Coroners Act, 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 15/15

I, Rosalinda Clorinda Vincenza Fogliani, State Coroner, having investigated the deaths of –

Ruby Natasha NICHOLLS-DIVER *with an Inquest held at the Coroner's Court in Perth on 28 April 2015 – 15 May 2015 find that the identity of the deceased person was* ***Ruby Natasha NICHOLLS-DIVER*** *and that death occurred between 1 and 2 March 2011 at Geo Lithgow Reserve, Bicton, as a result of ligature compression of the neck (hanging); and*

Carly Jean ELLIOTT *with an inquest held at the Coroner's Court in Perth on 28 April 2015 – 15 May 2015 find that the identity of the deceased person was* ***Carly Jean ELLIOTT*** *and that death occurred between 30 and 31 March 2011 at 6 Davies Street, Beaconsfield, as a result of ligature compression of the neck (hanging); and*

Michael Ronald THOMAS *with an inquest held at the Coroner's Court in Perth on 28 April 2015 – 15 May 2015 find that the identity of the deceased person was* ***Michael Ronald THOMAS*** *and that death occurred between 3 June 2011 and 2 September 2011 at Banksia Eucalypt Woodland Reserve Gibbs Road, Aubin Grove as a result of unknown causes; and*

Anthony Ian EDWARDS *with an inquest held at the Coroner's Court in Perth on 28 April 2015 – 15 May 2015 find that the identity of the deceased person was* ***Anthony Ian EDWARDS*** *and that death occurred on 20 March 2012 at 23 Adelaide Street, Fremantle, as a result of multiple injuries ; and*

Stephen Colin ROBSON *with an inquest held at the Coroner's Court in Perth on 28 April 2015 – 15 May 2015 find that the identity of the deceased person was* ***Stephen Colin ROBSON*** *and that death occurred on 28 March 2012 at the Emergency Department of Fremantle Hospital as a result of multiple injuries,*

in the following circumstances -

Counsel Appearing :

Ms Kate Ellson counsel assisting the State Coroner.

Ms Rachel Young (State Solicitor's Office) appearing on behalf of the Department of Health, Fremantle Hospital and Health Service (Fremantle Hospital), Child and Adolescent Mental Health Services (CAMHS), Doctors Singh, Argawal, Strunk, Kataria, Davis, Baily, Keating and Sorensen, Nurses Ward, Sheehan, Reid, Lamb, Murdock, Morgan, Lewis, Lampe and Daus, case workers Ms Noonan and Ms Cartwright, and the expert and policy witnesses Doctors Davidson, Gibson and Velayudhan, Professor Stokes and Nurses Murdock and Redknap.

Mr Chris Stokes (Chris Stokes & Associates) appearing on behalf of the Thomas family in the investigation into the death of Mr THOMAS

Mr Dominic Bourke (Clayton Utz, instructed by MDA National) appearing on behalf of Dr Caroline Goossens in the investigation into the death of Ms NICHOLLS-DIVER

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INTRODUCTION

The deaths of five former patients of the psychiatric unit known as Alma Street Centre, which comprised a part of the mental health services of Fremantle Hospital, were investigated at one inquest. The patients died within a twelve month period, between March 2011 and March 2012. Two of the former patients died within 24 hours of being discharged.[1] One was an involuntary patient who absconded and died that same day.[2] One former patient disappeared within 24 hours of being discharged and was subsequently located, deceased.[3] One former patient died one month after her last contact with Alma Street Centre.[4]

A number of the former patients had been long term consumers of mental health services with a history of diagnosed mental illnesses. At the material time, the cluster of deaths gave rise to concerns about the delivery of mental health services by Alma Street Centre. Former Chief Psychiatrist Dr Davidson reviewed the care and treatment of a number of the former patients and prepared a report. For the purposes of the inquest, Chief Psychiatrist Dr Gibson reviewed the care and treatment of the balance of the former patients, and he also prepared reports.

[1] Ms Nicholls-Diver, Mr Edwards
[2] Mr Robson
[3] Mr Thomas
[4] Ms Elliott

Four of the former patients had been at chronic risk of suicide for a number of years and displayed signs of being at acute risk of suicide at varying periods shortly before their deaths.[5]

Three of the former patients were young adults, the youngest being just 18 years of age. Two of the former patients were mature aged adults. The five deaths were tragic and the deceaseds' families and loved ones have been left profoundly grieving and with questions that need to be answered. The deaths also had far-reaching effects on the community. The occurrences were disturbing and unsettling at a broader level.

The five deaths were reportable deaths within the meaning of section 3 of the *Coroners Act* 1996 (the Coroners Act). Given the proximity of the deaths in both space and time, and having regard to the evidence concerning the circumstances attending the manner of the deaths, pursuant to section 40 of the Coroners Act, I directed that they be investigated at the one inquest. An inquest was held at the Coroner's Court at Perth between 28 April and 15 May 2015.

After the conclusion of the inquest I sought and received further information, including figures regarding recruitment for mental health staff and whether there is a sufficient

[5] Ms Nicholls-Diver, Mr Thomas, Mr Edwards, Mr Robson

number of qualified and experienced mental health staff in Western Australia. I finished receiving evidence on 26 June 2015.[6]

There are some primary matters of relevance concerning the treatment and care of mental health patients, in the context of whether suicide can be prevented or predicted. Former Chief Psychiatrist Dr Davidson and Chief Psychiatrist Dr Gibson gave expert evidence on these areas at the inquest, based upon their considerable experience in the area of delivery of mental health services. That evidence assisted in addressing these difficult questions and is relevant to the findings in respect of each of the deaths investigated at the inquest.

First, suicide is preventable. Many of the efforts by organisations that work tirelessly to understand and promote suicide prevention strategies emphasise the importance of collaborative approaches and community participation. Former Chief Psychiatrist Dr Davidson's view was that it is not always possible to prevent suicide, but nevertheless the utmost endeavours need to be applied by mental health clinicians in every situation, and suicide can thereby be prevented or its likelihood decreased.[7] Chief Psychiatrist Dr Gibson's view was that suicide prevention is a public health issue that involves the whole community, and is not confined to the mental health services. He

[6] Letter from Professor Stokes, Exhibit 10, Tab 5
[7] T 944

pointed out that it is not known how many people are prevented from dying by suicide, but that the clinical intervention is a very powerful process and psychiatrists are well placed to pursue the prevention of suicide.[8]

Clearly the mental health clinician has a pivotal role in suicide prevention. However, the question of what factors or set of actions would be likely to prevent a particular death by suicide is a fraught and complex one. It is my hope that lessons learned from this inquest will assist mental health clinicians who work in this important, yet difficult and sometimes volatile area.

Secondly, suicide is difficult to predict. Dr Gibson reported that "*suicide is a low prevalence event, in the context of high prevalence of both mental illness and suicidal ideation, and thus prediction of that cohort who will complete suicide remains challenging at an individual level*". In Dr Gibson's opinion, whilst the prediction of suicide is a vexed issue, clinical judgement and structured tools used by mental health clinicians can assist with that prediction.[9]

Thirdly, the treatment and care of each of the deceased is to be assessed by reference to the requirements of the *Mental Health Act* 1996 that was applicable at the material time. The objects of that legislation were to ensure that persons

[8] T 988
[9] Exhibit 9, Tab 3; T 988

having a mental illness receive the best care and treatment with the least restriction of their freedom and the least interference with their rights and with respect for their dignity. The patients' rights to confidentiality were protected under that legislation.

On 30 November 2015, the *Mental Health Act* 2014 commenced and it replaced the *Mental Health Act* 1996. The objects reiterate the same fundamental principle, namely that the best possible care and treatment be provided with the least restriction of patients' freedoms. However, the patients' rights to confidentiality, whilst still protected, are treated differently. Under this new legislation carers are entitled to information concerning the patient, under certain circumstances. The new legislation has been described as carer-centred. The relevance of the new legislation, in the context of the inquest, concerns my recommendations (addressed later in this finding).

Mental health clinicians work in an environment where they must place a high value upon a person's freedom of movement when considering whether or not to refer a person for examination by a psychiatrist, or make an involuntary patient order. Such an order results in the detention of that person for the period of the order (which is governed by law). Clearly, ordering the detention of a person is not a step to be taken lightly by a psychiatrist.

Equally, there is a duty to positively take this step to protect a person where the circumstances warrant it.

At the material time, those circumstances were set out in section 26 of the *Mental Health Act* 1996. The psychiatrist must balance these considerations and come to a decision, often in circumstances where suicide is difficult to predict. In those cases, as Dr Gibson pointed out, structured clinical judgement will assist. Evidence at the inquest reflected that the structured tools provided to mental health clinicians to assist with the exercise of their clinical judgement are undergoing a process of continuing development and improvement. The development and improvement in the structured tools to assist clinicians are relevant to my recommendations.

The considerations surrounding the making of involuntary patient orders at the material time are relevant, in the context of the inquest, because concerns were expressed to the effect that in certain cases before me, those orders should have been made, and might have prevented the deaths. This matter is addressed in the findings.

It has long been established that best practice is for mental health clinicians to engage productively with a patient's carers. In this regard, the new *Mental Health Act* 2014 supports a well-known principle. However, under section 206 of the *Mental Health Act* 1996, clinicians were required

to exercise caution when it came to divulging personal information to carers without the patient's consent (assuming the patient was capable of giving it). Whilst there was scope for this to create some confusion about the amount of information to provide to carers at a general level, for reasons addressed in the findings, those legislative constraints on disclosure do not afford a reason for the specific failures to inform carers in the matters before me.

Fourthly, it emerged during the evidence given at the inquest that clinicians placed a degree of reliance on patients' assurances that they would not act on suicidal thoughts. These were referred to variously as non-self harm contracts, or patients' "guarantees" as to their safety. In this regard some caution is to be exercised when considering whether a patient is likely to adhere to that assurance, as identified by Dr Gibson as follows:

> *"While there is little research evidence defining the value of "no suicide agreements" between clinician and patient, it is very common practice among mental health practitioners to use this as a strategy. In my experience, it should be used where it is considered likely to be adhered to, in conjunction with other therapeutic strategies such as contingency plans and possibly medication. It is likely more effective where there is a strong therapeutic relationship between the patient and therapist/health professional, although there is little research to validate my preceding two comments."*

Finally by way of introduction, mental health clinicians are often required to make very finely balanced judgements. When to this one adds resourcing problems, some of the

difficulties in managing the admission and discharge of mental health patients become apparent.

In November 2011, Professor Bryant Stokes AM, then a consultant neurosurgeon and clinical professor of surgery at the University of Western Australia, was appointed to undertake a review of the admission and discharge practices within the Western Australian public mental health services. The review was undertaken at the request of the Minister for Health. Professor Stokes' final report (the Stokes Review), was released in November 2012 and set out 117 recommendations, relating to nine broad themes. The recommendations were offered to improve processes of care of the patient with mental illness and concurrently their family and carers.[10]

Relevantly, a number of those themes included: governance, patients, carers and families, acute issues and suicide intervention and children and youth. Following the release of the Stokes Review, the Western Australian Government published a response to each of the recommendations, expressing support and establishing an implementation process. An implementation partnership group was established in March 2013 to oversee the implementation of the Stokes Review. At the time of the inquest, 34% of the recommendations had been completed.[11]

[10] Exhibit 7, Tab 1
[11] Exhibit 7, Tabs 2 and 4

At the inquest Professor Stokes, then the Acting Director General of the Department of Health, gave evidence about his consultations with clinicians in the course of the preparation of the Stokes Review. In his evidence he stated that he had never seen a group of staff so stressed as the mental health staff at virtually all of the institutions (save for one, not being Alma Street Centre), and he spoke of the effect in the following terms:

> *"The mental health staff both psychiatrists and nurses were extremely stressed – worked very hard but very stressed. And I wondered at the time whether because of that stress some of the tenderness of caring had disappeared, which is – I use that as an explanation for some of these things.....probably sometimes carers were felt a little bit of a nuisance.....because they would ask questions. And one of the problems, of course, is that carers expect to be able to talk to a doctor or to a psychiatric nurse. And often they would want to interrupt them during their work to talk to them about a patient. I understand that, but then when they were told to make an appointment to meet with a doctor they often found that very difficult to happen. So there were faults on both sides in that area but particularly, I think, because they were so stressed the mental health workers tended to often shy away from communication with relatives. ..."*[12]

These observations arise from consultations primarily undertaken in 2012. The Stokes Review found that the mental health force current as at that time was inadequate to meet the mental health needs of Western Australia.[13]

Professor Stokes made inquiry on the question of whether there are now sufficient numbers of qualified and experienced mental health staff in Western Australia. His

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[12] T 1207
[13] Exhibit 7, Tab 1

responses to me indicated that the North Metropolitan Health Service and South Metropolitan Health Service largely have sufficient numbers of qualified and experienced mental health staff to fill available positions. There are some shortages in the Child and Adolescent Mental Health Services and the Western Australian Country Health Service. Western Australia overall has the highest number of specialist mental health staff per 100,000 population in Australia (126.1/100,000) and has high numbers of mental health staff (overall) compared with other states. However, it has fewer psychiatrists (11 psychiatrists per 100,000 compared with the national average of 13.1).[14]

Professor Stokes responded that Western Australia has fewer MBS subsidised GP services and so there is more pressure on specialist mental health services. Further, that Western Australia still has models which often rely on psychiatrists being the first in line to see patients.

It is clear that the delivery of mental health services in Western Australia is undergoing considerable development and review at Government level, and this includes the Western Australian Mental Health, Alcohol and other Drug Services Plan 2015-2025 (the 2015-2025 Plan).[15]

[14] Exhibit 10, Tab 5, based upon information from Australian Institute of Health and Welfare as at 2012 and 2014.
[15] Exhibit 9 Tab 5

The responses from Professor Stokes concerning the per capita number of specialist mental health staff in Western Australia and the information contained within the details of the 2015-2025 Plan persuade me that much has certainly been achieved in ameliorating the difficulties faced by mental health patients and their carers in Western Australia since 2012. However there is no room for complacency. This is particularly the case where suicide is the main cause of premature death in mental health patients, and that mental health disorders represent an ever increasing burden of disease in the community.

The planning around improvements in the delivery of mental health services will need to translate into action. The seriousness of the problem cannot be underestimated.

THE ISSUES AT THE INQUEST

The inquest focused upon the actions taken by the mental health clinicians during the period leading to the deaths of the five former patients. This included a review of their clinical judgements, particularly where the deceased were discharged.

It was submitted that it is difficult, in the context of an investigation, to re-create the circumstances under which a particular clinical judgement was exercised. To a degree

that must be so, given that the clinician was present and exercising judgement in the context of the immediate circumstances. However, I am satisfied that clinical judgement is amenable to review. The words "clinical judgement" cannot be used as a panacea to stave off inquiry.

In reviewing the clinical judgements, inevitably the circumstances under which the clinicians were working became relevant. I heard evidence about time pressures faced by the clinicians, particularly where one of the consultant psychiatrists went on leave. Whilst I do not accept busyness or overwork as a justification for any lapse in care, I equally expect a mental health service provider such as Fremantle Hospital/Alma Street Centre to provide its clinicians with the environment and resources so that their work can be properly undertaken. The two sets of obligations are not mutually exclusive. One does not excuse the other. Rather, they run in tandem with each other and both clinician and service provider are responsible for ensuring that functions are discharged to a proper standard.

At Alma Street Centre in 2011 and 2012 some of the mental health clinicians were overworked, and there were lapses in care. Unfortunately, due to the perceived need to focus on the core function being the assessment of patients' conditions, and having many patients to attend to as well,

the engagement with the carers was of secondary importance. This meant that on occasion, vital information concerning the patient, which could have been provided by the carer, was missed. Consequently, on occasion clinical judgements were made in the absence of relevant information.

Professor Stokes' observations in 2012 regarding the relegation of carers were borne out. Some of the tenderness of caring had in fact disappeared, under the weight of the time pressures and a failure to understand the valuable contributions that carers are able to make.

The inquest highlighted the importance of taking information from carers to assist in the exercise of clinical judgement, particularly the decision to discharge, and the importance of giving information to carers to assist them in managing their loved one's condition following discharge.

FIVE DEATHS CONNECTED WITH ALMA STREET CENTRE

Ruby Natasha Nicholls-Diver (Ruby) died between 1 and 2 March 2011, one day after she was discharged from Alma Street Centre. Carly Jean Elliott (Carly) died on 31 March 2011, and her last contact with Alma Street Centre was on 3 March 2011, very shortly after Ruby died. Michael Ronald Thomas (Michael) disappeared some months later, on

3 June 2011, one day after he was discharged from Alma Street Centre. The following year, on 20 March 2012, Anthony Ian Edwards (Anthony) died one day after being discharged from Alma Street Centre. That same month, on 28 March 2012 Stephen Colin Robson (Stephen), an involuntary patient at Alma Street Centre, absconded and died on that same day.

Two of the deaths occurred in the context of a consultant psychiatrist needing to be on leave and other clinicians consequently having to cover for him. They were in the cases of Anthony and Michael.

Unsurprisingly, with such a number of deaths, in 2012, the former Chief Psychiatrist, Dr Davidson, prepared a report which, among other things, considered the care and treatment of Ruby, Carly and Michael.[16] The report was dated June 2012, and by the time of its release, the two subsequent deaths of Anthony and Stephen had occurred. In his report, Dr Davidson made recommendations proposing improvements to a number of policies and procedures used across the Western Australian Mental Health Service.

In November 2012, the Stokes' Review was released, making substantial recommendations concerning the delivery of mental health services in Western Australia.

[16] Exhibit 6, Tab 9

At my request, Chief Psychiatrist, Dr Gibson, prepared reports, which considered the care and treatment of Anthony and Stephen, dated April 2015.[17]

Dr Davidson, Dr Gibson and Professor Stokes all gave evidence at the inquest. I received it as expert evidence on the matters that they addressed.

My findings on cause and manner of death in respect of each deceased person appear below, addressed in the order in which the deaths occurred.

RUBY NICHOLLS-DIVER

Ruby's background

Ruby was a very bright and insightful child. Her father described her as funny and intelligent and bubbly and generous. She was creative and she liked to write and paint.

By the time of her death, at the age of 18 years, Ruby had had a very long history of self-harming behaviour, suicidal ideation and prior suicide attempts.

Ruby was the youngest child of Mr Geoffrey Diver and Ms Susan Nicholls, born on 24 September 1992 in Western

[17] Exhibit 9, Tabs 2 and 3

Australia. Ruby's parents separated when she was two and her mother moved to Tasmania with Ruby and her sister.[18]

Ruby soon presented with significant emotional and behavioural problems. She was seen by specialists in Tasmania following an act of deliberate self-harm at a tender age.

Ruby was referred to the Child and Adolescent Mental Health Service unit in Burnie. By the age of 13, Ruby's behaviour in Tasmania was continuing to deteriorate, and one of the diagnoses included emotionally unstable personality disorder.[19]

Ruby's father travelled to Tasmania in late 2005 and she returned to live with him in Perth for a brief period. However, due to Ruby's ongoing instability, Ruby returned to Tasmania, only to return to Perth again in May 2006. She then settled in Western Australia and was attended to by the mental health service providers in this State.

Ruby had a long history of regular contact with the Child and Adolescent Mental Health Services at Fremantle (Fremantle CAMHS). Consultant psychiatrist Dr Caroline Goossens managed Ruby's care, and a number of clinicians were involved in that care. As a child Ruby had difficulty regulating her emotions and was found to have had a

[18] Exhibit 4.1, Tab 2
[19] Exhibits 4.1, Tabs 2, 5A and 11

significant disturbance in the development of her personality. She was highly sensitive to environmental stressors and in particular to perceived challenge or rejection in her close relationships. It became apparent to her clinicians that Ruby had an emerging personality disorder of borderline subtype, but the clinicians considered it counter-productive to "label" a young person with a formal diagnosis of borderline personality disorder.[20]

Ruby was reviewed regularly by her psychiatrist at Fremantle CAMHS. She was prescribed antidepressants and their dispensation was managed. She underwent regular therapy with a clinical psychologist. Treatment during her involvement with Fremantle CAMHS included Dialectical Behaviour Therapy, an evidenced-based treatment model for people with borderline personality disorder, with a parent support component. Ruby developed a good relationship with her Fremantle CAHMS clinicians and she was able to identify when she needed to go to hospital, with assistance from her clinicians and her father.[21]

Between the ages of 13 and 16 Ruby had over 20 admissions to Princess Margaret Hospital (PMH) of between two and 15 days. These admissions were usually triggered by environmental stressors and often Ruby had

[20] Exhibit 4.1, Tab 8, report of Dr Goossens; T 589 - 590
[21] T 546

self-harmed. Over this period she displayed symptoms consistent with suicidal ideation.[22]

Once Ruby reached the age of 16 years her inpatient care no longer came under the jurisdiction of PMH and she required admission to Bentley Adolescent Unit (BAU). Ruby disliked BAU and her father considered private options for inpatient care, through the Marian Centre.

Ruby was admitted on five occasions to the Marian Centre, under the care of consultant psychiatrist Dr Michael Hagan, between March 2009 and May 2010. Her longest admission was 28 days. Dr Hagan's diagnoses at that time included major depressive disorder and post-traumatic stress disorder.[23]

Over this period Ruby became increasingly disengaged from the Fremantle CAMHS services and they asked the Marian Centre to take on full clinical responsibility for Ruby's care.[24]

Unfortunately, Ruby's mental health problems escalated and reached a crisis point. On 25 May 2010 Ruby was admitted to Fremantle Hospital after a significant medical overdose, and she was treated in the intensive care unit. Her condition was complicated by aspiration pneumonia.

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[22] Exhibit 4.1
[23] Exhibit 4.1, Tab 15
[24] Exhibit 4.1, Tabs 8 and 9

She almost died. She remained in hospital for several weeks.[25] This was a very critical event in Ruby's mental health history and would have given any clinician cause for having the utmost concern for her welfare.

After discharge from Fremantle Hospital, Ruby was transferred to BAU, being considered too high risk for management in the private sector at the Marian Centre. However, due to lack of engagement with BAU, in June 2010 Ruby was discharged into her father's care and referred by Fremantle CAMHS to Youth Reach South, a specialist public mental health outreach and support service. It was chosen by the Fremantle CAMHS team for its ability to deal with at risk young people who have serious mental health disorders and/or complex psychosocial issues, and who have difficulty engaging with mental health service providers.[26]

At Youth Reach South the management of Ruby's case was assigned to Ms Marti Noonan, a senior social worker who remained a constant and positive presence for the remainder of Ruby's life. Ms Noonan commenced her contact with Ruby on 2 July 2010 and thereafter maintained regular therapeutic contact with her.[27]

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[25] Exhibit 4.1, Tabs 2, 5A, 5W, 9 and 13
[26] Exhibit 4.1, Tabs 8, 9, 11 and 20; T 573
[27] Exhibit 4.1, Tab 20

The referral to Youth Reach South was part of Ruby's transition from Fremantle CAMHS (caring for her as a child) to the adult mental health services. As Ruby approached her 18th birthday, steps were taken by those two entities to facilitate the transition and ensure there was sufficient overlap, for continuity of care.

