the health service and the patient/carer during leave; and
   - implementation of a process to assess if the patient has access to lethal means, and if so what means and management of this risk.

2. Consequently, Austin Health developed a suite of new policy documents in accordance with the RCA recommendations. Among these documents are
   - "Leave Guidelines for Patients/Carers" and "Leave Guidelines for Staff which were in place from March 2012 and compliance-checked via quarterly file audit;
   - "Clinical Risk Assessment and Management" and "Patient Leave from Mental Health Inpatient Units" procedures, both implemented in July 2013; and
   - through the "Working with Carers" document in force from June 2012 the principles to underpin the mental health services' interaction with carers was established and subsequently implemented in a more prescriptive form in February 2014 in a procedure entitled "Working with Carers MHCSU Inpatient Units".

3. I commend, as likely to enhance patient safety, Austin Health's efforts to enhance its clinical procedures applicable to leave arrangements for psychiatric patients and encourage staff compliance with them to the same end.

I direct that a copy of this finding be provided to the following:

Mrs Bryce's family

Austin Health

Chief Psychiatrist

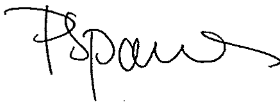
Dr Roslyn Rayner, General Practitioner, Andrew Place Clinic

Ms Hilary Chandler, Psychologist

Dr Rakesh Khanna, Consultant Psychiatrist

Constable Daniel Elliott ((#36701), c/o O.I.C. Greensborough Police

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 15 October 2015