Dr Goossens (Fremantle CAMHS) had provided stable care for Ruby in the four years leading up to her 18th birthday. Ruby turned 18 in September 2010 and she was formally discharged from Fremantle CAMHS on 19 October 2010 with the aim of transition to the Fremantle adult mental health services. These services comprised Alma Street Centre, with support from Youth Reach South.[28] To assist with continuity in the transfer from child to adult services, Dr Goossens (Fremantle CAMHS) continued to discuss Ruby's progress with Ms Noonan (Youth Reach South) over the next four months.[29]

Alma Street Centre received a referral to see Ruby on 23 October 2010 and was provided with a copy of a comprehensive report dated 22 September 2010 addressing Ruby's background with Fremantle CAMHS signed by Dr Goossens and two psychologists. The report was addressed to Ms Noonan and outlined critical information about Ruby garnered from five years' worth of sessions or contact with Fremantle CAMHS, ending with the caution

[28] Exhibit 4.1, Tab 8, 9 and 20
[29] Exhibit 4.1, Tab 8

that *"she remains very vulnerable"*. The authors made it clear that Ruby's capacity to manage as an adult would be dependent upon her ability to engage independently with Youth Reach South.[30]

After the referral, various attempts were made by Alma Street Centre staff members to engage Ruby in initial consultations. At about the same time, Ruby's father notified services that, in November 2010, he would be leaving Ruby in Perth to relocate up north for work reasons. This was a significant notification as Ruby's father had been a constant presence and support for his daughter over many years.

In late November 2010, Ruby commenced her engagement with Alma Street Centre. She was reviewed as an outpatient by Dr Singh, the psychiatry registrar for the Cockburn team, on 22 November and 20 December 2010 and 10 February 2011. Dr Singh's impression was that Ruby displayed cluster B traits (consistent with borderline personality disorder) but that she had no self-harm ideation. She was continued on her medications.[31] This comprised Ruby's first substantive contact with the adult mental health services.

[30] Exhibit 4.2, Tab 5J
[31] Exhibit 4.2, Tabs 5C and 5D

At Ruby's first review on 22 November 2010, she reported feeling stressed about seeing a new doctor and parting ways with Fremantle CAMHS. On the same date Ruby went to see her regular Youth Reach South case manager Ms Noonan, but declined an offer for her to engage in more frequent and after hours appointments with her.

Over this period, and well into February 2011, Ruby remained in contact with staff from both the Alma Street Centre, and Youth Reach South. Throughout this time, records also indicate that staff members of both services remained in contact with each other, for the purposes of co-ordinating an approach to her care.

Unfortunately despite these endeavours Ruby's mental state deteriorated.

Events leading to Ruby's death

In the early evening of 26 February 2011, Ruby self-presented to Fremantle Hospital Emergency Department (Fremantle ED) reporting an increase in suicidal thoughts and requesting voluntary admission. Some significant environmental stressors had adversely affected her.

A psychiatric liaison nurse and a doctor reviewed Ruby in Fremantle ED. An admission management plan was completed for her. The impression recorded in Ruby's

medical notes is one of a young woman displaying enough insight to request a voluntary admission.[32]

Ruby was admitted to the open ward that same night (26 February 2011) as a voluntary patient, under the care of psychiatrist Dr Steve Baily of the Melville inpatient team, for psychiatric review.[33] At the time of her admission Ruby was taking antidepressant and sleeping medications.

On Monday 28 February 2011 at approximately 11.00am Dr Baily reviewed Ruby in the company of his registrar Dr Claire Keating, intern Dr Simon Cheah and Nurse Lewis.[34] Ruby informed the team that this was the first time she had been in hospital without her father being able to visit her, as he had moved away. She stated that she could control her thoughts of self-harm but did not know if she would be safe on discharge. Dr Baily determined that Ruby was suffering a situational crisis as a result of recent stressors and that she exhibited symptoms consistent with a cluster B personality disorder, namely borderline personality disorder.

Cluster B personality disorders are evidenced by dramatic, erratic behaviors. Dr Baily described borderline personality disorder as a "*prolonged disturbance of personality function characterised by confusion about self-identity, impulsivity*

[32] T 612; Exhibit 4.1, Tab 5; Exhibit 4.2, Tab 5O
[33] Exhibit 4.2, Tab 5O
[34] Exhibit 4.2, Tab 5S

and variability of moods." Dr Baily also reported that "*one of the difficulties in treating patients with borderline personality disorder is the fact that they do not generally respond well to medication or hospitalisation. They can also be difficult to engage in psychological interventions such as counselling and cognitive behavioural therapy as they do not tend to act in a logical, rational or reasonable way.*" In his experience, patients with borderline personality disorder are prone to "*respond in an extreme way including believing that there is no point in living any more*". The management of these patients involves responding to acute periods of high risk. A situational crisis can trigger thoughts of suicide. In Dr Baily's view, it is not possible or desirable to hospitalise such patients for long periods of time as it often results in further deterioration.[35]

Dr Baily formed the view that he was able to engage very well with Ruby when he first reviewed her on 28 February 2011 and he was left with the impression that he had built a rapport with her. Ruby's medications were reviewed. Dr Baily contacted Ms Noonan in order to arrange a second meeting with Ruby later that day and to ascertain Youth Reach South's plan for Ruby.[36]

However that same day, very shortly after Dr Baily's review, and despite his impressions of the rapport he built with her, Ruby attempted to hang herself on the ward. At

[35] Exhibit 4.1, Tab 14
[36] Exhibit 4.1, Tab 14

approximately 12.30pm on 28 February 2011, Alma Street Centre staff members heard screams coming from the direction of Ruby's room and they ran to assist. It appeared, following inquiries, that Ruby had attempted to hang herself using a towel and that she had fallen and injured her ankle. [37]

Consequently, Ruby was started on 15 minute observations. An x-ray of her ankle was taken and it showed there was no fracture. Ruby was confined to the ward having given the nurses a verbal no self-harm "contract".[38]

Shortly after her hanging attempt at 2.30pm on 28 February 2011, Ruby was again reviewed by Dr Baily, this time with Ms Noonan and Nurse Lampe. Dr Baily was aware of Ruby's hanging attempt. Dr Baily's impression was that Ruby showed "*no evidence of depression or psychosis*" but she was noted as being perverse and oppositional. Ruby asked for seven days' admission (also describing herself as wanting three days of rest). Dr Baily decided that it would not be helpful for Ruby to stay for another seven days as in his view "*the longer patients like Ruby stay in hospital, the bigger the stakes are when it comes time to be discharged.*" Dr Baily therefore declined Ruby's request and instead decided that the most suitable management was for Ruby to stay in hospital for two more days to get her emotions under control and then to be

[37] Exhibit 4.1, Tabs 19 and 21
[38] Exhibit 4.2, Tab 5U; T 629

discharged on 2 March 2011, with follow up appointments. Dr Baily discussed distraction techniques with Ruby in order to help her overcome her negative thoughts. Ruby did not appear to be overly happy with this plan, but she appeared to accept it.[39]

Later that same afternoon on 28 February 2011, Ruby spent about one hour talking to Nurse Lampe, who was very comforting. She provided Ruby with helpful and constructive advice to assist with her anxiety and low mood. Ruby indicated to Nurse Lampe that she was disappointed about the shortness of her admission.[40]

Most likely later that night, Ruby wrote in her notebook. The note, discovered after her death, outlines Ruby's plans to take her life after she is "*sent home*".[41]

The next morning on 1 March 2011, Ruby approached Nurse Daus and requested discharge. This was unexpected, having regard to Ruby's request, the previous day, that she be afforded a longer admission. The likely explanation is that Ruby requested discharge as a reaction to being denied the longer admission that she had initially sought.

At this time, Ruby's psychiatry team were discussing her care and a plan was in the process of being formulated to

[39] Exhibit 4.1, Tabs 1, 2, 14, 17, 19 and 20, Exhibit 4.2, Tab 18, T 629 – 631; T 738 - 739
[40] T 712 – 714, 721
[41] Exhibit 4.1, Tab 22

avoid a longer hospital admission for her. During the meeting, Dr Keating was provided with information to the effect that Ruby was asking to go home, and she informed Dr Baily.

Whilst Dr Baily had other patients to attend to, he decided to interrupt his schedule and see Ruby for an unscheduled review. However, this left him with approximately 15 minutes to conduct the review, rather than the hour he had set aside the following day (for Ruby's scheduled discharge). On this third review, Ruby told Dr Baily she could not see the benefit of staying longer and reiterated her request for discharge. Dr Baily encouraged her to stay the extra night, but ultimately determined that it was reasonable for Ruby to be discharged as she was a voluntary patient and there were no good grounds to make her an involuntary patient.[42]

Ordinarily Dr Baily would have contacted Ruby's father (her next of kin) to advise him of her impending discharge, but did not do so on this occasion due to the short amount of time he had to review Ruby.[43]

With Dr Baily's approval Ruby was discharged from Alma Street Centre on the afternoon of 1 March 2011, with follow up appointments for review by Ms Noonan on 4 March and by him, approximately one week post discharge, being

[42] Exhibit 4.1, Tabs 14 and 17; Exhibit 4.2, Tab 5V; T 607 – 608, 697
[43] T 633

8 March 2011. Hospital notes record that Ruby was discharged home, "*determined to leave*".[44]

While her discharge arrangements were being made, and afterwards, Ruby spoke to a number of persons including her father. Mr Diver was interstate and his evidence was that he telephoned the hospital that day requesting that they delay her discharge until he could get back to Perth.[45] Ruby's medical notes do not disclose the contact from her father. I will come back to this later.

Upon her discharge on the afternoon of 1 March 2011, Ruby caught a bus home. Her father (who had not been informed by her clinicians) managed to make contact with Ruby himself on one occasion whilst she was on her way home and he asked her to go back to the Fremantle ED. Ruby did not do that.

Ruby arrived home. In an effort to reinforce strategies, Ms Noonan telephoned Ruby at her home that evening, but Ruby cut her telephone call short saying she "had done it all before". At a point between late 1 March and early 2 March 2011 Ruby hanged herself from a tree in a park near her home. Just after 5.00am on 2 March 2011 a passing resident located Ruby in the park under a tree, with no other person present or visible in that park. The resident endeavoured to render all possible assistance and a passing

[44] Exhibit 4.1, Tabs 13, 14 and 17
[45] Exhibit 4.2, Tab 1; T 551-552; T 559

motorist stopped to also assist. The St John Ambulance paramedics were called, but tragically, Ruby showed no signs of life. The paramedic certified that Ruby had died.[46]

Cause and manner of death of Ruby Natasha Nicholls-Diver

On 4 March 2011 forensic pathologist Dr J. McCreath made a post mortem examination of Ruby at the State Mortuary. The results of the examination reflect that Ruby hanged herself. Toxicological analysis revealed a therapeutic level of one of her antidepressant medications and a blood alcohol level of 0.07%. No illicit drugs were detected. On 23 March 2011 the forensic pathologist formed the opinion that the cause of death was ligature compression of the neck (hanging).[47]

The police investigated and found no evidence of the involvement of another person in Ruby's death.[48]

I find that Ruby undertook the actions by which she hanged herself with the intention of taking her life, and that as a result, she died between late 1 March and early 2 March 2011.

The cause of Ruby's death is ligature compression of the neck (hanging).

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[46] Exhibit 4.1, Tab 1, 2 and 10
[47] Exhibit 4.1, Tabs 6 and 7
[48] Exhibit 4.1, Tab 2

The manner of Ruby's death is suicide.

Ruby's care from Alma Street Centre

Former Chief Psychiatrist Dr Davidson reviewed Ruby's treatment and care from Alma Street Centre. He provided a written report[49] and he gave evidence at the inquest.

Ruby's father expressed concern about her treatment and care at Alma Street Centre, and in particular her discharge and the lack of communication with him.

Dr Davidson first reviewed the process by which Ruby was transitioned from the child mental health services to the adult ones. In his opinion, there was a reasonable attempt at transitioning Ruby from Fremantle CAMHS to Alma Street Centre. Dr Goossens (Fremantle CAMHS) had considered this transition process to be better than that experienced when they attempted to manage Ruby in conjunction with private providers.[50]

I am satisfied that Fremantle CAMHS undertook all reasonable and proper steps to guide Ruby's transition to Alma Street Centre, including making arrangements for support from Youth Reach South and ensuring there was a period of overlap in her care, for continuity.

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[49] Exhibit 6, Tab 9
[50] T 596 and T 949

The concerns regarding Ruby's treatment and care emerge once she was admitted to Alma Street Centre following her presentation on 26 February 2011.

No adequate individual management plan for Ruby

Dr Davidson opined that once Ruby was admitted to Alma Street Centre under the care of Dr Baily, no individualised treatment plan was developed for her, and there was no coherent individual management plan surrounding her admission.[51] In Dr Davidson's words:

> *"The care and treatment of this patient with a long history of vulnerability and self-harm, a diagnosis of Personality Disorder now presenting in crisis with increased suicidality required a comprehensive Management Plan. There was not a comprehensive Management Plan either on the electronic record (PSOLIS) or on the patient medical record for this admission addressing the specific needs of this patient.....The Individual Management Plan (IMP) is a longitudinal plan that integrates a patient's treatment (and short term plan) and rehabilitation with risk management and discharge planning to provide clarity and focus for clinical decision making...."*[52]

Fremantle Hospital and Dr Baily, though their lawyer, submit to me that admission planning was difficult given that Ruby came through Fremantle ED on a weekend. Further, that in any event the admission planning was executed in accordance with the procedures then in place and would have been formalised if Ruby had chosen to stay

[51] T 951-952; Exhibit 6, Tab 9; T 610-611
[52] Exhibit 6, Tab 9

until 2 March 2010.[53] They support their submission by positing that more formal written plans would not have changed the unfortunate outcome.

However, it is the accumulation of factors that needs to be taken into account when assessing the conduct and addressing the outcome. The absence of coherent admission planning is but one of those factors.

I am satisfied that an individual management plan for Ruby would have assisted in focussing the clinicians' decision making when, unexpectedly, she sought discharge earlier than had been scheduled.

No adequate risk management plan for Ruby

Dr Davidson opined that a risk management plan ought to have been developed for Ruby, especially after her attempted hanging. Plans that were on Ruby's medical file were not all completed and not all in one place.[54]

Dr Davidson highlighted the absence of a risk plan in the context of risk being a factor that required ongoing assessment:

> *"The patient's medical record does not contain a Plan for the overall integrated management of risk but contains a brief risk assessment and patient safety plan that are partially completed and makes (sic) statements about the patient's explanation of her*

[53] T 606 - 610; Exhibit 4.2, Tab 5
[54] Exhibit 6, Tab 9; T 623 – 627; T 953

level of risk and records an event of attempted self-harm. The patient demonstrated a high level of risk with the failed hanging attempt which should have prompted a risk plan or review of the current risk management plan. Actions taken to address ongoing risk after the failed hanging attempt did not reflect the possible implications of attempted self-harm or suicide".[55]

Fremantle Hospital and Dr Baily, through their lawyer submit that Ruby's integrated progress notes contain extensive comments on risk and that the absence of a risk management plan does not indicate that there was an absence of actual risk management by her clinicians.[56]

Dr Baily reviewed Ruby twice on 28 February 2011. During her second review, Ruby expressed a wish *"to stay in hospital another seven days for a rest"*. This was in the context of Ruby having attempted to hang herself several hours beforehand. Dr Baily agreed this had spiked her level of risk.[57]

It is self-evident that Ruby's attempt to hang herself elevated the risk of suicide. Whilst views may have varied as to whether her actions exhibited an intention to die, there was no cause to treat it other than with the utmost seriousness. Dr Davidson noted that whilst the self-harm attempt prompted increased observation of Ruby, her patient record did not contain information suggesting that staff members had explored the meaning of the attempt.[58]

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[55] Exhibit 6, Tab 9
[56] T 691
[57] Exhibit 4.1, Tabs 14, 17 and 18; Exhibit 4.2, Tabs 5S and 5U; T 601 - 603
[58] Exhibit 6, Tab 9

There are no notations on Ruby's file about why she requested a *"rest"*, although Dr Davidson agreed it was possible Ruby was expressing herself in this way because she wanted help, something common in people with borderline personality structure.[59]

There was no cause to presume, from her statement, that Ruby was seeking a *"rest"* for non-therapeutic purposes. It has to be borne in mind that Ruby had just turned 18 years old and had only recently begun her contact with the adult mental health system.

It appeared to Dr Baily that Ruby desired a longer admission because she wanted to have a break from her life, and to be free from the stress of living her life in the community. Through his lawyer Dr Baily submits that his decision regarding her shorter length of admission was a matter of clinical judgement that he was best placed to make. In his view this would not resolve her issues and may have been detrimental. He considered that a seven to ten day admission was a long admission.[60]

Dr Davidson noted that the explanation for the clinicians' decision that only a two-day admission was appropriate was

[59] T 956; T 631; Exhibit 6, Tab 9
[60] T 631; T 642

contained in Ruby's notes. It is described as a "*risk of increased difficulties with a longer stay*".[61]

Dr Davidson was asked about length of hospital stay, in the context of the principle that a longer admission was not advisable for Ruby having regard to the guidelines for the treatment of borderline personality disorder. Dr Davidson's opinion was that "*returning the patient to the longitudinal program of care is often of greater benefit than extending an inpatient period of care*". However, Dr Davidson considered that ten days in hospital came within a "*more reasonably short period of care*" and that seven days in hospital (as requested by Ruby) "*would not be a long period of inpatient care within the guidelines*".[62]

Ruby's father, who was interstate, spoke to her about her attempt to hang herself, and about her wanting to stay in hospital for longer. In his evidence he said:

> *"I spoke to her from the hospital after she had attempted suicide. And she said, "These people just don't believe me". You know, she said, "I'm here. I'm in hospital. I've tried this. They just don't believe me". And then, you know, she would ask for a week to contain and settle. And, once again – you know, very self-aware. And I spoke to her and she said, "I asked for a week. They've only offered me two days". And, once again, she's like, "By then it was either they don't believe me or they don't care". Yes. So obviously, you know, she was very unwell at that point."*[63]

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[61] Exhibit 6, Tab 9

[62] T 956; Dr Davidson's reference to guidelines includes the National Institute for Health and Clinical Excellence (NICE) Guidelines (Exhibit 6, Tab 6) and the National Health and Medical Research Council Guidelines (Exhibit 6, Tab 5); Evidence provided by Dr Gibson on length of stay in connection with the guidelines was not in the context of Ruby's case (T 1067)

[63] T 551

Dr Baily was aware that Ruby became more upset after they started discussing the length of her admission. He was focussed primarily on the avoidance of what he considered to be a long admission. He was prepared to allow her "*another couple of days extra to see how she was going*" but decided she would be discharged on 2 March 2011.[64]

Although, regrettably, Dr Baily had not seen Dr Goossens' comprehensive report addressing Ruby's significant mental health history, Ms Noonan, Ruby's case manager, had advised him of the key issues involved in her transition.[65] The information in that report addressed Ruby's history in relation to risk, triggers and previous risk management. It would have been preferable if Dr Baily had read it at the material time. Dr Baily's evidence was to the effect that, had he personally read the report, he would have realised how intensively involved Ruby's father was in her care.[66]

Dr Baily's view was that the next couple of days would give everyone "*time to see how [Ruby] was going", and see whether she further settled.* The intention was for Dr Baily to be provided with the opportunity to review her risk in significant depth on 2 March and to develop a much tighter, clearer plan.[67]

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[64] T 601
[65] T 601 - 602; T 638 - 639
[66] T 639
[67] T 601 - 602

However, this did not occur on 2 March because Dr Baily agreed to Ruby's discharge on 1 March 2011.

I am satisfied that Dr Baily had sufficient information before him from which he ought to have understood that Ruby was at chronic risk of suicide and that her attempt to hang herself elevated that risk.

Fremantle Hospital and Dr Baily, through their lawyer submit to me that management of Ruby's risk after she attempted to hang herself was appropriate, and point to factors including the institution of the 15 minute observations, confinement to the ward, review by Dr Baily, the no self-harm verbal contract with the nurses, and the interventions by Ms Noonan and Nurse Lampe.[68] These factors constitute the response to Ruby's attempted hanging, but they do not have the quality of a plan.

On his review of Ruby's care by Alma Street Centre, Dr Davidson considered that there was no risk management plan for Ruby to provide the basis for further review. He noted that after Ruby's attempted hanging, "*there was no reference to a review of a Risk Management Plan because one did not exist.*"[69]

[68] T 643 – 647, 675, 691, 738 – 743,
[69] Exhibit 6, Tab 9

I am satisfied that a properly prepared and reviewed risk management plan for Ruby would have assisted in focussing the clinicians' decision making when, unexpectedly, she attempted to hang herself and then, also unexpectedly, she sought discharge earlier than had been scheduled.

Efforts ought to have been made by Dr Baily to inform Ruby's father of her attempt to hang herself on the ward (or to ensure that a staff member conveyed that information to Mr Diver).

No clear discharge plan for Ruby

Dr Davidson opined that discharge planning should commence on entry and be integrated with the patient's individual management plan and risk management plan. It should include the patient, the carer and community supports. Upon Dr Davidson's review of Ruby's care, he identified the following:

> *"The record did not contain information that demonstrated that clinical outcomes for the admission had been identified and met and that attention had been given to risk issues as a result of the admission being considerably shorter than the patient wished for and that she had very recently acted in a way that could be an assumed suicide attempt whilst an inpatient....The discharge was discussed with the community case manager but the record does not confirm that the patient's father had been involved in the discharge decisions."*[70]

[70] Exhibit 6, Tab 9

When Dr Keating first saw Ruby on 1 March 2011 it appeared to her that Ruby wanted to discharge herself because she was frustrated and upset about not getting a longer hospital admission. Ruby appeared to be angry at Dr Baily for refusing to extend her admission, and Dr Keating believed this was Ruby's way of demonstrating to staff members that she was unhappy about only being offered a shorter stay.[71]

Dr Baily made the decision to discharge Ruby, but there was no clear discharge plan developed for her.[72] According to Dr Baily, it was difficult for him to devise a full-individualised plan for Ruby because she asked to go home on 1 March 2011. To do a complete plan, Dr Baily had set aside an hour and half for her on the next day, 2 March 2011. Instead he was called out of outpatient clinic to see Ruby for fifteen minutes, joining in on a meeting between Ruby and Dr Keating on the afternoon of 1 March 2011.[73]

In the limited time that he had, Dr Baily spoke to Ruby and to some of the nurses caring for her. Dr Baily spoke to Ruby about why she wanted to leave, whether she felt safe and whether she would be alright until 4 March 2011 when she could see Ms Noonan again. Dr Baily could not remember whether Ruby gave him the impression that no one cared about her, but he did recall speaking to nursing

[71] T 692 - 693
[72] Exhibit 6, Tab 9
[73] T 606 - 607

staff who had had some prolonged conversations with her, and gaining a sense that she was reasonably settled.[74]

Unfortunately, Dr Baily did not consider Ruby's wish to leave as an indication of anger or unhappiness. Instead he saw it as an expression of her inability to derive an additional benefit from a further short stay in hospital. He took Ruby at face value when she was telling him why she wanted to leave.[75] In short, Dr Baily thought it meant Ruby was feeling better. This could hardly be further from the truth. No doubt the short length of time he spent with Ruby on 1 March 2011 contributed to this misunderstanding, and as much is conceded by Dr Baily when he gave evidence that he was rushed:

> *"....did you suggest to her that she was leaving not because she was well, but because she got upset about not getting seven days?---No. I didn't suggest that to her.*
>
> *Was that – would that have been a reasonable assessment of the situation at the time?---It could have been, but I must admit I was – I was rushed."*[76]

Dr Baily acknowledged that such a scenario (if it had been understood) would have heightened Ruby's risk.[77]

Dr Baily was rushed on 1 March 2011 and as a consequence he did not comprehensively explore and then consider Ruby's reasons for requesting the earlier discharge.

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[74] T 608
[75] T 640
[76] T 639
[77] T 640

Despite feeling rushed, he ought to have turned his mind to options for carefully exploring Ruby's reasons for unexpectedly requesting a discharge.

Dr Davidson gave evidence relevant to an assessment of Dr Baily's decision to discharge Ruby, but qualified it by indicating that he was not able to reproduce the decision-making involved.[78] For these purposes it is not necessary to reproduce the precise conditions under which a previous clinical judgement was made. Otherwise, no clinical judgement could ever be amenable to review. Having regard to the evidence, there is sufficient information before me to enable a review of Dr Baily's clinical judgement.

Dr Davidson, noting that Dr Baily made a clinical judgement, pointed to two factors that would have made it desirable to continue Ruby's stay in hospital for the additional two or three days that she had requested (on top of the ones she had been granted). Firstly, her major support (namely her father) was not available (he was interstate and endeavouring to return to Perth when he became aware that Ruby was about to be discharged). Secondly, and self-evidently it must be added, allowing a period of time for Ruby's father to return would have then provided her with continuing and essential support:

> *"The factors of particular concern were that her major support, that is, her father, was not available. It was recognised by the*

[78] T 959

service that this did lead to difficulties for Ruby that [they] were ones that she had not previously had to manage and that the – the desirability of allowing a period of time in which her father could return and then provide that continuing and essential support would have been factors to take into account".[79]

Regrettably, no attempt was made by anyone at the Alma Street Centre to contact Mr Diver, who was interstate, to inform him of Ruby's attempt to hang herself on the ward. Dr Baily was aware that Mr Diver was interstate. Normally he would have taken steps to contact him and he could offer no explanation as to why he did not contact him. Dr Baily in hindsight, accepted that such efforts ought to have been made or that he should have had a clear plan to contact Mr Diver when Ruby left the hospital.[80]

Dr Baily should have contacted Mr Diver before Ruby was discharged or given instructions to have him contacted. If that process had been undertaken, Mr Diver may have been able to communicate, to Dr Baily, factors that bore on Ruby's risk and that may have materially affected his decision about whether to allow her earlier discharge on 1 March 2011. It must be borne in mind that Dr Baily was required, by law, to implement the least restrictive mode of treatment for Ruby, but he was also obligated to have regard to her risk of suicide.

I do not accept Dr Baily's submission, through his lawyer, that even if he had contacted Mr Diver, it would have been

[79] T 957
[80] T 609 and T633

unlikely to make a difference. This is submitted in the context of Dr Baily's evidence that on 1 March 2011, he had no grounds for holding Ruby as an involuntary patient, because although he recognised her to be at chronic risk of self-harm, she denied any risks and was future focussed.[81]

I do not accept that the only possible options were to allow Ruby to leave the hospital or to make her an involuntary patient. Other options were to spend more time with her, to comprehensively explore her reasons for wanting the earlier discharge and to seek information from her father. It cannot now be known what further knowledge these inquiries would have generated and how they may have impacted upon decision making.

That Dr Baily was managing numerous patients at the time does not afford him an adequate reason for failing to make or arrange contact with Ruby's father.

In Dr Davidson's view, based upon Ruby's medical records, there was no justification for making her an involuntary patient under the *Mental Health Act* 1996 at the material time.[82] However, those medical records are deficient in that they do not record, or take any account of Mr Diver's concerns about Ruby's discharge, nor do they disclose an adequate risk assessment.

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[81] T 610 and Exhibit 4.1, Tab 14
[82] T 966

In light of the clear failure by Dr Baily and/or Alma Street Centre to seek to make contact with Ruby's father regarding her discharge, I explored the circumstances surrounding the lack of contact from any staff member at the Centre and Mr Diver's own efforts to make contact with the Centre. These are addressed below.

No contact with Ruby's father regarding her discharge

When Ruby was discharged, her main support, her father, was in Melbourne. When he discovered (through Ruby) that she was to be discharged, he sought to return to Western Australia. Mr Diver is disappointed that, despite his repeated efforts to contact Alma Street Centre with the aim of avoiding Ruby's discharge in his absence, she was nonetheless discharged without reference to him.

There are no records of any contact Mr Diver made, or attempted to make, with the Alma Street Centre prior to her discharge, in Ruby's medical file or in the Psychiatric Services On-Line Information System (PSOLIS) records.[83]

There are no notes in Ruby's medical file, or in the PSOLIS records, of any concerns expressed by Mr Diver about Ruby being discharged while he was interstate.

[83] Exhibit 6, Tab 9

Dr Davidson's evidence was to the effect that the information regarding Mr Diver's contact should have been recorded preferably in Ruby's medical notes (as opposed to PSOLIS) because the clinical file is the most important source of information. Dr Davidson's view was that the information from Ruby's father should have been taken very seriously by the treating team. Based upon his review, Ruby's hospital notes "*did not adequately record the information or, indeed, the collaborative processes between the service and Mr Diver.*"[84] That is because there were no collaborative processes.

On the evidence before me at the inquest I am satisfied that Mr Diver attempted to contact Alma Street Centre on a number of occasions between 28 February and 1 March 2011. I accept Mr Diver's evidence that he called a staff member at the Centre and asked that Ruby not be discharged until he returned from interstate, indicating he would be back from Melbourne in a day or so.[85]

I do not accept Fremantle Hospital's submission, through its lawyer, that such a finding cannot be made where the person(s) taking Mr Diver's telephone call has (or have) not been identified. Such an outcome would be circuitous. The problem arises because the person(s) taking the telephone call failed to adequately record it and thereby identify

[84] T 958
[85] Exhibit 4.1, Tab 5G; Exhibit 4.1, Tab 2B and T 551

themselves. I have based my finding on accepting the evidence of Mr Diver.

It is by no means the case that a family member's concern about discharge must affect the decision to discharge. What is necessary is that concerns be taken into account by the relevant clinician. They may assist in planning the discharge. They cannot be dismissed as irrelevant to a discharge decision if it is not known what they are.

Dr Davidson gave evidence about clinicians needing to manage a conflict when a voluntary patient seeks discharge, contrary to the express wishes of family members:

> *"The clinician, again, must clearly be taking into account the different parts of both of those requests, that is, the one by the family and the one by the patient. And that then immediately becomes contextual as to the weighting that the clinician is then placing on both parts of diametrically opposed requests. But that – that's - the clinician's position is the attempt to resolve that particular conflict in a way that will continue to ensure the safety for the patient, the best and subsequent care that can be accomplished. So it becomes, certainly, a complex decision when there are two conflicting requests. The clinician has the difficult process, then, of weighting those requests and making a clinical judgment."*[86]

The problem in Ruby's case was that there was no opportunity for Mr Diver to provide his views because no efforts were made to contact him and when he contacted the Alma Street Centre, his concerns were neither properly recorded nor passed on to the treating team. He was

[86] T 966

informed that for reasons of confidentiality, information concerning Ruby's presentation could not be provided to him.[87]

I am satisfied that the failure by Dr Baily and or Alma Street Centre to contact Mr Diver fell below the standards that should ordinarily be expected from a mental health service provider.

Ruby was sent home alone

One of Ruby's known ongoing stressors included living on her own, and having her main support (her father) interstate. Despite this knowledge, Dr Baily agreed that Ruby was able to be discharged to go home, alone.

Dr Baily discussed the fact that Ruby would be sent home alone with Ms Noonan, her case worker. According to Dr Baily, Ruby was anxious about being by herself, but regrettably he formed the view there was not a lot he could do for her on that front.[88]

Dr Baily decided to manage the risk of discharge by arranging for follow up by Ms Noonan on 4 March 2011 and rescheduling other patients so that he could review Ruby himself on 8 March 2011.[89] Due to the obvious complexity of Ruby's case, Dr Baily, a senior and very experienced

[87] T 551
[88] T 607, T 631 – 632, T 636
[89] T 648, T 741

consultant psychiatrist, had decided to personally manage her case.

Dr Baily's conclusion that there were not a lot of options (other than to send Ruby home alone) was unfortunate. It was influenced in part by the fact that he was rushed that day, and limited by not having relevant information from her father.

Adverse findings in relation to Ruby's care

I am satisfied that between 26 February 2011 and 1 March 2011, there were no clear procedures and policies in place to support or guide Alma Street Centre's staff members in communications with Ruby's father.[90]

I am satisfied that there are no records of Mr Diver's repeated efforts to contact Ruby's treating team, and that such records ought to have been made.[91]

I am satisfied that between 26 February 2011 and 1 March 2011 Dr Baily was responsible for Ruby's care, and that he:

- did not formulate, nor cause to be documented, a clear admission plan for Ruby;

[90] T 609 - 610
[91] Exhibit 6, Tab 9

- did not formulate, nor cause to be documented, a clear risk management plan for Ruby;

- did not address Ruby's attempt to hang herself on the ward in a way which adequately reflected her increased level of risk at the time;

- did not reformulate any risk plans that may have been in place, to reflect, adequately, Ruby's altered level of risk following on from her attempt to hang herself on the ward;

- did not formulate an individualised discharge plan for Ruby which adequately addressed all of her stressors;

- did not adequately explore the reasons Ruby wanted to leave on 1 March 2011; and

- did not formulate a plan to contact Ruby's father at any stage during her admission or discharge from the Alma Street Centre.

In light of the matters referred to above, I am satisfied that Dr Baily did not exercise sound clinical judgement when he formulated and approved Ruby's discharge and follow-up plans on 1 March 2011. In addition to those matters, I take into account the following matters that Dr Baily knew or ought to have known:

- Ruby had a long history of serious mental health issues, extending back years into her childhood;

- Ruby had recently turned 18 and until that point, she had primarily been treated in the Child and Adolescent Mental Health system;

- Ruby was at chronic risk of suicide;

- Ruby had attempted to hang herself the day before, and this elevated her risk;

- Ruby unexpectedly sought discharge on 1 March 2011;

- Ruby's father, her primary carer, was interstate;

- No input had been sought from Ruby's father regarding her discharge;

- Ruby had initially requested a longer stay, expressed annoyance about the shorter stay, and did not want to be on her own;

- Ruby's borderline personality disorder (or its emergence) predisposed her to impulsivity and issues of abandonment;[92] and

- Dr Baily on his own evidence was rushed when he was reviewing Ruby on 1 March 2011.

[92] Exhibit 9, Tab 1; T 616 - 620

CARLY JEAN ELLIOTT

Carly's background

Carly was an only child born to Ms Becker and Mr Elliott in Subiaco on 13 October 1990. He parents separated when she was 18 months old, and arrangements were made for her to remain in contact with them both throughout her life. Carly's father described her as very intelligent, with a bubbly personality, a leader among her friends, and a loving caring girl, with a great social conscience and outstanding ability and potential.

By the time of her death at the age of 20 years Carly had completed two years of a law degree at University, before deferring for a gap year in 2010. During that year, Carly began to suffer from the effects of stress and she became withdrawn. Her instability and insecurity led to problems with her interpersonal relationships, particularly with her partner, and she began expressing thoughts of self-harm. She sought and received medical assistance in 2010, but occasionally she would disengage with service providers, missing appointments or otherwise declining to respond to calls for further contact. She did not demonstrate sufficient insight into her need for medical assistance and she tended to seek it only when she reached a crisis point.

On 27 August 2010, Carly attended the Fremantle Family Doctors GP practice and was seen by Dr Douglas. She presented with depressive symptoms and self-harming behaviour. She denied suicidal ideation and declined to see a psychiatrist. Dr Douglas made arrangements to review her within one week. Dr Douglas duly reviewed Carly on 3 September 2010, completed a mental health plan, referred her to a psychologist and made a follow up appointment for 17 September 2010. However, Carly did not attend her follow up appointment with Dr Douglas.[93]

A few days later, on 20 September 2010, Carly was taken to Fremantle Hospital ED by ambulance after her parents became concerned that she had repeatedly expressed her intentions to die by suicide. When Carly was assessed in ED by the psychiatric liaison nurse she maintained that her expressed intentions to die by suicide had not been made seriously by her.

The psychiatric liaison nurse's assessment is recorded in Fremantle Hospital's medical records. Carly's history of self-harming behaviour was noted. She denied any suicidal ideation and denied any perceptual disturbance. The psychiatric liaison nurse considered that that Carly displayed borderline personality disorder traits. The plan was for Carly to be reviewed by the psychiatry registrar. However Carly did not wait for the registrar and left the ED

[93] Exhibit 1.1, Tab 11

of her own volition. She had not been referred to Alma Street Centre at this stage.[94]

Approximately one month later, on 29 October 2010, Dr Douglas reviewed Carly again. Carly continued to present with symptoms of anxiety and depression. She had not seen the psychologist despite the earlier arrangement. Dr Douglas prescribed antidepressant medication and referred Carly to Alma Street Centre for an urgent psychiatric review. Her referral letter stated: *"I would appreciate your urgent review and opinion on how I can best manage her symptoms long term."* Dr Douglas also arranged to review Carly in one week's time. However, Carly did not attend that next appointment.[95]

The triage nurse at Alma Street Centre contacted Carly on the same day that Dr Douglas referred her, namely, 29 October 2010. Over the telephone, Carly reported that she was "*okay*" at the moment and denied any suicidal ideation. The triage nurse advised Carly that Alma Street Centre's triage service (Triage) was available over seven days and encouraged her to ring or present if she felt her symptoms worsening. At the material time, all referrals to Alma Street Centre would come through Triage, where they would be reviewed and assigned to the appropriate team.[96]

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[94] Exhibit 1.1, Tabs 22A - 22D
[95] Exhibit 1.1, Tabs 9A and 12
[96] T 114

On 1 November 2010, Alma Street Centre's intake team discussed Carly's referral from Dr Douglas, and an outpatient appointment with the consultant psychiatrist assigned to the GP consultation liaison clinic was scheduled for 15 November 2010. Dr Douglas was informed.[97]

The GP consultation liaison clinic was part of Alma Street Centre. Its primary role was to assist patients who were referred by their GP's to Alma Street Centre for an opinion, and to assist patients who were being discharged from Alma Street Centre back into the care of their GP's.[98]

However, on 4 November 2010 (well before her scheduled appointment) Carly telephoned Alma Street Centre and informed a staff member that she was not doing very well and that she needed to see someone. Records reflect that she was invited to present to discuss further. On 5 November 2010 it was noted that Carly had not presented to Alma Street Centre. She was contacted by telephone by an Alma Street Centre staff member and in conversation appeared to be bright and reactive. Carly reported that she was "*okay*" and had decided to stay at home. She was informed that she could contact them again if her mental state deteriorated prior to her scheduled outpatient appointment for 15 November 2010.[99]

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[97] Exhibit 1.1, Tabs 16, 22E and 22M; T 88
[98] T 57
[99] Exhibit 1.1, Tabs 12, 22E

Carly did not attend her appointment for psychiatric review at Alma Street Centre on 15 November 2010. The next day the nurse contacted Carly (who explained that she missed the appointment due to work commitments). A further appointment was made for her for 25 November 2010.[100]

Carly did not attend her 25 November 2010 appointment either and on that date the GP liaison nurse wrote to her, (copying Dr Douglas) and asked her to make contact if she required ongoing support. The letter advised that if there is no contact within one month "*we will discharge you from the services here at the Alma Street Centre*".[101]

Unbeknownst to Alma Street Centre, on 14 December 2010 Carly was assessed (comprehensively) by her private psychologist, with further sessions planned. However, by early January 2010, Carly decided not to continue with these sessions.[102]

On 31 December 2010 Alma Street Centre's GP liaison nurse contacted Dr Douglas to further discuss Carly's case. Both clinicians had left numerous messages for Carly and attempted to speak with her, without success. Following this discussion further attempts by Alma Street Centre staff

[100] Exhibit 1.1, Tabs 12, 16 and 22E; T 92 - 94
[101] Exhibit 1.1, Tab 22L; T 66
[102] Exhibit 1.1, Tab 20

members to contact Carly throughout early January 2011, directly and through others, were unsuccessful.[103]

Finally, on 11 January 2011 Carly telephoned Alma Street Centre in response to a message that had been left by the Centre with her mother. In the course of her discussion with the GP liaison nurse Paula Sheehan, Carly outlined her plans to resume her studies at University and she declined further outpatient appointments with Alma Street Centre, stating that she preferred to be managed by her GP. Consequently, by letter dated 12 January 2011, Carly was discharged from Alma Street Centre back into the care of her GP, Dr Douglas. The letter to Dr Douglas noted that Carly had moved in with her mother and that she declined psychiatric review at Alma Street Centre. Her parents were unaware of that discharge.[104]

Up until this point on each occasion that Carly had contact with mental health clinicians, it was usually in the context of a situational crisis, and she would deny active suicidal or self-harming thoughts. When challenged, she maintained that her actions, which would suggest an inclination to self-harm, were not genuine.

Carly was reluctant to engage with the help that she was offered by Alma Street Centre, missing appointments and refusing follow up. However, it is clear that she had

[103] Exhibit 1.1, Tabs 11, 12, 16, 17, 22E - 22F
[104] Exhibit 1.1, Tab 22K; T 100 – 101;

difficulty regulating her emotions and she continued to make impulsive threats to take her life. For those close to her, it became difficult to understand the severity of her condition.

Events leading to Carly's death

In early March 2011, approximately one and a half months after her discharge from the GP consultation liaison clinic, Carly experienced another situational crisis and she was severely affected by it. Carly's parents were very concerned about her resultant unstable behaviour.

On the evening of 1 March 2011 Carly's father, Mr Elliott, telephoned Alma Street Centre and made contact with Ms Millicent Reid, the mental health nurse on duty at Triage. Both of Carly's parents spoke on the telephone and relayed information that indicated that Carly's risk to self and others had escalated. It appeared to most likely be related to the breakdown in Carly's relationship with her partner. Carly was at home but refused her parents' request to come to speak with the nurse on the telephone. Her parents requested a home visit. Nurse Reid referred the matter to the South Metropolitan Mental Health Services Community Emergency Response Team (CERT) for a formal assessment of Carly.[105]

[105] Exhibit 1.1, Tabs 2, 13, 15 and 22G; T 119 - 120

At the material time, the CERT teams did not fall within the remit of clinical governance at Alma Street Centre. A certain number of CERT clinicians were allocated to work from Alma Street Centre's site in order to service the patients that fell within that catchment area. CERT's role was to provide after-hours care (3.00pm to 11.00pm) and emergency assessments for mental health patients. CERT did not provide continuing treatment, prepare management plans or case-manage the patients.

All CERT clinicians were authorised mental health practitioners under the *Mental Health Act* 1996 and could refer a potential involuntary patient for psychiatric examination.[106] CERT's role was to perform an urgent assessment of a person's mental state and level of risk to self and others.

The two CERT clinicians who assessed Carly were Ms Tracy Lamb, a psychologist, and Ms Jane Murdock, a registered nurse. Ms Lamb obtained further information from Carly's father regarding her stressors and was informed by him of specific self-harm threats that had been made by Carly. Ms Lamb and Nurse Murdoch also checked PSOLIS and ascertained that there were no alerts or management plans in place for Carly.

[106] Exhibit 1.1 Tab 15; T 168; T1083

Ms Lamb and Nurse Murdoch arrived at Mr Elliott's house at about 7.45pm on 1 March 2011. They went to see Carly, who lived in separate lodgings at the back of his house. It is to be borne in mind that they had been asked to attend by Carly's parents and not with Carly's agreement. This would not be an uncommon scenario. When the CERT clinicians approached Carly, she was hostile to them and avoided eye contact. She did not engage with them and denied experiencing any problems or having suicidal ideation. Consequently, they were only able to spend approximately 15 minutes with Carly, before they departed at her insistence.

Within those 15 minutes, Ms Lamb and Nurse Murdoch performed a mental state examination and a risk assessment of Carly. The mental state examination indicated to them that Carly did not present with any acute psychiatric illness. Consequently she did not meet the requirements under the *Mental Health Act* 1996 for her to be made an involuntary patient. Carly agreed to receive a follow-up call and support from Alma Street Centre. The CERT clinicians formed the view that Carly was not in immediate danger and assessed her risk of self-harm as low.[107]

After Ms Lamb and Nurse Murdoch left Carly's room, they spent approximately 40 minutes with Carly's parents at the

[107] Exhibit 1.1, Tabs 2, 12, 14, 22I; T 171, 180 – 185, 208 - 214

house discussing Carly's case with them. They advised the parents to treat each self-harm threat seriously and provided them emergency contact numbers.[108]

That night, the CERT clinicians completed their report (which was also sent to Carly's GP) and they provided a verbal handover to Alma Street Centre's Triage nurse (Nurse Reid).[109]

The next evening, on 2 March 2011, Carly telephoned Alma Street Centre and spoke with Nurse Reid. In conversation Carly appeared to recognise the need to address her mental health problems and to commit to engaging in therapy. Whilst she said she felt increasingly out of control, she denied any current self-harming behaviour or suicidal thoughts. She apologised for her behaviour during the CERT clinicians' assessment the previous night. She informed Nurse Reid that she had a GP appointment scheduled for the following day and that she would seek re-referral to Alma Street Centre. From this conversation, Nurse Reid formed the view that Carly appeared insightful and settled. Nurse Reid planned to relay this information to Carly's GP the following morning, and to discuss the reactivation of her referral with Alma Street Centre's GP liaison clinic.[110]

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[108] Exhibit 1.1, Tabs 14 and 15; T 184 – 185; T 210
[109] Exhibit 1.1, Tabs 13, 14 and 25; T 212
[110] Exhibit 1.1, Tabs 12, 13 and 22G; T 128 – 133; T 142

On 3 March 2011 Nurse Reid duly attempted to contact Carly's GP, Dr Douglas at Fremantle Family Doctors. She was informed by staff members that Dr Douglas had left the medical practice and that Carly had not made any appointments with any of the other doctors at the medical practice. Consequently, Nurse Reid made contact with Carly to ascertain the details of her current treating GP. Nurse Reid explained some options regarding mental health services to Carly, including Headspace and the procedures for accessing a private psychologist.

However, Carly relayed that she would make her own arrangements, that she intended to continue to attend the Fremantle Family Doctors practice and that she would locate a private psychologist herself as she still had 11 funded appointments left under her mental health plan. She declined any further assistance from Alma Street Centre. Nurse Reid encouraged Carly to contact Alma Street Centre at any stage if she needed any further support, and Carly agreed to do so. To Nurse Reid, Carly did not appear to be in crisis or at acute risk of suicide.[111] This telephone call on 3 March 2011 was the last contact between Carly and Alma Street Centre.

Relevantly Dr Douglas, who had initially referred Carly to Alma Street Centre, was no longer available to her. Dr Douglas was Carly's primary health care provider, having

[111] T 135 - 137

developed a positive therapeutic relationship with her. Dr Douglas had left (or was in the process of leaving) Fremantle Family Doctors medical practice.

During March 2011 Carly's mental health appeared to improve. She returned to her studies and obtained part-time work.

However, at the end of the month, in the early hours of 30 March 2011 Carly experienced another severe situational crisis and she became unstable and erratic. On this occasion the police were called and they accompanied Carly home due to concerns about her safety. Upon arrival the police spoke with her father. Carly went straight into her lodgings at the back of the house but she later departed at an unknown point in time.[112]

Despite numerous attempts Mr Elliot was unable to make contact with Carly during the day or evening of 30 March 2011. The following morning on 31 March 2011, Mr Elliott accessed Carly's room and tragically found her to be deceased. He called for an ambulance and upon their arrival, the paramedics confirmed that Carly had died. Carly had left a handwritten note reflecting on her intention to take her life.[113]

[112] Exhibit 1.1, Tabs 2 and 7
[113] Exhibit 1.1, Tabs 2, 4, 7 and 8

Cause and manner of death of Carly Jean Elliott

On 1 April 2011 forensic pathologist Dr D. Moss made a post mortem examination of Carly at the State Mortuary. The examination reflected that Carly had hanged herself. Toxicological analysis revealed a therapeutic level of one of her anti-anxiolytic medications. No alcohol or illicit drugs were detected. On 15 April 2011 the forensic pathologist formed the opinion that the cause of death was consistent with ligature compression of the neck (hanging).[114]

Police investigated and found no evidence of the involvement of another person in Carly's death.[115]

I find that Carly undertook the actions by which she hanged herself with the intention of taking her life, and that as a result, she died between late 30 March and early 31 March 2011.

The cause of Carly's death is ligature compression of the neck (hanging).

The manner of Carly's death is suicide.

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[114] Exhibit 1.1, Tabs 5 and 6
[115] Exhibit 1.1, Tab 2

Carly's care from Alma Street Centre

Former Chief Psychiatrist Dr Davidson reviewed Carly's care from Alma Street Centre. He provided a written report[116] and gave evidence at the inquest.

Carly's parents expressed concern about her treatment and care by Alma Street Centre and its connected services, her discharge from the GP consultation liaison clinic and the lack of communication with them.

Carly had contact with various sections of Alma Street Centre's mental health services (including CERT) between 29 October 2010 and 3 March 2011. She had presented at Fremantle Hospital ED approximately one month prior to her first contact with Alma Street Centre, namely on 20 September 2010. At the inquest Dr Davidson's opinion was sought on the degree to which Carly's presentations to the various sections of Alma Street Centre's mental health services were integrated. He expressed his reservations as follows:

> *" ...I – I don't believe that they were well integrated. That good integration would absolutely require that there is both a flow of information and a flow of clarity with regard to what elements can then contribute to the other elements of the system in providing that continuous and appropriate level of care. And, by that, I mean, indeed, as your Honour has referred to already, the issue of the crisis or emergency response team being able to have good communication with the next set of providers who would undertake the continuing care. And that may include both the*

[116] Exhibit 6, Tab 9

general practitioner as well as the community mental health service that would have responsibility for her continuing care".[117]

There were no processes or systems in place for integrating Carly's care when she had contact with the various sections at Fremantle Hospital (or its connected mental health services). This resulted in a lack of continuity in her care.

No adequate risk assessment and risk management plan for Carly

Dr Davidson reviewed Carly's medical records and opined that the contacts that the mental health clinicians had with Carly were in response to acute situations where the primary concern was her immediate risk of self-harm or suicide. Unfortunately however, Carly's ongoing needs, when she was not in a situational crisis were not fully attended to. Referring to Carly's acute episodes, Dr Davidson identified the deficiency in the following manner:

> *"These episodes settled quickly but were never fully attended to in the context of an overall Risk Assessment and Management Plan that takes into account the patient's longitudinal risk issues for the previous six months. The risks posed by the primary care provider with whom the patient had developed a therapeutic relationship, no longer being available, were not documented as having been explored with the patient".*[118]

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[117] T 932
[118] Exhibit 6, Tab 9

Dr Davidson points to the following factors as indicating a need for a crisis management plan and a risk management plan:

- Carly's previous history including her presentation to Fremantle Hospital ED in September 2010;

- Dr Douglas' referral letter dated 29 October 2010 that outlined self-harming behaviours for the previous six months; and

- The escalation in Carly's self-harm threats that culminated in the CERT clinicians' attendance at her home on 1 March 2011.

By this stage it was becoming evident that Carly was most likely going to present to the Alma Street Centre in the future.[119]

The absence of an overarching risk assessment and risk management plan for Carly contributed to the fragmentation of her care. On 4 November 2010 when Carly contacted Alma Street Centre triage section stating she was not doing very well, she was invited to come in to the centre, but did not attend.[120] By this stage, she had already presented to Fremantle Hospital ED after expressing her intention to die by suicide (on 20 September 2010) and

[119] Exhibit 6, Tab 9
[120] Exhibit 1.1, Tab 12

Dr Douglas' letter (dated 29 October 2010) indicated a course of self-harming behaviour over six months. At the material time, Triage did not have the capacity to bring Carly's 15 November 2010 appointment with the GP consultation liaison clinic forward. They could only offer a face-to-face meeting at Triage.[121]

On 5 November 2010, as a consequence of Carly's non-attendance the day before, an Alma Street Centre staff member accepted Carly's assurance that she felt well at face value.[122] On that basis, it was left to Carly to contact the Alma Street Centre, as needed. However, unbeknownst to the centre, Carly also missed her GP appointment on 5 November 2010.[123]

Carly then missed her 15 November appointment and her re-scheduled 25 November appointment with Alma Street Centre. There were grounds for considering whether Carly's inconsistent behaviour was a reflection of the borderline personality traits identified when she presented to Fremantle Hospital ED on 20 September 2010, but the connections were not made as there were no processes for making them.

On 14 December 2010, Carly's private psychologist reported to Dr Douglas that Carly was in the moderate range for

[121] T 91
[122] Exhibit 1, Tab 22E
[123] Exhibit 1.1, Tab 11; T 91

depression, but Alma Street Centre was not informed. Meanwhile Carly's file at Alma Street Centre was set down for review, which occurred on 31 December 2010.[124]

Between 31 December 2010 and 11 January 2011, Alma Street Centre staff members persisted in their efforts to contact Carly by telephone. As a consequence of those efforts, Carly retuned the telephone calls on 11 January 2011.[125]

However, when Carly did finally make telephone contact with Alma Street Centre she informed Nurse Sheehan that she would make her own arrangements with a psychologist in the community. Based upon the information relayed to her by Carly, Nurse Sheehan's concerns were allayed.[126]

This resulted in the decision to discharge Carly from the GP consultation liaison clinic at Alma Street Centre, into the care of her GP, Dr Douglas. However, the processes in place at Alma Street Centre for planning and guiding the discharge were less than satisfactory.

No clear discharge plan for Carly

Dr Davidson opined that the discharge letter to Carly's GP dated 12 January 2011 did not outline a plan of community

[124] Exhibit 1.1, Tabs 16, 17 and 20; T 96
[125] T 100 - 101
[126] T 101 - 102

involvement by Alma Street Centre. Rather it focussed on Carly not engaging for the requested psychiatric assessment. By reference to Carly's last contact with Alma Street Centre on 3 March 2011, and the related entry in her medical notes, Dr Davidson states that:

> *"On the 3 March 2011 there is no discharge plan rather an entry outlining possible actions by the patient. There is no clarity around how the patient will be supported to address the need to engage with a new GP and psychological support services despite only the previous day stating "recently she has felt increasingly out of control". The responsibility is left with the patient to contact the service if she is in crisis or needs further support".*[127]

In Dr Davidson's opinion, Carly may have benefitted from community follow up and monitoring for an opportunity when she may have been willing to accept an assessment by a psychiatrist.

Nurse Sheehan had telephoned Fremantle Family Doctors to speak with the Carly's GP, Dr Douglas, prior to Carly's discharge but was informed that Dr Douglas was unavailable. Consequently, Carly was discharged by Alma Street Centre's GP consultation liaison team without Dr Douglas being informed. This was consistent with the practices in place at the material time.

It would have been preferable for Nurse Sheehan to speak with Dr Douglas about discharging Carly into her care before the GP consultation liaison clinic made its discharge

[127] Exhibit 6, Tab 9

decision (as reflected by the letter dated 12 January 2011). Whilst Dr Douglas did leave Fremantle Family Doctor's practice, the records show that as at 13 January 2011 (two days after Nurse Sheehan's last telephone conversation with Carly), Dr Douglas was still at the practice, endeavouring to make arrangements for follow up with Carly, in light of her impending departure.[128]

I accept Fremantle Hospital's submission through its lawyer, to the extent that Carly's discharge was consistent with the practice adopted at the time by Alma Street Centre. However, I am not satisfied that Carly's discharge was appropriate.

The circumstances of Carly's care and treatment raise the issue of the degree of proactivity that a mental health service ought to engage in when a patient (or a prospective patient) displays a reluctance to engage. At the inquest the Chief Psychiatrist tendered a skeleton policy concerning the management of patients who decline to follow-up, including patients who do not attend.[129]

The stated aim of this policy would be to assist clinicians in balancing the rights of a capacitous patient to decline participation in the therapeutic process and the responsibility of clinicians to track risk and assertively follow-up:

[128] Exhibit 1.1, Tab 11
[129] Exhibit 9, Tab 11

> *"Discharge from a mental health service will be an active, not a passive process. Discharge of patients who do not attend scheduled appointments will only occur after consideration of the reasons, the clinical need and risk, appropriate follow-up strategies have been attempted and appropriate liaison with other key stakeholders has occurred."*

This policy would guide clinicians into a more proactive discharge process where patients who have mental health issues or problems decline to engage.

No adequate process for integrating CERT clinicians' assessment into Carly's overall care

The CERT clinicians who attended Carly at her home on the evening of 1 March 2011 operated from Alma Street Centre's site, but were not employed by the centre.

The CERT clinicians' role was to provide emergency assessments for mental health patients, but the team did not provide continuing treatment. Their assessments were made as at a point in time. They typically received referrals from Triage.[130]

On 1 March 2011, at the request of Nurse Reid the CERT clinicians that operated in the South Metropolitan area attended upon Carly as a matter of urgency. Nurse Reid sent them because Carly had refused to come to the

[130] T 168; T 1083; T 1121

telephone and accordingly, she was unable to assess her mental state. Based upon the parents' concerns, she formed the view that Carly required a formal assessment. By sending CERT clinicians to see Carly, Nurse Reid expected a decision would be made as to whether or not Carly needed to see a psychiatrist.[131]

The CERT clinicians attended, assessed Carly and formed the view that, on that night, her risk of self-harm was low. Dr Davidson opined that, on balance, the CERT clinicians' decision to the effect that there was a sufficient level of safety for there not to be an immediate risk was supportable. In coming to this opinion he also took into account that there was a very clear intent for both Carly and the family to have follow up.[132]

I have no criticism of the CERT clinicians' assessment of Carly on 1 March 2011. Their assessment was borne out as being correct because Carly did indeed remain safe that night.

I accept Fremantle Hospital's submission through its lawyer, that on 1 March 2011 there were no grounds for suspecting that Carly should have been made an involuntary patient pursuant to the *Mental Health Act* 1996.

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[131] T119
[132] T 920

Unfortunately however, there were no adequate processes for integrating the information about the outcome of the CERT clinicians' home visit with the other information held by Fremantle Hospital and/or Alma Street Centre concerning Carly. This fragmentation in the services resulted in there being no adequate follow up.

Nurse Reid's shift at Triage ended at 9.30pm on 1 March 2011, and her evidence was that she would usually have spoken with Ms Lamb and Nurse Murdock upon their return. However, the records do not disclose any notes by Nurse Reid about any discussions with the CERT clinicians when they returned to Alma Street Centre at approximately 8.40pm. Nurse Reid had no recollection of whether she had such discussions.[133]

Although the CERT clinicians had access to PSOLIS, there is no mention in either the CERT records, or in PSOLIS, that such a discussion ever took place. Instead, records indicate that a copy of the CERT clinicians' report, in the form of feedback to the referring source, was sent by facsimile to Triage at approximately 9.40pm on 1 March 2011.[134] Consequently, it is difficult to discern a clear path for integrated feedback flowing from the CERT clinicians back to Alma Street Centre and specifically, on to the GP consultation liaison clinic.

[133] Exhibit 1.1, Tab 22I; T 121
[134] Exhibit 1.1, Tab 22I

The processes within Alma Street Centre for documenting the outcome of the CERT clinicians' home visit were not satisfactory and contributed to the fragmentation in Carly's care.

No adequate contact with Carly's parents

Carly's final contact with Alma Street Centre comprised her telephone conversation with Nurse Reid on 3 March 2011. By that time, Nurse Reid had ascertained that Carly's GP, Dr Douglas, had left Fremantle Family Doctors, and that Carly had no further appointments at that practice.[135]

When Carly informed Nurse Reid that, whilst she had not spoken to her doctor, she would nonetheless continue at the Fremantle Family Doctors and that she would endeavour to independently locate a private psychologist, Nurse Reid formed the view that there was no need for any further pro-active follow up from Alma Street Centre. No contact between staff members at Alma Street Centre and Carly or her family is recorded after this point.[136]

Notwithstanding their involvement with the CERT team on 1 March 2011, Carly's parents were not informed that their daughter had been a patient of Alma Street Centre (through the GP consultation liaison clinic), or that she was subsequently discharged. They expressed concern that as a

[135] Exhibit 1.1, Tab 22G
[136] T 137; Ex 1.1, Tabs 13 and 22G; T 155

consequence they could not keep an eye on her as well as they would have liked to. Had they known, they would have been able to be more proactive about her care.[137]

The CERT clinicians' assessment on 1 March 2011 was made following serious and urgent concerns expressed by Carly's parents. After they assessed Carly, the CERT clinicians spent considerable time with her parents in their home, noting that they were both exhausted and that Carly's mother in particular was anxious and distressed.[138] As a result of this meeting, Carly's parents felt reassured that the there was no real issue at that point in time. Equally the CERT clinicians had grounds for expecting that Carly would be well supported overnight.[139]

However, when Carly telephoned Nurse Reid at Triage for assistance the following evening on 2 March 2011, neither of her parents was informed, even though Nurse Reid had sent the CERT clinicians to Mr Elliott's address the previous night at the request of both parents.[140]

It would have been preferable for Nurse Reid, knowing of the circumstances of the CERT clinicians' home visit the previous night, to have contacted Carly's parents to notify them of her subsequent call for assistance. In her parents' view, this would have prompted at least one of them to

[137] T 37; T 44
[138] T 45
[139] T 45
[140] T 45

speak with Carly about how she was feeling, take her to hospital, and/or stay with her until she was seen.[141]

However, there were no processes or procedures in place to prompt Nurse Reid to contact Carly's family on 2 or 3 March 2011.

Given that it was Carly's parents who precipitated the CERT assessment and were left assured as to her safety, I do not accept Fremantle Hospital's submission through its lawyers to the effect that, when Carly rang Alma Street Centre the next day seeking help, there were competing needs to balance Carly's right to confidentiality. This does not provide a justification for not contacting them.

Since that time, the State-wide Standardised Clinical Documentation has been implemented, as a response to a number of the recommendations in the Stokes Review. Nurse Reid's evidence was that had this system been in place at the material time, it would have prompted her to contact Carly's parents by telephone and discuss the nature of Carly's contact with her, advising them of the outcome.[142]

By way of example, the mental health clinician completing the new treatment, support and discharge plan documentation is prompted to turn his or her mind to persons involved in the care planning process. The new

[141] T 48
[142] T 62

system contemplates the patient's support person signing the plan, as well as the patient (who is now referred to as the consumer).[143]

Adverse findings in relation to Carly's care

Carly's care was not well integrated. Her care was fragmented as a result of the structure of the mental health services at Fremantle Hospital. The processes adopted by her clinicians were guided by that structure.

Whilst there are now new systems in place at Alma Street Centre for recording clinical decision making, integrating patients' care and involving carers, I am concerned with Carly's care at the material time.

I am satisfied that between 20 September 2010 and 3 March 2011, or at stages between those dates, the mental health services provided by Alma Street Centre to Carly lacked cohesion and continuity, such as to leave Carly responsible for following up on her own care, in circumstances where she had been exhibiting behaviour and ideations capable of being interpreted as suicidal in nature.

[143] Exhibit 6, Tab 11

MICHAEL ROLAND THOMAS

Michael's background

Michael was born in Bristol, England in 1954. Educated in the United Kingdom, he completed school and qualified as a telecommunications worker. He worked in this area throughout his life.

In 1978, at the age of 24, he moved to Australia with his partner, who later became his wife. The couple had three children, and they had been married for over 33 years at the time Michael died, aged 57 years.

Michael's wife described him as a hardworking, competent, sociable and energetic man. He had a quick wit and sense of humour, a passion for travel and music, and a warm and driven nature. He was also a perfectionist, which sometimes operated to his detriment. He took his responsibilities very seriously.

When they arrived in Australia, Michael was employed by Telstra, and over time he was promoted to the level of business faults manager, a position in which he worked for approximately ten years. In January 2008, he was made redundant. Following that Michael obtained more physically demanding work, in the same industry. However, after only approximately two and a half years, he was made redundant again and was thereafter unable to find work

commensurate with his skills. Consequently Michael registered with Centrelink to obtain financial assistance.

Never having been unemployed, Michael became extremely unhappy. He began to suffer from anxiety, but was reluctant to acknowledge his problems or seek medical assistance. His mental health deteriorated and in December 2010 his wife urged him to seek help.

In early January 2011, Michael sought help from his general practitioner for his mental health problems. He was given antidepressant medication and asked to return for a review, but he did not return. He did not display insight into the severity of his condition.

With no structured ongoing mental health treatment, inevitably Michael reached a crisis point. On 8 January 2011 and he was admitted to Fremantle Hospital after having been brought in to the ED by ambulance due to having made a non-fatal attempt on his life. He had not had any previous admissions to psychiatric units. Several social and environmental stressors had adversely affected him. The clinicians' diagnoses included depression, alcohol abuse and anxiety. He was prescribed antidepressant medications and admitted, as a voluntary patient to the open ward of Alma Street Centre, under the care of the consultant psychiatrist. Ms Andrea Cartwright was allocated as his case manager. Michael was treated for

approximately three weeks as an inpatient. His wife was involved in his treatment decisions.[144]

At the end of the three weeks, Mrs Thomas remained concerned that Michael may make another attempt on his life if he was discharged home. Consequently he was transferred to Hampton Road Services on 3 February 2011, for a four-week stay, with ongoing review as an outpatient. Hampton Road Services provided short-term, community-based, supported accommodation for adults experiencing deterioration in their level of functioning as a result of their psychiatric condition. The aim was to assist Michael with his transition back into the community. Ms Cartwright continued as his case manager.[145]

Michael was accommodated at Hampton Road Services until 3 March 2011. On that date consultant psychiatrist Dr Pankaj Kataria reviewed Michael at Alma Street Centre's outpatient clinic. Dr Kataria conducted a mental state examination and formed the view that Michael had undergone a situational crisis but that he was no longer at acute risk of self-harm. Michael denied suicidal ideation. He appeared future focussed and was engaging with his multidisciplinary team. With Dr Kataria's approval Michael was discharged home with follow up in three weeks' time.[146]

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[144] Exhibit 5.1, Tabs 7, 8, 14, 18 and 19; Exhibit 5.2 Tab 4E, 4Q, 4R
[145] Exhibit 5.1, Tabs 8, 14, 18 and 19; Exhibit 5.2, Tabs 4E and 4G; T 782
[146] Exhibit 5.1, Tabs 14, 18 and 19; T 779 - 787

Dr Kataria reviewed Michael again, as planned, on 24 March and 14 April 2011. A range of complementary specialist supports was also provided to Michael over this period. Dr Kataria's continuing assessment was that Michael was not at risk of self-harm. The continued aim of the clinical team was to assist Michael to transition back to work.[147]

Michael missed two scheduled outpatient appointments in May 2011 and Dr Kataria had to reschedule the third one that had initially been set for 28 May 2011.[148] Despite the assessments made of Michael, his mental health deteriorated and he experienced another crisis.

Events leading to Michael's death

On 31 May 2011, shortly after Michael missed his two outpatient appointments and had the third one re scheduled, he was conveyed by ambulance to Fremantle Hospital ED after another non-fatal attempt on his life. He had self-administered his wife's prescribed insulin medication and he was unconscious when paramedics arrived at his home. He was admitted to the Medical Assessment Unit (MAU) of Fremantle Hospital under the care of Dr Kandanarachchi. As a result of his actions he required emergency medical care. Shortly after his presentation Michael conceded that his actions amounted to

[147] Exhibit Tabs 14 and 18; T 779 - 780
[148] Exhibit 5.1, Tabs 7, 8 and 18

an attempt on his life. However after that point, on further inquiry Michael denied this and maintained that he self-administered the insulin for therapeutic purposes. Michael's clinicians formed the view that he was at chronic risk of suicide or self-harm, but it was decided that he was not at acute risk. Accordingly a psychiatric admission was not arranged for him at that time. He was kept in the MAU as a medical patient, but not specifically as a psychiatric patient.[149]

However, given that Michael was also an Alma Street Centre patient, and due to concerns about him minimising what appeared to be a non-fatal attempt on his life, his psychiatric treating team was notified.

At the material time, consultant psychiatrist Dr Kataria was on leave and psychiatry registrar Dr Singh was covering for him. Dr Singh did not personally go and meet with Michael at the MAU on 1 June 2011 because on that day, in addition to covering for Dr Kataria, he had a full clinic of outpatient appointments and was also preparing patients for university psychiatry clinical exams that were to be held the next day. Consequently, on 1 June 2011 Michael's case manager, Ms Cartwright, attended the MAU to assess Michael because she understood that Dr Singh was unavailable and Dr Kataria was away.[150]

[149] Exhibit 5.1, Tabs 2 and 7; Exhibit 5.2, Tabs 4I and 4H
[150] T 813; T 820; T 873 - 874

Upon assessing Michael, Ms Cartwright formed the view that he was future oriented and able to guarantee his safety. She considered there were a range of protective factors in place for him. Michael relayed to her that he was receiving psychological counselling and his next appointment was in two weeks' time. She discussed various other support options with him. Her assessment of Michael was not recorded as a formal brief risk assessment of a mental health patient.[151] At the inquest, I heard evidence about whether a psychiatry registrar (as opposed to a case worker) would normally make this assessment prior to discharge and the issues are addressed below.

Following her assessment of Michael, Ms Cartwright returned to Alma Street Centre and reported on the outcome to Dr Singh. One of the matters that she brought to Dr Singh's attention concerned Michael's fear that he would not be allowed to go home, because his wife was afraid he would self-harm. These fears, understandably, created stress within their domestic environment.[152] This situation reflects on the need for clinicians to ascertain whether carers need to be supported when patients are discharged home.

Based upon his discussion with Ms Cartwright, taking account of her impressions and the fact that Michael's wife had Alma Street Centre's emergency contact numbers, on

[151] Exhibit 5.1, Tabs 8, 15, 17, 19, 25 and Exhibit 5.2, Tab N
[152] T 874

1 June 2011 Dr Singh decided that Michael could be discharged home with follow up from Alma Street Centre the next day. Dr Singh made his decision subject to the consultant medical physician in MAU clearing Michael for discharge from a medical perspective.[153]

It is self-evident that the circumstances of Michael's admission to the MAU required him to undergo urgent medical treatment, and that he also required a psychiatric assessment.

Dr Singh's decision caused Ms Cartwright to contact Mrs Thomas by telephone to inform her of the plan to discharge Michael the following day (being 2 June 2011), with follow up by Dr Kataria on 8 June 2011. During this telephone conversation Mrs Thomas became distressed. She vigorously objected to Michael's discharge fearing that he would likely make another attempt on his life. Mrs Thomas was adamant that Michael should remain in hospital for his safety. She informed Ms Cartwright that she would attend personally at the MAU with the aim of further conveying her concerns.[154]

Ms Cartwright had left by the time Mrs Thomas arrived at the MAU in the late afternoon on 1 June 2011. Mrs Thomas spoke with the intern Dr Sorensen in order to convey her concerns about Michael's impending discharge. The intern

[153] Exhibit 5.1, Tabs 17 and 19; Exhibit 5.2, Tab 4N; T 796 – 805; T 876
[154] Exhibit 5.1, Tabs 7, 8 and 19

had been called upon by staff members at the MAU to attend upon Mrs Thomas, with a view to identifying her concerns and relaying that information back to Michael's treating team. Mrs Thomas found the conversation to be unsatisfactory, forming the view that Dr Sorensen was sent to appease her. Dr Sorensen found the conversation to be challenging, and whilst she endeavoured to explain her understanding of Michael's diagnosis and treatment, the outcome was that neither party was satisfied that their perspectives had been understood. Dr Sorensen duly conveyed Mrs Thomas' concerns to Michael's treating team. She was not in a position to make decisions regarding his treatment.[155]

There is an entry in Michael's integrated progress notes by Dr Sorensen made in the late afternoon of 1 June 2011 stating that the intention to discharge Michael was discussed with his wife: *"She was very unhappy with this and feels he should be hospitalised for his depression.... She demands that he be seen by psychiatric doctor."* Dr Sorensen had informed Mrs Thomas that Michael had been seen by his case worker who felt he was not a risk to himself at present, but in the light of Mrs Thomas' expressed concerns, arrangements were made for Michael to be reviewed by a psychiatry registrar prior to his discharge.[156]

[155] T 766 – 767; T 832 - 834
[156] Exhibit 5.2, Tab 4N

Michael was reviewed at approximately midday the next day 2 June 2011 by the psychiatry registrar Dr Claire Keating. Dr Keating obtained a history that included exploring the reasons for Michael's most recent non-fatal attempt on his life. Michael continued to deny the self-evident implications of his actions. By this stage, Michael's medical team had determined that he was ready for discharge (from a medical perspective) and Dr Singh had already decided Michael could be discharged subject to that medical clearance.[157]

Dr Keating performed a mental state examination and a risk assessment. Dr Keating determined that Michael was at chronic risk of self-harm, but that he was not at acute risk. She explained that a "*chronic risk of self-harm usually reflects the person has persistent long-standing factors that are resistant to treatment, such as personality traits of impulsivity in Michael's case.*" Dr Keating formed the view that Michael "*genuinely presented as someone who was not severely depressed or acutely suicidal*" and opined that "*the difficulty with Michael's condition was that there was no predictability as to when Michael may respond impulsively to stress by self-harm.*"[158]

During his assessment Michael identified several current stressors. Dr Keating decided there was no benefit to be gained from admitting him to Alma Street Centre's psychiatric ward as the main reason to admit someone was

[157] Exhibit 5.1, Tab 16; Exhibit 5.2, Tabs 4J, 4O and 4P; T 853
[158] Exhibit 5.1, Tab 16

to contain a very acute risk of self-harm or to trial a new therapy. She also considered that Michael was well supported in the community with follow up by his case manager and an appointment with his treating psychiatrist in one weeks' time.[159]

Dr Keating did not recall whether she spoke to Michael's family after she assessed him. She could not recall whether or not Michael wanted his wife to be notified before he was discharged, and Michael's hospital notes do not shed any light on this.[160]

Dr Keating believed it was the medical team's responsibility (at MAU) to inform Michael's family and to arrange transport once he had been medically cleared for discharge. This is because Dr Keating was of the belief that it was the consultant medical physician (at the MAU) who made the ultimate decision to discharge Michael. Dr Keating did not confer with the consultant psychiatrist because she formed the view that there were no features in Michael's presentation that seemed out of the ordinary. She was aware that on the previous day, Dr Singh had decided that Michael could be discharged subject to the consultant medical physician in MAU clearing him for discharge from a medical perspective. She believed that was indicative of the team's plan to discharge Michael.[161]

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[159] Exhibit 5.1, Tab 16
[160] Exhibit 5.2, Tab 4; T 856
[161] T 800; T 866 - 868

On all of the evidence before me, although Dr Keating was the last clinician from the psychiatric team to assess Michael, I am satisfied that, from a psychiatric perspective, Dr Singh made the ultimate decision to discharge Michael. Dr Singh was senior to Dr Keating and he accepted that he made that decision on 1 June 2011 and it would have led to Michael's discharge the next day. Dr Keating's role was introduced following Mrs Thomas' complaints. It would have been appropriate for Dr Singh to have undertaken the face-to-face review on 2 June 2011 but he was on leave that day. At the material time he made the decision to discharge Michael (from a psychiatric perspective) Dr Singh was aware that Mrs Thomas did not want Michael to be discharged. She had previously informed the hospital that she would not collect Michael as she firmly believed he would harm himself. [162]

Michael was discharged in the early afternoon on 2 June 2011 and Mrs Thomas was not informed by any staff member from Alma Street Centre at that point. She collected him from their son's house later that night.[163]

At approximately 10.00am the following morning, on 3 June 2011, Michael telephoned Alma Street Centre and spoke with Ms Cartwright. Michael told her he felt suicidal and he

[162] Exhibit 5.1, Tabs 7 and 17; T 797 - 804
[163] Exhibit 5.1, Tabs 7, 8 and 15; Exhibit 5.2, Tab P

could not remain at home. She could not assess his mental state or risk due to his high level of distress. She discussed the case with Dr Singh, who instructed her to book him into his clinical list at 1.30pm that day, his earliest available appointment time. Ms Cartwright called Michael back to offer him the 1.30pm appointment. Ms Cartwright ascertained through Michael that Mrs Thomas was with him and agreed that she would bring him in to his 1.30pm appointment with Dr Singh later that day.[164]

Tragically, at approximately 12.30pm on 3 June 2011, as Mrs Thomas was readying herself to take Michael to his appointment, unbeknownst to her he left the house, and she could not make contact with him. He did not take belongings with him. Concerned, Mrs Thomas informed Alma Street Centre and she was advised to call the police.

Police were notified that Michael was missing at approximately 2.00pm on 3 June 2011 and they promptly commenced a full-scale search, including police air wing and land search, and utilising State Emergency Service (SES) resources. On the day he was reported missing, the air wing search made use of heat sensing technology, but this did not yield a result. The SES dog handlers took part in the first two days of the search, FESA sent out alerts by text message to approximately 14,000 residents, but these efforts did not yield any results either. The search was

[164] Exhibit 5.1, Tabs 7, 8, 14, 17 and 19; Exhibit 5.2 Tab 4A; T 808; T 811; T 879 -881

thorough and concluded on 5 June 2011. Michael could not be found and his details were passed on to the Missing Persons Unit.[165]

Cause and manner of death of Michael Roland Thomas

On 2 September 2011, thirteen weeks after Michael was reported missing, City of Cockburn workers located his remains in wooded and dense scrubland at Aubin Grove, approximately 1.6 kilometres from his home. Police were contacted and conducted a thorough search of the area where he was found. This search did not yield evidence of articles likely to be related to Michael's death. The clothing the deceased wore was consistent with what he reportedly wore on the day he was reported missing. Police posited that a sheet of corrugated iron located close to Michael when he was found may have defeated the police air wing's heat sensing technology during the initial search. No note or any other form of correspondence from Michael was ever found. Due to the extent of the initial search, police formed the view that Michael had been avoiding detection.[166]

Bureau of Meteorology records reflect that in the six days following his disappearance, overnight temperatures ranged from 8.2 degrees down to 4 degrees. As a result of their investigations, police formed the view that there did not

[165] Exhibit 5.1, Tabs 2, 7, 8 and 14
[166] Exhibit 5.1, Tab 2, T 774 - 776

appear to be any involvement by any other person in Michael's death.[167]

The state of Michael's remains reflected that he had lain in that area for some considerable time. It was necessary to identify Michael other than by visual means. On 7 October 2011 forensic odontologist Dr Stephen Knott identified Michael by dental examination and I accept that identification.[168]

On 8 September 2011 forensic pathologist Dr J. White made a post mortem examination of Michael at the State Mortuary. Within the limits of the examination, there was no significant pathology identified.

Toxicological analysis revealed a therapeutic level of an antidepressant medication. Records before me reflect that Michael had not been prescribed that medication. No alcohol or illicit drugs were detected. However, toxicology results must interpreted with caution given the degree of decomposition affecting the samples. On 15 December 2011 the forensic pathologist formed the opinion that the cause of Michael's death remained unascertainable.[169]

Police explored whether Michael may have, again, self-administered his wife's insulin. It was not possible to make

[167] Exhibit 5.1, Tabs 2, 9 and 10
[168] Exhibit 1, Tabs 2 and 4
[169] Exhibit 5.1, Tabs 5 and 6

a toxicological analysis for the presence of insulin, nor was it apparent that any of Mrs Thomas' insulin doses were missing. There is insufficient evidence before me from which I may find the cause of Michael's death at Aubin Grove. There is no evidence of a specific act of self-harm. If Michael self-administered his wife's insulin, he may have again lost consciousness, and coupled with the cooler overnight temperatures, he may have experienced hypothermia. However, due to the passage of time resulting in decomposition changes, the post mortem examinations that were able to be conducted were necessarily limited.[170]

Given his mental health history, the timing of his previous non-fatal attempts on his life, the content of his telephone call to Alma Street Centre on 3 June 2011, his mental state on that date, and his actions in disappearing without taking his belongings or notifying or contacting his family, I am satisfied that Michael undertook a set of actions with the intention of taking his life and that as a result he died at the location where he was found, at Aubin Grove.

Whilst the precise mechanism of his death remains unknown, in finding his manner of death I am particularly persuaded by the statements Michael made to Ms Cartwright over the telephone shortly before he disappeared. He explicitly told her, amidst his high level of distress, that he was feeling suicidal.

[170] Exhibit 5.1, Tab 2; T 776 - 777

The cause of Michael's death is unknown (unascertainable).

The manner of Michael's death is suicide.

Michael's care from Alma Street Centre

Former Chief Psychiatrist Dr Davidson reviewed Michael's care from Alma Street Centre. He provided a written report[171] and gave evidence at the inquest.

Michael's wife expressed concern about his treatment and care by Alma Street Centre, in particular his discharge and the lack of communication with her.

Dr Davidson identified three matters of relevance:

- Whilst Michael's medical records contained a client management plan dated 13 January to 20 January 2011, there was no updated (longitudinal) plan for his current presentation and community care;

- Dr Keating's review on 2 June 2011 referred to current multiple stressors for Michael which, despite the brief risk assessment indicating a low acute risk, should have prompted a risk management plan. There was no risk management plan despite the previous suicide attempt; and

[171] Exhibit 6, Tab 9

- The record of Michael's discharge includes notations to the effect that it was discussed with Mrs Thomas, but an agreed position was not achieved and he was discharged anyway.

No clear discharge plan for Michael

The discharge planning for Michael on or about 2 June 2011 lacked clarity on the point of whether the clinicians, the patient and his wife agreed to the plan.[172] The absence of a longitudinal plan and a risk management plan contributed to this lack of clarity.

Fremantle Hospital through its lawyers acknowledges that due to an unfortunate series of staff unavailability and resource limitations, Michael was not able to be seen or treated by the full suite of his community team when he was admitted to the MAU in June 2011. However, they submit that Michael's case manager (Ms Cartwright) was closely involved in his admission and subsequent discharge, and that a comprehensive psychiatric assessment was undertaken (by Dr Keating) before he was cleared for discharge.

[172] Exhibit 6, Tab 9

The lack of clarity regarding Michael's discharge planning has its genesis in the decision by Dr Singh on 1 June 2011 to discharge Michael without seeing him. Fremantle Hospital through its lawyers accepts that it is best practice for a psychiatry registrar to review a patient in person prior to discharge. In evidence, both Chief Psychiatrists, Dr Davidson and Dr Gibson were in support, but they also noted that there are justifiable exceptions to that practice. For example, depending on the circumstances, a psychiatry registrar could quite properly rely on advice from the patient, family members and the case manager, (especially an experienced one). Dr Singh's evidence was that had he had the benefit of time he would have liked to see Michael in person.[173]

In Dr Davidson's opinion it would have been most desirable for Dr Singh to see Michael before discharging him in these circumstances, notwithstanding that there may have been a relatively complete relay of information to him by Ms Cartwright. Dr Davidson explained it as follows:

> *"In my view, a well-trained and senior case manager can, indeed, provide the contributory evidence and views at a high level. However, the point of discharge will still require – and, again, I emphasise where it is contentious or where there are specific sets of concerns. In that situation it is essentially most desirable that that should involve the face-to-face contact and decision-making by the more senior medical practitioner."*[174]

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[173] T 820, T 969, T 990 - 991
[174] T 969

The discharge decision was made by Dr Singh without seeing Michael, in the face of very specific and vigorous concerns raised by Mrs Thomas. It was clear to Ms Cartwright, to Dr Singh (from Ms Cartwright), and to Dr Keating, that both Michael and his wife were concerned about Michael being discharged, and about him going home. Further, each of them were also aware of particular domestic stressors which impacted upon Michael at the time his discharge was being considered.

I accept that Mrs Cartwright had built rapport with Michael over the six months that she had been his case manager, that she was experienced in assessing risk and that Dr Singh knew her to be thorough and comprehensive in her risk assessments. I also note that Dr Singh made Michael's discharge conditional upon follow up with Alma Street Centre the next day.[175]

However, Dr Singh's decision to discharge Michael was based on incomplete information. Dr Singh did not see Michael in person, and because of this, he accepted that he could not have formed an independent psychiatric opinion as to his level of risk, and could not make an independent medical assessment of the least restrictive preferred option for Michael's treatment at the time. Dr Singh explained that whilst he did not form an individual opinion, he and the

[175] Exhibit 5.1, Tab 19; T 816; T 889 - 890

case manager worked as a team and trusted each others' judgement.[176]

It is clear that whilst Dr Keating's subsequent assessment of Michael on 2 June 2011 did not identify additional risk factors, in making his discharge decision Dr Singh relied substantially upon the communications from Ms Cartwright. Given that Mrs Thomas had conveyed a specific set of concerns, this was not desirable.

Dr Singh was covering for Dr Kataria at the time, the latter being on leave. The arrangements caused Dr Singh to have to work to a very tight schedule. I accept Dr Singh's evidence that he would have preferred to see Michael in person. However, I do not accept the submission that being extremely stretched in terms of resources and availability fell squarely within the exception to the best practice, namely that there be a face-to-face meeting between the psychiatry registrar and the patient.

Inadequate response to Michael's call for help

Michael's telephone call to Ms Cartwright at Alma Street Centre on the morning of 3 June 2011 represented a call for emergency assistance. Michael clearly communicated that he felt at acute risk of suicide during that telephone call. Dr Davidson's opinion, Michael was expressing "... *an*

[176] T 799; T 800

emergency with significant risk associated with it and that that would usually have prompted the series of interventions which were more time specific or at least driven by a need to reduce the risk of suicide as quickly as possible."[177]

Fremantle Hospital through its lawyers submits to me that when Michael telephoned Alma Street Centre and spoke with Ms Cartwright on 3 June 2011, it was a protective factor for his risk in the sense that he was able to reach out and follow the emergency plan, and that he had insight into his risk. Whilst Dr Davidson did agree there was a protective component in Michael's behaviour, he also opined that by that contact Michael was demonstrating his need and his distress, and that there may not be an ongoing protective factor as his distress increases.[178]

Ms Cartwright accepted, in hindsight, that Mrs Thomas could probably have brought Michael into Triage immediately.[179]

Whilst Dr Davidson noted that Dr Singh made a clinical judgement in deciding to make an appointment for Michael in three hours' time, he also said he would perhaps have been seeing that situation differently, as essentially an emergency.[180]

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[177] T 972
[178] T 980
[179] T 880 - 882
[180] T 823; T 972; T 981

Ms Cartwright's evidence was that she took into account that Fremantle ED and Alma Street Centre Triage are often traumatic environments in the sense that they are busy and chaotic, and that if Michael had presented at either one of these services, he would have had to wait many hours before he was seen. Dr Singh had similarly formed the view that in those circumstances, Fremantle ED or Triage were not ideal places for Michael to spend time. In Dr Davidson's experience, ED and triage are "*difficult areas to wait*" because they have other patients with their own levels of distress, are very busy and are not anxiety reducing places.[181]

Dr Singh had also taken into account the likelihood that it would have taken Alma Street Centre's community team members approximately two hours to attend on Michael at his home. His evidence was that had Michael verbalised that he was not safe to wait until 1.30pm that day, they would have directed him to the ED (notwithstanding the undesirability of waiting in ED).[182] However, in order to rely upon Michael's indication that he would be safe to wait, consideration would need to be given to the likelihood of this being adhered to, and Dr Singh did not himself speak with Michael in order to make a critical assessment of that likelihood.

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[181] T 981
[182] T 808; T 811; T 822

On 3 June 2011 Dr Singh considered that from a therapeutic perspective, due to her previous involvement and familiarity, it was preferable for Ms Cartwright to speak directly with Michael over the telephone, rather than himself.[183]

It is unfortunate that Dr Singh did not discuss Michael's condition or his ability to attend the 1.30pm appointment with Michael himself or with Mrs Thomas. Instead, Dr Singh relied solely upon information provided to him by Andrea Cartwright. Michael's agreement to attend at 1.30pm was accepted at face value by Ms Cartwright over the telephone, and hence by Dr Singh when it was relayed to him.

It was undesirable, in the circumstances as Michael reported them, for him not be referred to either Alma Street Centre's Triage, or to an ED immediately when he telephoned to say he was feeling suicidal. It should not have been left up to Michael, in the state that he was in, to make arrangements to attend an appointment approximately three hours from the time of his telephone call, even if those arrangements were made with the assistance of his wife.

Fremantle Hospital through its lawyers submits to me that in making an appointment time for Michael with Dr Singh three hours hence, Dr Singh and Ms Cartwright were

[183] T 822

intending to protect Michael from the additional stress of the ED or Triage environment, whilst still ensuring that Michael was seen within a similar (and not unreasonable) time frame and further, that Michael accepted the plan and he was with his wife.[184] The degree to which Michael was able to accept the plan is questionable given his high level of distress. The burden placed on his wife to keep him safe for that period of time was unacceptable.

No adequate contact with Michael's wife regarding Michael's discharge

Whilst I accept that Ms Cartwright had contacted Mrs Thomas by telephone on 1 June 2011 to inform her of the plan to discharge Michael, there were significant subsequent intervening events. Accordingly this telephone call does not operate as adequate notice of Michael's impending discharge. Nor does the subsequent discussion between Mrs Thomas and Dr Sorensen.

In the circumstances I do not accept the submission made by Fremantle Hospital through its lawyers, to the effect that Mrs Thomas knew that Michael was going to be discharged by reason of her conversations with Ms Cartwright and Dr Sorensen. In coming to this conclusion I take account of the following:

[184] T 808; T 880; T 894

- Mrs Thomas expressed vigorous disagreement in her conversation with Mrs Cartwright and told her she was coming to the hospital;

- When Mrs Thomas came to the hospital she spoke with Dr Sorensen who informed her that she was neither a psychiatrist nor the decision maker and that she would feedback the concerns to the treating team.[185]

It was well known amongst Michael's clinicians that Mrs Thomas had expressed concerns about her husband's mental state and her ability to care for him at home when he was discharged.[186]

In evidence Dr Davidson agreed that there is no record of any staff member from Alma Street Centre contacting Mrs Thomas to notify her of the decision to discharge Michael before he was allowed to leave on 2 June 2011. He also agreed that it would have been desirable for contact to have been made with Mrs Thomas before Michael was discharged on 2 June 2011.[187]

In evidence Dr Davidson provided compelling reasons as to why family members ought to be informed prior to a patient being discharged:

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[185] T 834
[186] T 761 - 762; T 767
[187] T 970

"I believe there are multiple effects and that the most prominent issue is that this, again, is a form of transition, clearly, from inpatient care back into the community - and back into the community in a setting where there had already been a major set of difficulties for the family. In those types of circumstances, clearly, the family needs to be aware of the interventions at least that had increased the safety and had reduced the risk for any similar recurrence. And the contact from the service will include the assurances that that has been managed, the patient is ready to be discharged and returned to the community without the protections and care that had been conducted in the inpatient setting. It is also, of course, for families a matter of timing. Families may need to put in place some additional supports and additional factors when the patient returns to the community. And the families always need to have some notice of those actions that they're going to undertake as the person returns from hospital."[188]

Mrs Thomas became aware that Michael had been discharged when she received a telephone call from an Alma Street Centre staff member after Michael was discharged. At that point, she did not know where Michael was. As it transpired, Michael went to his son's home and his wife was contacted and collected him later that evening and took him home.[189]

The failure to inform Mrs Thomas that Michael was going to be discharged was wholly undesirable. She was considered to be one of his supports. The only place Michael could reasonably return to upon discharge was the home he shared with his wife.

It is unfortunate that more was not done to support Mrs Thomas through the process of Michael's discharge.

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[188] T 970
[189] T 768 - 769

Adverse findings in relation to Michael's care

On 3 June 2011 Ms Cartwright was an experienced social worker, employed by Alma Street Centre, responsible for informing herself of matters relevant to Michael's continued care, and she was someone who became aware that Michael was expressing suicidal ideation. Whilst she did subsequently discuss the situation with Dr Singh and act in accordance with his instructions, as an experienced and independent person she had her own obligation to act upon Michael's information upon its receipt by her. In the circumstances, she failed to refer Michael to a service which may have been able to attend to him immediately (such as an ED, the police, an ambulance, and/or the Alma Street Centre Triage).

Between 1 and 3 June 2011 Dr Singh was qualified as a medical practitioner, employed as a psychiatry registrar in training, and was responsible for informing himself of matters relevant to Michael's assessment, discharge and continued care, and:

- on 1 June 2011 Dr Singh made the decision to discharge Michael without assessing him personally; and

- on 3 June 2011 Dr Singh, being aware that Michael had informed Ms Cartwright that he felt suicidal and could not stay at home, failed to recommend that Michael be referred to a service which may have been able to attend to him in a more timely way (such as an ED, the police, an ambulance, and/or Alma Street Centre Triage).

I accept the submission by Fremantle Hospital through its lawyers that there was no want of care or disregard for Michael on the part of Dr Singh.

In needing to cover for Dr Kataria who was on leave, Dr Singh was faced with competing workloads. He had appointments with patients between 9.00am until after 4.00pm. If any of those appointments had been cancelled, those patients would likely be without medical care for 8 – 12 weeks. After seeing those patients there were follow up actions to attend to, he was writing scripts for patients under his team's care, reviewing laboratory results and other matters that would normally be dealt with by the consultant who was on leave. To add to the complexity, the covering consultant psychiatrist was trying to cover several jobs.[190]

It is unfortunate that Dr Singh, who was still in the training program, was placed in this position at Fremantle Hospital.

[190] T 800; T 816 - 820

The hospital submits that clinical decision making cannot be seen outside the context of the effects of a high demand for mental health services. Whilst this may be true to a degree, care needs to be taken to ensure that the treatment of patients does not give way to considerations of an overly pragmatic nature.

As a psychiatry trainee Dr Singh's level of autonomy is not comparable to that of a more senior consultant psychiatrist. However, it is to be borne in mind that he was personally charged with very important decision making on 1 June 2011. His evidence was that he chose not to seek out a consultant psychiatrist's opinion because was not concerned about his discharge decision given the information that had been provided to him by Ms Cartwright. [191]

ANTHONY IAN EDWARDS

Anthony's background

Anthony was born in Fremantle in 1985. He was one of five children and he was raised in a close family environment. He went to primary school in Palmyra, and started high school at John Curtin College. He excelled at sport during his school years and had lots of friends and cousins that

[191] T 800-801

went to the same school. Anthony's parents described their son as a typical child, adventurous, kind-hearted, loving and caring. His father introduced him to golf at a young age and it became apparent that Anthony had a natural talent. Some way into his high school studies, Anthony earned a golf scholarship and transferred to Como Senior High School.

By the age of 14 Anthony played to a handicap of 3, was a member of the Western Australian state squad, and represented Royal Fremantle and Royal Perth Golf Clubs in an open age tournament. At the age of 15 he was permitted to leave school early to pursue golf as a career. Anthony was dedicated to his golf and he practiced continually. He supported himself by working part time as a plasterer and as an assistant in a golf shop.

Unfortunately, outside the world of golf, Anthony met people who introduced him to illicit drugs, including cannabis and amphetamines. Anthony began to experiment with illicit drugs and as a result, in 2003 Anthony's mental health began to deteriorate. By the time of his death at the age of 26 years in 2012, Anthony had a significant history of severe mental health problems.

Between 2003 and 2012, Anthony had multiple admissions to a number of psychiatric inpatient services, with multiple

suicide attempts in 2004. In 2004 he was diagnosed with schizophreniform psychosis.[192]

Between May and September 2005 Anthony was a patient at the Forensic Unit (Frankland Centre) at Graylands Hospital. There he was diagnosed with a number of illnesses, including schizophrenia. He was prescribed the anti-psychotic clozapine and his psychosis appeared to improve. He was treated for drug and alcohol abuse. He suffered seizures and when he was discharged, his psychiatrist recommended close and intensive psychiatric follow up.

Throughout this turbulent period, commencing from 2003, Anthony maintained a strong and positive relationship with his general practitioner, Dr Paul Babich, who assisted him with his alcohol withdrawal symptoms and his anxiety.[193] It is to Dr Babich's credit that the therapeutic relationship persisted despite unavoidable interruptions over numerous years.

From May 2007 Anthony was reviewed regularly by the Alma Street Centre. The clinicians found him to be reluctant to engage and he was considered to be at chronic risk of suicide. He continued to be prescribed clozapine. Regular blood tests were taken (as required) to monitor this

[192] Exhibit 3.1, Tabs 2, 2A, 15 and 16; Exhibit 3.2, Tabs 1K, 3
[193] Exhibit 3.1, Tab 17, Exhibit 3.2, Tab 1D

medication's side effects on his white blood cell count.[194] He required prompting and follow up to attend his appointments at the clinic. His parents supported him in his engagement with his treatment.

During the six to seven years that Anthony was treated with clozapine he appeared reasonably stable. Unfortunately in early December 2011 his white blood cell count was found to have dropped to dangerously low levels and consequently, his clozapine had to be stopped. His anti-psychotic medication was changed to olanzapine.[195]

Chief Psychiatrist Dr Nathan Gibson reviewed Anthony's care at Alma Street Centre and produced a report. Dr Gibson opined that the cessation of clozapine was reasonable in the circumstances given the potentially life threatening impact on Anthony's white blood cell count. However, ceasing clozapine can lead to a rebound psychosis, meaning psychosis can return quickly and severely if other strategies (such as another anti-psychotic medication) are not put in place to prevent this.[196]

Unfortunately, Anthony was reluctant to take his substituted medication, olanzapine, possibly due to a perceived effect on weight gain. This proved problematic for him. Whilst it appeared to those close to him that his

[194] A side effect of clozapine is the risk of developing neutropenia, a condition where white blood cells drop to dangerously low levels, exposing the patient to possibly fatal infections.
[195] Exhibit 3.1, Tab 2; Exhibit 3.3, Tab 1M and 1Q
[196] Exhibit 9, Tab 3

deterioration was triggered by the cessation of clozapine the more likely explanation is that it was due to his unwillingness to take the substituted anti-psychotic medication.

In December 2011, when Anthony's mother noticed adverse changes in him, it coincided with the change in his regular medication, causing her to question the cessation of clozapine. Anthony's mental state worsened and in late December 2011 he was admitted twice to Fremantle Hospital and treated for alcohol withdrawal/dependence following deranged liver function tests. Anthony was discharged on 23 December 2011 but failed to attend his outpatient review on 28 December 2011.[197]

Anthony also missed a number of his other psychiatric outpatient appointments at Alma Street Centre, and on occasion clinicians attempted to gather information regarding his health from Dr Babich and his mother.[198]

In addition, every two or three weeks from December 2011 onwards, there were conversations between Dr Babich and the clinicians at Alma Street Centre. Dr Babich considered that anxiety was a major factor in Anthony's presentations and he believed that Anthony's anti-psychotic medication should have been ceased altogether. In contrast, Anthony's

[197] Exhibit 3.1, Tab 16
[198] Exhibit 3.3, Tab 10

psychiatric treating team considered it important for him to be on anti-psychotic medication.[199]

When Anthony was reviewed by Alma Street Centre psychiatry registrar, Dr Deepak Davis twice in February 2012, it was apparent that he was not taking his olanzapine. Anthony agreed to trial another anti-psychotic medication (risperidone) and he was referred to occupational therapy, which he commenced in late February 2012.[200]

It is likely that Anthony also commenced taking his risperidone in late February 2012.[201] However, in March 2012, Anthony's mental state took a turn for the worse.

Events leading to Anthony's death

On 11 March 2012 Anthony presented to Alma Street Centre Triage. He had used an illicit drug, namely amphetamine, and was experiencing an adverse reaction. He was assessed, given an anti-psychotic medication and advised to return the following day for further review.[202]

On the following day, 12 March 2012, when Anthony was contacted by telephone by an Alma Street Centre staff member, he reported an improvement and denied any risk

[199] Exhibit 3.3, Tab 1O; T 367 – 371; T 439; T 523 – 524;
[200] Exhibit 3.3, Tab 1P and 1Q
[201] Exhibit 3.3, Tab 1Q
[202] Exhibit 3.1, Tab 16; Exhibit 3.2, Tab 3A

of self-harm. He had an outpatient appointment scheduled for the following day and was reminded to attend.[203]

Shortly thereafter however, Andrew experienced a crisis. On 13 March 2012 at about 3.30am Anthony attended the Fremantle Hospital ED claiming his drink had been spiked with amphetamine the previous day, and presenting as unable to walk. His mother accompanied him. Anthony was assessed by the medical intern on duty. He was agitated and his symptoms were similar to what he had previously experienced with the onset of psychosis. Taking account of the fact that Anthony had an appointment to attend at Alma Street Centre later that day, the clinician discharged him and he went home shortly before 6.00am that same morning.[204]

Anthony was still at crisis point. Later that same day, at approximately 5.30pm on 13 March 2012, Anthony presented at Alma Street Centre Triage accompanied by his father, and he was assessed by the psychiatry registrar. Anthony's father reported that his son had been paranoid over the previous few days. Anthony was agitated and did not engage with the clinician. He oscillated between claiming his drink had been spiked the previous day, and conceding that he knowingly took the amphetamine himself. The clinician took a history and Anthony was offered

[203] Exhibit 3.1, Tab 16; Exhibit 3.2, Tab 3A
[204] Exhibit 3.3, Tab 1A

admission. However Anthony declined and left with his father.[205]

Later that same evening the psychiatry registrar reviewed Anthony's medical records and she noted his long history of schizophrenia with previous non-fatal attempts on his life. She also noted that he had been non-compliant with his anti-psychotic medication since December 2011, that he was erratic with his outpatient appointments and that he had missed an appointment earlier that day. She telephoned the consultant psychiatrist for advice and it was agreed that Anthony required admission as an involuntary patient. The psychiatry registrar took the necessary steps to arrange this and at approximately 7.45pm Anthony returned, with his father, to Alma Street Centre Triage. There he was referred for examination by a psychiatrist and admitted under the care of consultant psychiatrist Dr Kataria to await his review. Anthony was initially placed on 15 minute visual observations. He appeared guarded and for this reason his level of risk was difficult to assess.[206]

The next day, on 14 March 2012, Anthony was reviewed by another psychiatry registrar and then the consultant psychiatrist, Dr Kataria examined him. Dr Kataria formed the view that Andrew was suffering from a relapse of psychosis due to illicit drug use and non-compliance with his medication. Dr Kataria decided that Andrew required

[205] Exhibit 3.1, Tabs 2, 16 and 18; Exhibit 3.2,Tab 3E
[206] Exhibit 3.2, Tabs 3F, 3N and 3O; T 399

admission and detention as an involuntary patient under the *Mental Health Act* 1996, and he completed the procedures to effectuate this. Anthony's detention was scheduled to end on 11 April 2012.[207]

Anthony was detained in the locked ward at Alma Street Centre and he was commenced on the anti-psychotic medication risperidone. He was granted escorted ground access to be undertaken at the nurse's discretion. This allowed Anthony to briefly go out to the courtyard, under the supervision of Anthony's mental health nurse, as part of a process to assist his transition back into the community. A client management plan was prepared for Anthony. His mental state was required to be regularly assessed, any significant changes were to be reported, and the aim was to ensure he complied with his medication. He was continued on 15 minute observations. Despite the clinicians' attempts Anthony did not engage with them. He made it clear at that stage that he did not want his condition discussed with his father.[208]

The next day, on 15 March 2012, Dr Kataria reviewed Anthony, who continued to be difficult to engage with. The notes disclose that Anthony described himself as feeling "*irritable/frustrated due to his inpatient stay*". However, Anthony's mental state examination reflected that he was much improved. He did not show any signs of

[207] Exhibit 3.2, Tabs 3D, 3F and 3O; T 419
[208] Exhibit 3.2, Tabs 3G and 3H,

hallucinations, or paranoid thinking and did not have suicidal ideation. This matched his objective presentation.[209]

As Anthony had used his escorted ground access without incident and was taking his medications, he was granted unescorted ground access. His first unescorted ground access went well, but during his second unescorted ground access, at approximately 4.00pm on 15 March 2012 Anthony left the grounds without permission. Efforts were made to locate him and with the assistance of his parents, Anthony voluntarily returned to the locked ward about one and a half hours later, claiming he believed the doctor had said he could leave the ward.[210]

On the night of 15 March 2012, Dr Kataria was unexpectedly injured and required leave. Consequently, Dr Kataria conducted verbal handovers to consultant psychiatrist Dr Kartikey Argawal and to psychiatry registrar Dr Deepak Davis (he was not a trainee). Dr Argawal was assisted by the fact that he had previously treated Anthony in outpatient clinics. Accordingly, between 15 and 19 March 2012, Anthony was under the care of Dr Argawal, assisted by Dr Davis.[211]

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[209] Exhibit 3.1, Tab 2I; Exhibit 3.2, Tab 3H;
[210] Exhibit 3.2, Tab 3I
[211] T 420; T 489

On 16 March 2012 Anthony was comprehensively reviewed by Dr Davis, who formed the view that whilst he was suffering a relapse of his psychosis, he was also showing signs of improvement. At this stage, Anthony was keen to go home and his family had also expressed a desire to take him home.[212]

A family meeting that had been scheduled for later that day duly took place at Alma Street Centre commencing at approximately 11.00am on 16 March 2012, and lasting 35 to 40 minutes. The meeting was attended by Dr Davis, a nurse, an intern, Mr and Mrs Edwards and, for the first half of the meeting, Anthony. Clearly it would have been preferable for Dr Kataria to be present, but this was not possible due to his unexpected leave. Dr Kataria instructed Dr Davis to attend in his place, taking into account his earlier review of Anthony and the establishment of a positive rapport.[213]

The purpose of the meeting was for the clinicians to hear the family's concerns and discuss what was to happen with Anthony's treatment and care. His family reported that this particular episode resulting in his detention was "*relatively mild in comparison to others*". His father voiced concerns regarding Anthony being over medicated and asked that consideration be given to non-pharmacological

[212] Exhibit 3.1, Tab 20; T 447; T 508; T 528
[213] T 507 - 508

interventions. His mother was agreeable to low-dose medication as per the proposed regime.

Anthony acknowledged his susceptibility to psychotic symptoms following amphetamine use and expressed a willingness to continue engaging in occupational therapy. Both parents were concerned about Anthony's frustration and anger about being in hospital. The clinicians considered that Anthony was difficult to engage. In their view although his insight and judgement appeared improved, he still required hospitalisation. At the conclusion of the meeting, it was decided to continue Anthony's medications and his unescorted ground access, with a view to discharge the following week.[214] Anthony therefore remained at Alma Street Centre, as an involuntary patient.

Records disclose that as at 18 March 2012 Anthony was still not engaging with staff members but he was utilising his unescorted ground access appropriately. He was due to be discharged the next day.[215]

On the morning of 19 March 2012 Anthony was reviewed again by Dr Davis. The clinician found no evidence of self-harming behaviour, aggression or paranoia. Anthony indicated he would comply with his medications as prescribed. Dr Davis considered Anthony was not at acute

[214] Exhibit 3.2, Tab 3J and 3K; T 516; T 528
[215] Exhibit 3.2, Tab 3L

risk, and that he did not display any signs of psychosis. His recorded impression was one of resolved drug induced psychosis and associated cluster B personality traits. Dr Davis contacted Anthony's father to advise him of his current discharge plan, medications and outpatient follow-up plan.[216]

Consultant psychiatrist Dr Agarwal, who was covering for Dr Kataria, then reviewed Anthony, with Dr Davis. In Dr Agarwal's opinion, Anthony had improved significantly in the context of the current psychotic episode and there was no evidence of any mood disorder. They discussed support measures. The mental state examination did not disclose imminent risks. Consequently on 19 March 2012, Dr Argawal completed the necessary paperwork and authorised Anthony's discharge, thereby releasing him from his detention as an involuntary patient.[217]

This had the effect of Anthony being discharged directly into the community, from the locked ward. Anthony contacted his parents and his sister arrived to collect him at approximately 10.30 am on 19 March 2012.[218]

As part of his discharge plan, Anthony was scheduled to be reviewed by Dr Davis within seven days of discharge. This was consistent with the policy that was then in place at

[216] Exhibit 3.1, Tab 2; T 529
[217] Exhibit 3.2, Tabs 3L, 3M and 3O; T 530
[218] Exhibit 3.1, Tab 2; Exhibit 3.2, Tab 3M

Alma Street Centre. The occupational therapist was also going to follow him up, though no time frame was specified. It was anticipated that in the usual course his case manager would also follow him up, though no procedure for this was documented.[219]

Little is known of what happened to Anthony within the next 24 hours, but tragically, at approximately 10.00am on 20 March 2012 Anthony went to an apartment building where, on his own, he consumed some alcohol and then jumped from a significant height at the rear of the building to the ground below.[220]

Shortly before he jumped to his death, Anthony had sent a text message that reflected upon his intention to take his life. CCTV footage confirms Anthony's intention to take his life.[221]

Shortly thereafter a witness observed Anthony lying on the ground and an ambulance was called for. When the St John Ambulance paramedics attended, they confirmed that Anthony had died.[222]

[219] Exhibit 3.2, Tab 3L; T 421; T 460; T 472
[220] Exhibit 3.1, Tabs 2 and 7; Exhibit 3.2, Tab 4
[221] Exhibit 3.1, Tabs 2 and 7
[222] Exhibit 3.1, Tabs 2 and 8

Cause and manner of death of Anthony Ian Edwards

On 22 March 2012 Chief Forensic Pathologist Dr C. T. Cooke made a post mortem examination of Anthony at the State Mortuary. The examination reflected that Anthony had fallen to his death. The examination showed severe injuries with fractures and lacerations. Toxicological analysis revealed a therapeutic levels of analgesics and an anti-anxiolytic, a sub therapeutic level of a sleeping tablet, and a blood alcohol level of 0.05%. No illicit drugs were detected. On 22 March 2012 the Chief Forensic Pathologist formed the opinion that the cause of death was multiple injuries.[223]

Police investigated and found no involvement of another person in Anthony's death.

I find that Anthony undertook the actions by which he jumped to his death with the intention of taking his life, and that as a result, he died on 20 March 2012.

The cause of Anthony's death is multiple injuries.

The manner of Anthony's death is suicide.

[223] Exhibit 3.1, Tabs 10 and 11

Anthony's care from Alma Street Centre

Chief Psychiatrist Dr Gibson reviewed Anthony's care from Alma Street Centre. He provided a written report[224] and gave evidence at the inquest.

Anthony's parents expressed concern about his treatment and care by Alma Street Centre, in particular his medication regime, his discharge and the lack of communication with them.

The records disclosed varying opinions concerning Anthony's diagnosis on his last admission. The differences centred on whether Anthony suffered a relapse of his schizophrenia or whether he had experienced a drug induced psychosis. Concerns were expressed that a misdiagnosis may have compromised his medical treatment. Dr Gibson opined that he would not ordinarily give a diagnosis of drug induced psychosis to someone like Anthony who had a persistent history of schizophrenia: "*....what you would be looking at is a relapse of schizophrenia rather than a new secondary diagnosis of drug induced psychosis*".[225]

Fremantle Hospital, through its lawyers submits to me that on all of the evidence, Anthony's diagnosis was of

[224] Exhibit 9, Tab 3
[225] T 1000 - 1001

schizophrenia, complicated by possible substance abuse and anxiety.[226]

I accept Dr Gibson's evidence that the differences in diagnoses did not make a substantive difference because Alma Street Centre's clinicians were as rigorous in treating the psychosis as they would do for schizophrenia.[227]

In Dr Gibson's view, the primary factor for Anthony's relapse of his schizophrenia appears to have been the use of amphetamines, without the potentially protective effect of regular anti-psychotic medication.[228]

Dr Gibson described clozapine as the "*gold standard*" in anti-psychotic agents. Whilst this medication had been very useful for Anthony, Dr Gibson also noted that its cessation as a result of the serious side effects raised a significant challenge for his treating team to identify an alternative treatment with equivalent effectiveness.[229]

Continuation of clozapine in Anthony's circumstances risked exposing him to a fatal infection (due to his adverse reaction). The fact that he appeared to "*brighten up*" after it was ceased would not have been unusual. It did not indicate that anti-psychotic medication was inappropriate for him. The substituted medications, olanzapine and then

[226] T 369; T 395; T 403; T 480
[227] T 1000
[228] Exhibit 9, Tab 3
[229] Exhibit 9, Tab 3

risperidone are commonly used anti-psychotics.[230] There is no evidence that the risperidone precipitated Anthony's actions on 20 March 2012. It is unfortunate that Anthony was not always compliant with his medications.

It is likely that Anthony had a relapse of his schizophrenia precipitated by amphetamine use, and that his condition was further complicated by his non-compliance with prescribed anti-psychotic medication after the cessation of his clozapine. The cessation of his clozapine was appropriate in the circumstances. The substitution with olanzapine and then risperidone were also appropriate.

In exploring Anthony's discharge on 19 March 2012, I heard evidence concerning the follow-up that was arranged for him. On 19 March 2012, rather than being transitioned through an open ward, Anthony was discharged directly from the locked ward into the community. This is not uncommon. At the material time the clinicians turned their minds to the question of whether to move Anthony to an open ward as part of his transition from his involuntary patient status back into the community. Taking account of the improvement in Anthony's mental state and the fact that he was unhappy being on the ward, preferring instead to be at home, the clinicians decided it was appropriate for Anthony to be discharged straight home. There were no grounds for keeping him as an involuntary patient at this

[230] T 368; T 384; T 400 – 401; T 424 – 426; T 439 – 440; T 458; T484 – 487; T 499; T 1023 - 1024

point in his treatment. In Dr Gibson's experience, and regrettably so despite attempts to prevent this, some patients such as Anthony are at risk of drug use on an open ward, which can precipitate a relapse, as well as other problems for other patients and staff on the ward.[231]

I accept Dr Gibson's evidence and the submissions before me to the effect that there were proper grounds for Anthony to have been discharged on 19 March 2012.[232] There was no basis for continuing his detention as an involuntary patient under the *Mental Health Act* 1996. A further stay in the open ward may have been counterproductive and could not have been enforced in any event.

However, the follow-up period of seven days after Anthony's discharge is a matter of concern. At the time Anthony was discharged, it was a requirement at Alma Street Centre for there to be a patient review by the registrar within seven days of any inpatient discharge.[233] This did not preclude an earlier follow-up if the circumstances warranted it. No distinction was drawn between involuntary patients being discharged directly into the community, and voluntary patients.

Although seven days is considered the national benchmark for follow up in the community, this does not necessarily

[231] T 422; T 444; T 1003 - 1004
[232] T 1003-1004
[233] Ex 8, Tab 1.1

require face-to-face contact. It could be satisfied by making a telephone call. Anthony's medical notes do not provide specific guidance for clinicians on this point.[234]

Follow up requirements are best considered on a case by case basis. Dr Gibson opined that given Anthony's history, the planned follow up time of one week would ordinarily have been "*inappropriately long in a case with equivalent features*". In his view, follow up contact within 24 hours by Alma Street Centre clinical staff would have been more appropriate. In evidence Dr Gibson pointed to factors that were reasonable guides to drive the earlier follow up, being Anthony's mental state, the earliness of his change to risperidone, the fact that he was not necessarily stable on it and the fact that he was difficult to engage.[235]

At the material time, Alma Street Centre's clinicians did not consider that there were grounds to shorten the usual follow up of one week. Fremantle Hospital through its lawyers submits that it would have been extremely difficult to have an appointment with a doctor within 24 hours of discharge, particularly Dr Davis who was then covering two jobs. They also draw my attention to Dr Gibson's belief, expressed in his report, that given Anthony's history, sadly this would not have changed the outcome in this case.[236]

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[234] Ex 3.2, Tab 3L; T 1008
[235] Exhibit 9, Tab 3
[236] Exhibit 9, Tab 3

It is not necessary for me to positively find that the 24 hour follow-up would have changed the outcome, in order to comment upon the seven day follow-up plan. The 24 follow-up may occur by telephone call, if that is appropriate to the circumstances.

I accept Dr Gibson's evidence to the effect it is well known that patients will often encounter higher risk in the first 24 hours after a point of transit, such as discharge from hospital.[237] Dr Gibson in his role as Chief Psychiatrist is supportive of more assertive follow-up and he described it as follows:

> *"Seven days is, if you like, a national benchmark on follow up in the community. By follow-up contact, I mean at least a telephone call. It doesn't – that may not have necessarily meant a face to face. But given that, as – as mentioned earlier, that discharge points are an increased risk point, I think the idea that if someone is needing close follow up then, really, there should be quite assertive initial follow up. Not – again, not necessarily face to face, but – but early on. Because, really, the first two to three days are the risk period post – post discharge. And therefore, you know, within 24 hours is not – not unreasonable to – to expect, I think, a call. Is that common practice? It's not necessarily common practice at the moment and I think it's something that we are seeking to embed in – in services, particularly in the context of the shift to acute assessment teams rather than just generic community teams. So the idea that an acute assessment team is designed around prompt, proactive follow up rather than a community team, which may be having to deal with people coming out of hospital, people going into hospital, people with long-term illness in the community and having to juggle all of those. So that's one strategy that has been used, I think, to try and improve the post-hospital engagement."*[238]

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[237] T 989
[238] T 1008

Although I have no criticism of the decision to discharge Anthony, there were aspects of his discharge planning, particularly in the area of follow-up that could have been improved upon.

Since late 2014, Alma Street Centre to its credit has been requiring follow-up within 24 hours after discharge and they have been auditing compliance. The 24 hour follow-up is to be made a requirement in the next revision of the inpatient admission to discharge guidelines and responsibilities.[239]

No adequate communication with Anthony's family regarding Anthony's post-discharge care

I accept Fremantle Hospital's submission through its lawyers that the clinicians did communicate with Anthony's family at various time over the years, including in relation to dealing with Anthony and facilitating his attendance at appointments. Relevant information was imparted to Anthony's parents at the family meeting on 16 March 2012.[240]

However Mr Edwards was not told what Anthony's risks might be when he was discharged, or what effects his recently prescribed medication may have.[241] Although Mr Edwards believed the family meeting process gave him and his family the opportunity to have some input into their

[239] Exhibit 8, Tab 1.1 and 1.1A; T 1172 - 1173
[240] Exhibit 3.3, Tab F
[241] T 337

son's care, his evidence was that he was left in no better position to understand what might be expected for Anthony after he was discharged. Anthony's discharge planning was not discussed at that meeting, or at any stage prior to his discharge.[242] It is to be borne in mind that Anthony had been diagnosed with a severe mental illness of a long standing duration and that a relapse placed him at risk. Those closest to Anthony ought to have been provided with some understanding of factors that might trigger or indicate a relapse. For these reasons the communication with Anthony's family in connection with his care post-discharge was not adequate.

In formulating my recommendation concerning Carer's Plans (addressed below) I considered how such a plan might have assisted Mr and Mrs Edwards. It would undoubtedly have been helpful for them to have been provided with some clear written information upon Anthony's discharge. Such information could usefully have included Anthony's diagnosis, the reason for him being in hospital, what the hospital wanted to achieve from his admission, what his medication was and what its side effects were, the warning signs that may indicate that Anthony is deteriorating, and what to do if they needed help with Anthony (including after-hours). It could also have usefully included a relapse prevention plan.[243] However, this was not part of Alma

[242] T 339-340; T 353
[243] T 512-513; T 1132

Street Centre's procedures at the material time, nor is it standard practice generally.

Adverse findings in relation to Anthony's care

I am satisfied that on or about 19 March 2012 Alma Street Centre did not have policies and procedures, of a sufficient standard or quality, to provide for the assertive follow-up of involuntary patients being discharged directly into the community.

STEPHEN COLIN ROBSON

Stephen's background

Stephen was born in Oakland New Zealand. He moved to Australia with his family as a teenager and studied at a high school in Perth. In 1985, he was accepted into the University of Western Australia into the arts faculty. He later transferred to Murdoch University to study commerce, and he worked part time.

In 1988, at the age of 24, Stephen left university and started working as a porter in a hotel, but resigned when his shift was changed to require night work. At around this time he moved in with his mother, who supported him.

Stephen remained a single man with no children. By the time of his death at the age of 47 years he had an extensive history of mental health problems including personality disorder, depression, anxiety, benzodiazepine dependence and alcohol abuse. Over a number of years Stephen had sought treatment for his mental health problems, but from time to time he would also disengage with the mental health services.

Stephen had been under the care of Alma Street Centre on a number of occasions during 2007. On two occasions in 2011 he presented to Fremantle Hospital ED with suspected drug overdoses and he received treatment.[244]

In the latter part of 2011 when his mother moved into a nursing home, Stephen struggled to adjust to living by himself and his mental state deteriorated. He became highly anxious, abusing alcohol and taking excessive quantities of other medications, primarily anti-anxiolytics. On 16 November 2011 he self-presented to the ED of Sir Charles Gairdner Hospital, reporting anxiety and a depressed mood. He was admitted as a voluntary patient to the psychiatric unit of the hospital for just over two weeks, with follow-up by the alcohol and drug information service.[245]

[244] Exhibit 2.2, Tab 2O, 2P, 2Q and 2S
[245] Exhibit 2.2, Tab 2S

After some further contact with Fremantle Hospital's services in early 2012, Stephen's mental state took a turn for the worse. On 23 January 2012 Stephen experienced a situational crisis and took an overdose of an antidepressant. Between 24 and 27 January 2012 he was admitted as a voluntary patient at Alma Street Centre under the care of Dr Argawal. The provisional diagnosis was one of dysthymia, possible major depressive disorder and cluster B and C personality traits.[246]

Two days after discharge, namely on 29 January 2012 Stephen self-presented to Alma Street Centre Triage requesting admission, citing an inability to cope at home. The clinicians found no indicators for admission and accordingly he was sent home, with arrangements made for him to be followed up by CERT clinicians. However, the next day, on 30 January 2012 Stephen again self-presented to Fremantle Hospital ED after a suspected overdose. He was treated and then referred to Hampton Road Service, for further management of his depression, and his dependence on alcohol and prescribed sedatives.[247]

Between 3 and 6 February 2012 Stephen was admitted to Alma Street Centre from the ED of Fremantle Hospital after he refused to return to Hampton Road Service. He was requesting sedation and he had consumed excessive amounts of alcohol. He was under the care of Dr Argawal

[246] Exhibit 2.1 Tab 29; Exhibit 2.2, Tabs 2, 2AB-AC, 2B, 2N, 2ZZ
[247] Exhibit 2.2, Tabs 2C and 2K

and he denied self-harm ideation. He was treated and upon improvement, he was discharged back to Hampton Road Service where he remained for just under two weeks, whilst staff there attempted to assist him with his accommodation, his alcohol abuse and psychological problems.[248]

Between 17 and 23 February 2012 Stephen received treatment through the ED of Fremantle Hospital, where he would self-present, and through CERT clinicians.[249]

By this stage, Stephen's contact with Fremantle Hospital and Alma Street Centre had escalated, a clear reflection of his unstable mental state.

Events leading to Stephen's death

During the last month of his life, Stephen was a patient at Alma Street Centre. He was initially admitted to the psychiatric ward as a voluntary patient on 25 February 2012, under the care of consultant psychiatrist Dr Agarwal, after again self-presenting to the ED of Fremantle Hospital (twice on that date) physically unwell and also indicating that he would self-harm if he was not admitted to hospital.[250]

[248] Exhibit 2.1, Tab 29; Exhibit 2.2, Tabs 2, 2A, 2I, 2VV, 2WW, 2YY, 2ZZ
[249] Exhibit 2.2, Tabs 2C – 2G, 2OO – 2SS
[250] Exhibit 2.1, Tab 2; Exhibit 2.2, Tabs 2L, 2U – 2Z

Dr Agarwal assessed Stephen and determined that he was suffering from an alcohol induced mood disorder with alcohol dependence and abuse of his prescribed sedatives. The differential diagnosis was of possible depression, superimposed on dysthymia. The management plan was to encourage Stephen to attend group sessions with the occupational therapist, to monitor him for alcohol withdrawal and observe his sleeping patterns. His medications were reviewed. The option of treatment by electroconvulsive therapy (ECT) was initially considered to be premature given Stephen's history of rapid improvement after his previous admissions.[251]

I accept Fremantle Hospital's submission, through its lawyers, that Stephen had medical reviews or team discussions about his case on at least 13 occasions between 27 February and 28 March 2012. Stephen was treated by a combination of medication to treat his depression, group therapy and interventions to reduce his alcohol dependence. A case manager assisted him with plans for accommodation and with his financial concerns. However, unlike on previous occasions, Stephen did not commence to improve following this final admission. He reported being more depressed than ever before.

Stephen appeared to have become treatment resistant and towards the middle of March 2012, given the severity of his

[251] Exhibit 2.2, Tab 2BB

condition, the option of ECT was reconsidered by Dr Argawal and discussed with him. Stephen was amenable to the ECT, requesting it himself at one point. A second opinion was sought from consultant psychiatrist Dr Kataria, who recommended some further treatment options and agreed that ECT ought to be considered if those other options failed.[252]

Medical consultations regarding the administration of ECT continued and Stephen received his first ECT treatment on 23 March 2012. At this stage, Stephen was still a voluntary patient and he had consented to it. He recovered well and in good time. His medical records disclose that it was considered to be an "*excellent result*". Chief Psychiatrist Dr Gibson reviewed Stephen's treatment and care and he opined that Stephen's ECT treatment was an indicated therapy and that it was a reasonable and appropriate strategy at the time.[253]

Up until this time, Stephen had denied any acute risk of self-harm or suicidal intent and there was nothing that indicated to the clinicians that Stephen might try and harm himself. Accordingly the day after his first ECT treatment, namely on 24 March 2012, at his request Stephen was granted a period of six hours' leave from Alma Street Centre. It was understood he wished to go and see his mother. However Stephen went to his home, consumed alcohol and

[252] Exhibit 2.2, Tab 2AA – 2DD and Tab 2LL
[253] Exhibit 2.2, Tab 2 DD; Exhibit 9, Tab 2

shortly before he was due to return to the ward, he was observed by his neighbours to attempt an apparent act of self-harm whilst on his balcony. They called for an ambulance, paramedics arrived and Stephen was conveyed to the ED of Fremantle Hospital. He was not seriously injured. After he was medically cleared he was returned to the open ward at Alma Street Centre, where he was placed on 15 minute observations. Despite Stephen continuing to deny having thoughts of self-harm or suicide, his risk of such was now clearly elevated.[254]

Whilst Stephen was assessed by an ED consultant on 24 March 2012, he was not assessed by a psychiatry registrar or consultant psychiatrist until 26 March 2012. Upon his review, Dr Gibson was concerned to find that there was no formal risk assessment undertaken on 24 March 2012 following what he described as a "*significant suicide attempt*".[255]

On 26 March 2012 Stephen was reviewed by consultant psychiatrist Dr Argawal and psychiatry registrar Dr Singh. The clinicians considered whether the incident on the balcony was more likely an attempt at self-harm rather than an attempt by Stephen to take his life, given the public nature of his actions. Nevertheless, it was, as is appropriate, treated seriously.[256]

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[254] Exhibit 2.2, Tab 2, Tabs 2EE, 2MM and 2T; T 258
[255] Exhibit 9, Tab 2
[256] Exhibit 2.2, Tabs 2EE and 2FF; T 262 – 263; T 900 - 905

At around this time Stephen became anxious about his ECT treatment. Inquiries reflected that it was most likely due to the fact that in order to undergo the treatment he was required to cease his sedative medication, as it was contra indicated. On 26 March 2012, on the second occasion when Stephen was due to be administered ECT, the clinicians suspected that he had intentionally taken fluids to circumvent the treatment. Stephen continued to state that his mood was very low and verbalised self-harm ideation. He started to display some troubling thought patterns. In view of concerns for his safety, pursuant to the *Mental Health Act* 1996 Dr Singh referred Stephen for examination by a psychiatrist, and he completed the necessary paperwork. Accordingly, on the night of 26 March 2012, Stephen was transferred to Alma Street Centre's locked ward to await his examination by a psychiatrist.[257]

The next morning, on 27 March 2012, Dr Argawal examined Stephen. As a consequence, at 10.30am on that date Dr Argawal made an involuntary patient order under the *Mental Health Act* 1996 that resulted in Stephen's detention. The order was based upon Stephen being an acute suicidal risk in the context of active suicidal intent and planning, and recent history of hanging attempt. Pursuant to Dr Argawal's order, Stephen's detention would have ended

[257] Exhibit 2.2, Tabs 2FF and 2AG; *Mental Health Act* 1996, section 29, Form 1

on 24 April 2012. Dr Singh was also present during this assessment and he recorded the notes. Those notes reflect that Stephen requested escorted ground access (EGA) and represented that he could guarantee his safety while on EGA. Stephen's treating team approved EGA for him, and it was to be arranged at the nurses' discretion. It is documented by Dr Singh in Stephen's medical notes as "*EGAs @ NS discretion*".[258]

Given that Stephen later absconded whilst on EGA on 28 March 2012 and died shortly afterwards I explored the manner which his EGA was granted and arranged, and the processes in place at Alma Street Centre to prevent Stephen from absconding, or to locate him once he had absconded.

Dr Singh's evidence was that the grant of EGA at the discretion of nursing staff enables them to be flexible in reducing, increasing, or cancelling the leave and that it was a joint decision made by Stephen's treating team.[259] That included Dr Singh, and also Dr Argawal, who was the senior member of that team.

Dr Gibson, on his review, opines that the process of making Stephen an involuntary patient can reasonably be seen to reflect the significant concern that the treating team had regarding his risk at the material time. The grant of Stephen's EGA is to be assessed in the context of his status

[258] Exhibit 2.2, Tabs 2FF and 2AG; *Mental Health Act* 1996, section 43(2)(a), Form 6
[259] T 297- 300

as an involuntary patient. Dr Gibson commented on the function of EGA (and unescorted ground access (UGA)) describing these as important and common therapeutic processes at authorised hospitals. He explained their function as "*stepwise strategies to transition to community care and as a way to provide opportunities for less restrictive care in accordance with the tenets of the Mental Health Act 1996.*" The regimen during EGA (or UGA) is dependent upon the needs of the individual patient, their risk and the physical layout and environs of the authorised hospital.[260]

In Dr Gibson's experience, granting escorted ground access "*at nurses' discretion*" is common in the context of documentation for medical records. However he noted that the documentation remained unclear because the phrase may refer to nursing availability to escort, or it may refer to changes in the patient's mental state, requiring reconsideration of EGA. These are quite different issues and he proffered the view that the documentation provides little guidance for nursing staff. It could be interpreted as requiring the nurse to consider if it was clinically appropriate to take the patient out at that particular time.[261]

In Dr Gibson's experience nursing staff decline to conduct EGA if they are concerned about particular risk issues that have escalated in the time since the doctor has seen the patient. However, allowing EGA at the nursing staffs'

[260] Exhibit 9, Tab 2
[261] Exhibit 9, Tab 2; T 1032

discretion does not particularly give guidance to the nursing staff as to how to manage that.[262]

At the material time Alma Street Centre had in place the "*Missing Inpatients*" policy, also referred to as the "AWOL" policy. This policy indicated that the amount of protection and care that was to be provided must be assessed on clinical grounds by the medical registrar/registrar on call and documented in the patient's integrated patient notes.[263] Further, the "*Escorted Leave From Hospital for Involuntary Mental Health Patients*" policy required that an appropriate risk management plan be documented in the patient's health record before escorted leave was granted.[264]

Dr Gibson opined that on balance it was reasonable for Stephen, as an involuntary patient, to have escorted ground access on the morning of 28 March 2012.[265] The terms of the escorted ground access were not sufficiently clear. It is desirable to aim for clarity, in order to avoid the risk of the misunderstandings alluded to by Dr Gibson. Fremantle Hospital through its lawyers accepts that the direction could have been more detailed, but submits that if the EGA does not need to be conditional, such detail would not have assisted on this occasion.

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[262] T 1032
[263] Exhibit 8, Tab 6.6
[264] Exhibit 8, Tab 6.5
[265] Exhibit 9, Tab 2

Shortly before his EGA on the morning of 28 March 2012 at approximately 9.00am Stephen received his second scheduled ECT treatment. I explored the likely effects of Stephen's ECT on his cognition on that morning in order to address all of the circumstances attending his death, and specifically his intentions surrounding his actions when he absconded.

Dr Argawal recommended the ECT and had sought and obtained Stephen's consent to ECT after he was made an involuntary patient. In accordance with section 104 of the *Mental Health Act* 1996, a second opinion was sought from Dr Kataria, who approved Dr Argawal's recommendation for the ECT.[266]

After the administration of his ECT, Stephen was in the recovery suite until he was moved back to locked ward 4.1 by Nurse John Morgan at approximately 9.35am. The medical records disclose that the clinicians considered Stephen recovered well from his ECT treatment. Although it was not part of his function that day, Dr Singh went and saw Stephen on locked ward 4.1 shortly after his return from his ECT treatment. By reference to those observations Dr Singh formed the view that Stephen was awake and alert and his recovery was within range. This was supported by Dr Singh's subsequent review of the medical records. There is no evidence of Stephen having been grossly confused after

[266] Exhibit 2.2, Tabs 2MM and 2NN

his treatment. The ECT dose was not a high dose; it was described by Dr Singh as probably 15% to 20% of a full dose.[267]

In Dr Gibson's experience, from a cognitive perspective, the recovery from any anaesthetic and any seizure (thus ECT) will be incremental. The Chief Psychiatrist's Guidelines for the Use of Electroconvulsive Therapy in Western Australia 2006 state that the patient must be accompanied when leaving the ward for 24 hours post-treatment, and this refers primarily to the physical recovery issues. There is no routine cognitive assessment following ECT recovery, because the recovery period is different for each individual.[268]

The evidence from the treating psychiatrists at the inquest was to the effect that ECT does have side effects which include short term memory loss, but such side effects would not be expected before 10 to 12 ECT treatments. Any confusion after the anaesthesia typically lasts for about 10 to 15 minutes.[269] On the morning of 28 March 2012, when Nurse Morgan took him back to locked ward 4.1, Stephen requested EGA because he wanted to smoke a cigarette. Upon inquiry Nurse Morgan ascertained that Stephen felt certain in himself and that he could guarantee his security. The door to locked ward 4.1 was a secure door

[267] Exhibit 2.2, Tabs 2MM and 2NN; T 303 - 310
[268] Exhibit 9, Tabs 2 and 2.1
[269] T 251; T 901; T 907

requiring security pass access. At the material time, in order to smoke, involuntary patients who had been granted escorted ground access had to be escorted from locked ward 4.1 into the court yard of Alma Street Centre. Once taken there, the rule was that Stephen was to be observed by his escorting nurse at all times. The court yard was not a secure area. It faced onto sliding doors (the Triage doors) going out towards the outpatient area and onto the road.[270]

The previous day, namely 27 March 2012, Nurse Morgan had escorted Stephen on his ground access on three occasions without incident. As Stephen appeared bright and reactive, and given that his EGA was granted "*at nurses' discretion*", at approximately 9.40am on 28 March 2012, Nurse Morgan decided to escort Stephen to the court yard so he could smoke a cigarette.[271]

In the context of Stephen's circumstances, and the procedures then in place at Alma Street Clinic, I am satisfied that it was reasonable for his treating team to grant him EGA at the nurses' discretion (though it could have been worded with more clarity) and that it reasonable for Nurse Morgan to decide to afford Stephen that access by escorting him to Alma Street Centre's court yard on the morning of 28 March 2012.

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[270] Exhibit 2.1, Tabs 2 and 9; Exhibit 2.2 Tab 2JJ; T 286 - 289 and T 278; T 1033 and 1034
[271] Exhibit 2.1, Tabs 2 and 9; Exhibit 2.2, Tab 2JJ

Nurse Morgan did not smoke cigarettes and understandably, was not within arm's reach of Stephen, who was smoking and interacting with other patients. However, he positioned himself between Stephen and the unsecured Triage doors that led out of the building, meaning he was able to see Stephen quite clearly, and when necessary follow him, given the configuration of the court yard.

It was a busy area and a busy time of day. On an occasion, Nurse Morgan had to retrieve Stephen from the catering room just off the court yard. He encouraged Stephen to return to the court yard to ensure he was within sight. Nurse Morgan then continued to watch Stephen, who was sitting between three or four other patients, from a distance of approximately 20 metres. Not long after they both returned to the court yard, another patient approached Nurse Morgan to speak with him, resulting in him being momentarily distracted. Within this very short period, Stephen disappeared from view. In Nurse Morgan's words:

> *"as this other patient had been talking with me, I asked them if they wouldn't mind excusing me, but – I wasn't being rude, but I was on escorted ground access and I was observing a patient and so I couldn't interact with them at that time, and as I was saying those words, I looked up and Stephen had vanished from the courtyard."*[272]

It is common ground that Nurse Morgan would not have been expected to physically restrain Stephen from leaving

[272] T 279; T 291; Exhibit 2.1, Tab 2; Exhibit 2.2, Tab JJ

the court yard area. Alma Street Centre's arrangement for involuntary patients to smoke cigarettes on escorted ground access within the unsecured court yard was undesirable.

As it transpired, Stephen did not abscond through the Triage doors. CCTV footage has since shown that at 9.58am on 28 March 2012 Stephen entered the lift doors from the court yard area and travelled to the fifth floor where, less than one minute later, he seized the opportunity to walk out of Alma Street Centre through the entry/exit doors as a medical student entered using her access card, along with another. There was no security or swipe card access to enter the lifts (or the stairwell) to the fifth floor, from the court yard. The medical student on the fifth floor had not received any induction or training regarding patient security. There was nothing that she saw or could have seen that would have given her cause to believe that Stephen was an involuntary patient absconding from the hospital.[273]

Meanwhile as soon as Nurse Morgan lost sight of Stephen, he asked other staff members for assistance in locating him. The records disclose that Nurse Morgan commenced to look for Stephen in the court yard at approximately the same time as Stephen was exiting the building from the fifth floor exit doorway. Nurse Morgan did a quick sweep of the courtyard and then he ran to the locked ward to seek the

[273] Exhibit 2.1, Tabs 2 and 31; T 315 - 318

assistance of the ward coordinator. Together they conducted an immediate search of the Triage area, the front of W block, the car park, the court yard, the kitchenette and the open ward. They returned to the locked ward, and informed Dr Argawal, resulting in the Missing Persons procedure being initiated. Nurse Morgan called the police. All this occurred between approximately 10.05am–10.15am.[274]

At the material time, other than using the courtyard's wall mounted alarm (generally used for safety risks) there was no personal alarm available to Nurse Morgan or other staff on duty to alert staff members to a missing person. One of Nurse Morgan's options was to alert the staff member at the Triage entry door, who would then inform the ward manager, who would in turn implement the Missing In-patients procedure. Nurse Morgan's other option was to return to Stephen's locked ward and activate the Missing In-patients procedure himself, which is what he did.[275] In either case, a delay, even a small one, was inevitable.

When Stephen exited Alma Street Centre at approximately 10.00am, he went straight to the main road nearby. On at least two occasions he narrowly avoided being hit by oncoming vehicles after he appeared, to witnesses, to step into their pathways. Stephen then walked to the median strip and moments later he stepped into the path of a prime

[274] Exhibit 2.1, Tabs 2 and 9; Exhibit 2.2, Tabs 2JJ and 2X
[275] T 287 – 288; T 298

mover with a trailer attached. The driver endeavoured to take evasive action but tragically, Stephen was hit. The evidence of the driver and other witnesses who observed Stephen's behaviour whilst he was on the median strip and immediately afterwards, persuades me that Stephen's actions in stepping onto the road and into the path of the vehicle that hit him were deliberate. This occurred just after 10.00am, and whilst Alma Street Centre staff members were still looking for him at the hospital. The driver was driving within appropriate speed limits and his vehicle was found to have no defects.[276]

In the immediate aftermath, the driver and other persons close by rendered assistance to Stephen. An ambulance was called for, the paramedics promptly arrived and they commenced cardiopulmonary resuscitation. Stephen was immediately conveyed to the ED of Fremantle Hospital, where the trauma team, that had just been alerted, was waiting for him. Cardiopulmonary resuscitation continued at the ED, but Stephen was unable to be resuscitated and he was pronounced dead at 10.58am on 28 March 2012.[277]

Cause and manner of death of Stephen Colin Robson

On 30 March 2012 forensic pathologist Dr G. A. Cadden made a post mortem examination of Stephen at the State Mortuary. The examination showed that Stephen had

[276] Exhibit 2.1, Tabs 2, Tabs 12 – 16 and Tab 27
[277] Exhibit 2.1, Tabs 2 5 and 28; Exhibit 2.2, Tab 2A

severe chest injury with internal fracturing of the ribcage and bruising of the lungs. Bony pelvic injury and long bone injury was also evident. On that date the forensic pathologist formed the opinion that the cause of death was multiple injuries including serious chest injury.[278]

Subsequent toxicological analysis did not result in any change to the forensic pathologist's opinion on the cause of death. The analysis revealed therapeutic levels of prescribed anti-psychotic medication and anti-depressant medication. No alcohol or illicit drugs were detected.[279]

I find that on 28 March 2012 Stephen stepped into the pathway of an oncoming vehicle with the intention of taking his life, and that as a result, he died on that date.

The cause of Stephen's death is multiple injuries.

The manner of Stephen's death is suicide.

Comments on the quality of Stephen's supervision, treatment and care

As an involuntary patient within the meaning of the *Mental Health Act* 1996, Stephen was, immediately before death, a "*person held in care*" as described in section 3 of the

[278] Exhibit 2.1, Tab 6
[279] Exhibit 2.1, Tab 7

Coroners Act. Pursuant to section 22(1)(a) of the Coroners Act, an inquest into his death must be held.

Section 25(3) of the Coroners Act requires me to comment on the quality of the supervision, treatment and care of Stephen while in that care.

From 25 February 2012 until shortly after his attempted hanging on 24 March 2012, Stephen was a voluntary patient, and was therefore not a person held in care. Up until that time he had been cared for by several doctors, he had a clear management plan for his treatment and he also had a case manager to assist him with financial and accommodation issues. The approval of Stephen's leave for 24 March 2012 was appropriate having regard to the reasons provided by Stephen, the perceived therapeutic benefit, and his previous behaviour with grants of goal directed leave.[280]

On 26 March 2012, two days after his attempted hanging, Stephen was reviewed by the psychiatric team (they were not called in over the weekend to review him). I accept Dr Gibson's opinion that the two day wait was not acceptable practice and that psychiatric medical assessment and documentation was required on 24 March 2012, with notification of the team or duty consultant psychiatrist at a minimum. The failure to document a formal risk

[280] T 259 – 261; T 907

assessment on 24 March 2012 was not an acceptable standard of practice either.[281] Fremantle Hospital through its lawyers submits to me that, despite there being no completed brief risk assessment form, the doctors who conducted a mental state examination of Stephen were looking and thinking about the same risk factors in their comprehensive analysis of him (citing Dr Singh's evidence in support).[282] Certainly this ameliorated the situation. However it is clear that, having regard to the seriousness with which a hanging attempt ought to be treated, a documented risk assessment would have been appropriate.

As a consequence of Stephen's psychiatric review and having regard to his elevated risk, on 26 March 2012 he was, quite properly, made an involuntary patient and transferred to the locked ward. I accept Fremantle Hospital's submission, through its lawyers that Stephen was appropriately treated, having regard to the course of his depressive illness, through ECT, and that the evidence establishes that ECT is not associated with an increase in suicidal ideation.[283]

I accept that, given the information available to him, it was reasonable for Nurse Morgan to have made the decision (at his discretion) to afford Stephen his escorted ground access on the morning of 28 March 2012 after he had recovered

[281] Exhibit 9, Tab 2
[282] T 308
[283] T 901; T 1030; T 1047

from his ECT treatment. I am satisfied that in executing his functions during Stephen's escorted ground access, Nurse Morgan acted in accordance with the applicable guidelines and policies relating to that ground access. However, I am not satisfied that Alma Street Centre had security measures that were adequate for containing an involuntary patient within the courtyard, nor did it have security measures that were adequate to ensure that an alert could immediately be raised if an involuntary patient went missing from the courtyard.

Fremantle Hospital through its lawyers submits that the lift from the courtyard to the fifth floor (from which Stephen absconded) needs to be accessible without a secure card as it is one of the lifts that enables people to attend community clinics situated on this floor.[284] At the material time on any given day, the court yard was used by a range of inpatients, outpatients, visitors and staff members. Clearly as it was not a designated secure area, it would not be expected that access to the lifts be solely by way of secure card.

Fremantle Hospital through its lawyers also submits that allowing for the escorted ground access in the court yard was not solely for the purpose of allowing involuntary patients to smoke a cigarette. They point to other benefits, namely assisting patients to experience some autonomy, building up trust between patients and clinicians, allowing

[284] T 1154

patients to interact with persons outside of the locked ward, allowing patients to have time away from what can be a stressful environment in the locked ward and allowing clinicians to measure the patient's progress in potentially transferring to unescorted ground access, the open ward, and eventually discharge.[285]

However, Stephen's presence in the courtyard on 28 March 2012 was primarily for the purpose of smoking a cigarette. In considering the adequacy of Fremantle Hospital's security measures in this matter, I take account of Dr Gibson's evidence to the effect that it is expected that there be a smoking area in a locked ward court yard where possible.[286]

The evidence does not establish that Stephen's ability to abscond could have been prevented by there being an immediate alarm available to Nurse Morgan. This is particularly so given the short time frame within which Stephen managed to abscond and undertake the actions resulting in his death. Once an involuntary patient is off the Alma Street Centre grounds, staff members do not attempt to apprehend the patient and it becomes a police matter.[287]

However, it is clear that the ability of an alarm system to immediately notify all staff members (as opposed to invoking

[285] T 294; T 311; T 908; T 910
[286] T 1034
[287] T 1129

the Missing In-patients' procedure) could in practical terms have reduced any delay in locating Stephen. This is so even if the pressing of the alarm would cause staff members to attend upon the clinician who set off the alarm. In this regard I do not accept the submission that an immediate alarm would not have reduced delay in locating Stephen. It may have reduced that delay.

At the time of the inquest, Dr Gibson had recently visited a number of locked wards of psychiatric facilities that all had a smoking area within the locked ward. Whilst there is no one single type of structure in mental health services, Dr Gibson did note that the structure used for involuntary patients at Alma Street at the material time, with the court yard facing onto the sliding doors which go out to the outpatient area and then out to the road, was unusual. Dr Gibson's expectation is that where possible, there is in fact a smoking area in a locked ward court yard so that you do not have to leave the secure area to do that.[288]

In January 2013 the Department of Health formalised an amendment to the Smoke Free WA Health System Policy that had been introduced in 2008. A partial exemption was made for involuntary mental health patients aged 18 years and over where nicotine replacement therapy or other treatment options have first been fully considered. Smoking will be allowed in designated outdoor smoking areas at sites

[288] T 1033 - 1034

where this is practicable. The outdoor smoking area must meet the infrastructure requirements of a secure area. Under the amendment to the policy, a range of measurers are also introduced to allow for natural observation without staff members being exposed to environmental tobacco smoke.[289]

After Stephen's death, Alma Street Centre implemented number of improvements in their security measures. Between late 2013 and early 2014 personal duress alarms were introduced, in the form of a pendant worn by relevant staff members. Wearers can activate their alarm when necessary, including if an involuntary patient absconds. The alarm conveys information to the whole duress team regarding the location of the active alarm to enable team members to come to assist.[290]

Entrance to the court yard from the Triage doors has now been secured. The number of persons accessing the court yard from the Triage doors has been limited to persons who are identified as having an outpatient appointment or visitors during visiting hours. Together with patients from the wards and relevant staff members, the effect has been to reduce the number of persons within the court yard, thereby assisting staff members who escort involuntary patients on ground access in that area.[291]

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[289] Exhibit 8, Tabs 3.3 and 3.4
[290] T 1128; T 1159
[291] T 1126

Involuntary patients who wish to smoke at Alma Street Centre now do so in another court yard that is adjacent to the main dining room of the locked ward. This court yard is a secure area, meaning that an involuntary patient does not require escorted ground access in order to smoke a cigarette. There are designated smoking areas within this court yard to minimise the inhalation of tobacco smoke by other persons who are within that area.[292]

The improvements outlined by Fremantle Hospital will assist in preventing another death in similar circumstances.

Section 25(3) of the Coroners Act requires me to comment on the quality of Stephen's supervision, treatment and care while in that care, that is while he was an involuntary patient. I am satisfied that the standard and quality of medical treatment and care provided to Stephen while he was a person held in care at Alma Street Centre was adequate and appropriate in the circumstances. However by reason of the inadequacy of the security measures in place when Stephen absconded from the court yard I am satisfied that the quality of his supervision fell below the standard that can reasonably be expected of an involuntary mental health service.

[292] T 1127

Adverse findings in relation to Stephen's care

I am satisfied that on or about 28 March 2012, Alma Street Centre:

- did not have adequate security measures in place to contain an involuntary patient on escorted ground access in the court yard; and

- did not have adequate measures in place to ensure an alert could be raised immediately if an involuntary patient went missing from the court yard.

MATTERS COMMON TO SEVERAL OF THE DEATHS

Communication was of a standard below that expected of a professional mental health service

The families of the deceased expressed concerns about the adequacy of the communications between them and the Alma Street Centre clinicians.

I accept Fremantle Hospital's submission, through its lawyers, that the evidence did not show that the clinicians were uncaring, deliberately dismissive of or disrespectful of carer's views.

Alma Street Centre points to two matters that affected the delivery of information by clinicians to the families:

- the understanding by clinicians, at the material time, that it was preferable to protect a patient's rights to confidentiality except where there were grounds to contact a carer because of specified concerns that a clinician had with a patient; and

- the fact that the clinicians were treating numerous patients in any given work day; the caseload for one psychiatry registrar in Alma Street Centre's outpatient clinic was 80 - 100 patients and usually Alma Street Centre struggled with too few beds;[293]

I accept that at a general level the issue of legally permissible contact with carers appeared to have been vexed in 2010 – 2012, and that the matter was rendered more complex where stressors were noted between the patient and carer. However the evidence before me at the inquest reflects that the circumstances of the engagement with the carers were not affected by the clinicians' concerns regarding the legal prohibition on divulging patient information.[294] Specifically:

- Ruby had not prohibited contact with her father, Mr Diver; and Dr Baily's evidence was that he did not

[293] T 816; T 1174
[294] *Mental Health Act* 1996, section 206

have time to contact her father on 1 March 2011 and that he had not realised how intensively involved her father had been in her treatment;

- It was Carly's parents, Ms Becker and Mr Elliott, who contacted CERT on 1 March 2011, due to their concerns for their daughter, and after their assessment of Carly, the CERT clinicians spent some considerable time with the parents;

- Mrs Thomas was the recognised contact for her husband Michael, to the point where the arrangement for Michael to come in to see Dr Singh on 3 June 2011 was reached with her acquiescence; and

- Mr and Mrs Edwards were, with their son Andrew, involved in the family meeting with Dr Davis on 16 March 2012.

Dr Davidson gave evidence at the inquest concerning the practical application of the previous prohibition on divulging a patient's personal information under the then applicable *Mental Health Act* 1996. In his experience the balance between patient confidentiality and disclosure to carers supports Fremantle Hospital's lawyers' submission that it was a vexed question at the material time:

> *"Is there a practical ability for a mental-health practitioner, when dealing with a voluntary patient, to override the consent of someone and form the view that it's more important for the*

patient to involve their family than not?---There is, as – essentially, as allowed in the Act. But they – the Mental Health Act 1996 does not, in fact, allow for a public-interest matter in regard to confidentiality, although national Acts do. And those, of course, are the essential aspects of where there is such outcome as is likely to result in very significant harm and that therefore warrants essentially a breach of confidentiality. The clinicians, in general, understood that all such actions will be a breach of confidentiality. And the clinical decision, for that reason, is usually made in conjunction with legal advice as to whether that breach can essentially be supported.

Is that always practical, Doctor, when you're dealing with people who may be at imminent risk from suicide, for example?---It may not always be practical.

What, if anything, can be done where it's not?---Where it's not, my advice to services has always been that it is necessary to assume that the clinical judgment to be made is made still on a proper balance between risk, outcome and the confidentiality provisions. But most attention still needs to reside with the severity of outcome in those decisions. It remains a clinical judgment."[295]

Professor Stokes in his 2012 Report[296] opined that "*the sanctity of patient confidentiality should not be used as a reason for not informing the carer that the patient is going on leave or is to be discharged.*" Two of Professor Stokes' recommendations concerning carers and families are as follows:

- Carers must be involved in the care planning and most significantly in a patient's discharge plan, including the place, day and time of discharge (R 3.2); and

- Carers of patients need education, training and information about the "patient's condition" as well as

[295] T 938
[296] Exhibit 7, Tab1

what are the signs of relapse and triggers that may cause relapse (R 3.3).

The evidence before me does not establish that communications with the family members was limited or truncated by clinicians due to legal concerns about patient confidentiality. Taking account of the evidence of Dr Davidson and Professor Stokes, I am also satisfied that if such concerns did exist they were unfounded where the matter concerned the circumstances surrounding the discharge of patients.

Since that time there have been improvements in the area of communication with families.

My attention is drawn to the Chief Psychiatrist's guidelines, published after these deaths, namely the Clinical Guidelines on "*Communicating with Carers and Families*" dated March 2012 and the publication "*Communicating with Carers and Families – information sharing for better outcomes*".[297] These were based upon the then applicable *Mental Health Act* 1996, and assisted in underscoring the importance of families and carers as vital partners together with mental health service providers in enhancing the health and wellbeing of those people they care for, and also highlighting the need to comply with the Western Australian Carers Charter pursuant to the *Carers Recognition Act* 2004.

[297] Exhibit 10, Tabs 3 and 4

A further improvement was achieved by the introduction of the State-wide Standardised Clinical Documentation (SSCD) entitled "*Triage to Discharge*" which is mandatory for use by clinicians in public mental health facilities. The SSCD documents include fields for consumer and carer/support person details and signatures. A copy of the signed document must be provided to the consumer and carer. They were introduced to address a number of the Stokes Review recommendations concerning individual management plans for patients and communication with carers. The fields that must be completed prompt or remind clinicians to communicate with carers in respect of treatment, management and discharge decisions. In respect of risk assessment and management plans, consultation with the carer is required in relation to a number of matters including trigger factors and early warning signs.[298]

Notwithstanding that legal prohibitions were not the driving force behind lapses in communication, it is clear that the provisions of the new *Mental Health Act* 2014 create a greater level of certainty in this area. This includes mandating that in determining what is in the best interests of person, the decision maker must have regard to the views of a carer (if the person has a carer), specifying that a carer is entitled to be provided with certain information relating to

[298] Exhibit 6, Tab 11; Exhibit 7, Tab 4

a patient's treatment and care (subject to the best interests of the patient). [299]

Fremantle Hospital through its lawyers submits to me that an adverse finding regarding communication between staff members and family members ought not be made as the issue has been rectified by a number of new measures, including those outlined above. I accept that significant steps have been taken to support the rectification of the issue. However, my findings concerning the inadequacy of the communications are made as at the time of the contact with the relevant families, in 2011 and 2012.

On the evidence before me in this inquest, and for the reasons outlined above in this finding I am satisfied that the manner in which communication occurred between various staff members of the Alma Street Centre and Mr Diver, Ms Becker and Mr Elliott, Mrs Thomas and Mr and Mrs Edwards was of a standard below that expected of a professional mental health service.

No adequate polices or procedures to support staff members in their contact with carers

The evidence at the inquest established that there was no formal policy or procedure that required clinicians to involve a patient's carers or family in the admission planning or

[299] *Mental Health Act* 2014, sections 7 and 285, Part 9 and Schedule 2

discharge planning for patients at Alma Street Centre at the material time, though it is generally accepted by clinicians as being best practice.[300]

Fremantle Hospital through its lawyers submits to me that issues of patient confidentiality needed to be addressed by the clinician in balancing the different factors for each patient, and that in the context of these investigations, prescriptive policies are unlikely to have assisted.

It is clear to me that had there been policies and procedures to prompt or remind the clinicians to involve carers and consult with them, rather than being prescriptive, they would have afforded a clear expression of the standard of conduct expected by a clinician in the area of contact with carers.

I am satisfied that at the material time, Alma Street Centre did not have adequate policies or procedures in place to support staff members in dealing with the manner in which contact should be made with family members, or next of kin, in relation to an admission or discharge of their loved one.

[300] T 464; T 1090; Exhibit 8, Tab 1.2

No adequate procedures for taking into account a patient's longitudinal risk factors

A recurrent feature in the evidence at the inquest into the deaths concerned the problems with addressing the patient's longitudinal risk factors.

Fremantle Hospital through its lawyers submits to me that it is an irresistible conclusion that the history of the patient must have been appreciated by the clinicians and point to Dr Davis and Dr Argawal who had previously seen Anthony in an outpatient setting, Dr Kataria and Ms Cartwright who had previously managed Michael as an outpatient, and Dr Goossens who had previously managed Ruby through CAMHS before her transfer to the adult services.

All of the above instances relied on the past knowledge of certain clinicians, but there was no adequate procedure for efficiently drawing that knowledge together, so as to enable the immediate treating clinician to assess a patient having regard to the material longitudinal risk factors, particularly in a crisis situation. It would take time for a clinician to go through a patient's medical history in order to identify relevant factors.

The problems associated with failing to address longitudinal risk factors is most evident in Carly's case, and were identified by Dr Davidson as follows:

> *"The contact the clinicians had with the patient were in response to acute situations where the potential for self-harm/suicidality were of primary concern. These episodes settled quickly but were never fully attended to in the context of an overall Risk Assessment and Management Plan that takes into consideration the patient's longitudinal risk issues for the previous 6 months."*[301]

Fremantle Hospital through its lawyers submits that the situation is now rectified. My attention is drawn to the evidence concerning the recently established Assessment and Treatment Team (ATT) that replaces CERT (which assessed Carly on 1 March 2011).

At the material time whilst the CERT clinicians would attend a patient's home to deal with the immediate crisis, they were not involved with case management or follow-up with patients.[302]

The ATT became operational in February 2015 and is an amalgamation of the Triage team and CERT. It operates from 8.00am until 10.00pm, and is followed by an on-call service for the South Metropolitan area.[303]

In addition to making home visits and follow up visits, the ATT clinicians are able to continue to case manage patients for up to 12 weeks. If further or other involvement is considered appropriate, the ATT clinicians may refer the patient for continued outpatient care (through a community team) or arrange admission to hospital. This is a clear

[301] Exhibit 6, Tab 9
[302] T 197 - 198
[303] T 195 - 196

improvement to the previously fragmented care when CERT was utilised. I accept Nurse Murdoch's observation, given in evidence at the inquest, that in her experience the ATT system offers a much better opportunity for significant positive outcomes by working with patients and carers in their own homes and more intensively rather than on a more reactive basis.[304]

I accept Fremantle Hospital's submission through its lawyers that the introduction of the ATT will enable crisis situations to be seen in the context of ongoing assessment and follow up. This development deserves to be commended.

However, I am satisfied that at the material time, there were no adequate procedures in place to assist clinicians in taking into account a patient's longitudinal risk factors.

RECOMMENDATIONS

Carer's Plans

Whilst the decision making in connection with the treatment and care of mental health patients is clearly a matter of clinical judgement, families and carers are well placed to provide relevant information about a patient to clinicians, for their consideration.

[304] T 196 – 197; T 215

However, the evidence at the inquest disclosed that family members into whose care the patient was discharged were left with insufficient understanding of their loved one's diagnosed condition, their medication regime, the factors that may indicate there is a risk of relapse, and when to re-engage with the mental health system. Not all of these factors are addressed in the SSCD suite of documents. There is no process for providing family members with a Carer's Plan.

At the inquest Dr Velayudhan gave evidence that the biggest challenge to providing patient specific information to carers in written form was resources and time. He did however indicate that it may be feasible for a relapse prevention plan to be provided to family members.[305]

I received evidence about the type of factors that might be addressed in a Carer's Plan and they included addressing the carer's concerns about caring for the patient, addressing carer fatigue, respite and carers' allowances.[306]

The Department of Health through its lawyers submits that Carer's Plans may be useful but that it is appropriate to first focus on patients' care, management and discharge plans. It is clear to me that much of this focus, which is most important, is being achieved by the introduction of the

[305] T 1162 - 1163
[306] T 1132

SSCD suite of documents and the draft policies tendered at the inquest that will no doubt be the subject of continual review and improvement particularly in light of the introduction of the *Mental Health Act* 2014.

What is missing is a greater focus on information for the carers, bearing in mind that the *Mental Health Act* 2014 aims to change the focus of clinicians to a more carer-centric model. There are recognised therapeutic benefits for patients when they re-engage with the community at an appropriate stage. In many instances, this transition can only be successfully achieved in the long term with the support of family members and carers. It is clearly undesirable for mental health patients to become institutionalised.

The draft care planning standard being developed in response to Stokes Review recommendation 3.2 stipulating carer involvement in care and discharge planning is along this continuum.[307] The range of benefits to be derived from Carer's Plans would be found not only in the transmission of clear information to carers; it would also help focus the clinicians' minds on the discharge planning.

[307] Exhibit 7, Tab 4, Annexure C

I recommended that the Western Australian Department of Health develop policies and procedures for the implementation of Carer's Plans, and that such policies and procedures address matters of patient consent and risk issues, and that the following matters be explored for inclusion in Carer's Plans –

- **information concerning the diagnosed condition and medication regime;**
- **information relevant to a relapse prevention plan;**
- **information relevant to guidance as to when to proactively re-engage with the mental health services;**
- **information relevant to the individual needs and concerns of the carers; and**
- **information relevant to support services available to carers.**

Resourcing for Mental Health system

Since 2012 there have been significant developments in the planning for the delivery of mental health services in Western Australia. This includes the new legislation, the responses to the Stokes' review, including the SSCD suite of documents, and progress towards the long term 2015 – 2025 Plan for the mental health system. Improvements in specialised youth/adolescent care include the Youth Unit at Fiona Stanley Hospital and renovations to the Bentley Adolescent Unit.

In terms of practices involving the day to day care of mental health patients, much of the improvement is at the planning stage. At the inquest, a number of draft or skeleton policies at varying stages of development were tendered. They are designed to implement some of these plans, and include the draft care planning standard, the draft risk assessment and management standard, the draft transfer of care standard, the draft seclusion and bodily restraint standard, the draft consumer and carer involvement in individual care standard, the draft assessment standard, the skeleton policy in respect of management of patients who decline follow up including patients who do not attend, and the draft physical care of mental health consumers standard.[308]

There continues to be a real need to maintain the progression from the planning stage to the implementation stage.

I recommend that for the purposes of implementing improvements in the delivery of mental health services, the Western Australian government continues its efforts to provide the funding and resources required to progress the Stokes Review recommendations and the Chief Psychiatrist's standards from the planning stage to the implementation stage.

RVC FOGLIANI
STATE CORONER
31 December 2015

[308] Exhibit 7, Tab 4; Exhibit 9, Tabs 7 to 12