STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquiry	**Inquest into the death of DA**
Hearing dates:	8 April – 9 April 2015
Date of findings:	14 July 2015
Place of findings:	NSW State Coroners Court – Glebe
Findings of:	**H.Barry Coroner**
File number:	2012/281428
Representation:	**Seargent P Bush assisting the Coroner** **Ms K Doust representing NSWNMA** **Mr P Rooney instructed by Ms S. Henry representing Northern NSW Local Health District**
Findings: **Non Publication Order**	**Identity of deceased**: The deceased person was DA **Date of death**: died on 9 September 2012 **Place of death**: died at (street number and name redacted) Yamba, NSW **Manner of death:** **Self inflicted with intention to end life** **Cause of death:** **Neck compression due to hanging** A Non – Publication order pursuant to section 75(2)(b)(i) was made concerning the identity of the deceased

Table of Contents

Introduction: 1
The Inquest: 1
The Evidence: 2
Background: 2
The identity of the deceased 10
Date of death 10
Place of death 10
Cause of death 10
Manner of death 11

The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of DA

Introduction:

DA was 34 years old at the time of his death.
He was living at ………………………..with his partner RF and three children.

His parents, who attended the inquest each day, caused a letter to be read to the court on behalf of the family.

DA was described as a good student at school and a talented athlete and sportsman, competing in Little Athletics and Rugby League. He won the State under 8 relay and his team won the Rugby League Grand final.

He was close to his family and two brothers. They enjoyed many family holidays.

After school he worked as a roof tiler for a while and later worked with his father at a company near to where they lived, for about four years. He was well liked in the work place.

He met RF who had a little boy, J. DA loved him and looked after him.

He and RF moved to Grafton and then Yamba and had three children.

DA became the house father, staying home to mind the children and RF went to work.

His parents would visit the family 3 – 4 times each year and he and his father would spend time engaged in discussions covering a wide range of topics

DA was capable and knowledgeable.

He loved his children and is very much missed.

The Inquest:

A Coroner's function is to attempt to answer five questions:
Who died? When did he or she die? Where did he or she die? What was the cause of death and What was the manner of death?

The focus of this inquest is the manner of DA's death and the circumstances that led to it.

The Evidence:

Background:

DA had a history of drug use and high alcohol intake, reportedly 30 cans of beer daily.

In July 2012 he attempted to take his life by gassing himself in his car. He was admitted to Richmond Clinic at Lismore where he spent 5 days as a voluntary patient. DA requested a discharge from the unit after an altercation with another patient.

On 7 September, 2012 DA had an altercation with a person by the name of Vince. Later that same night he broke a window at the family home. His partner and children left the house for the night.

On Saturday 8 September, 2012 RF took DA to hospital at Maclean Hospital.
He was assessed at hospital and scheduled under the Mental Health Act by Dr Paul Condon after consultation with Registered Nurse Sheehan, a mental health specialist nurse. He was transferred to Richmond Clinic at Lismore.

On the evening 8 September he was assessed by a psychiatrist at the clinic, Dr Keith Abel.

Following that assessment DA was admitted as a voluntary patient. He was placed in the High Dependency Unit (HDU) awaiting a bed in the Mental Health Unit.

In the morning 9 September 2012, DA demanded that he be discharged.

Dr Seifken, an on-call Psychiatric Registrar was contacted by telephone by the nursing staff who approved DA's discharge.

Later that same day, RF arrived home and found DA asleep in bed. She tried to converse with him but he was largely unresponsive.

RF left the premises returning at about 5pm that day. She discovered DA in the wardrobe after forcing the door open. A blue electrical cord was attached through a man hole in the roof to a timber frame in the roof space.

An ambulance was called and no signs of life were found.

Sometime later RF found two notes at an address where the family had previously resided. One, addressed to RF stated his intention to harm himself. There was also a goodbye note to his children.

It is not known when these notes were written.

The Issues

At the outset two main issues were identified.

> Was the change in status from an involuntary patient to a voluntary patient on 8 September 2012 justified in all the circumstances?
>
> What risk assessment, if any was conducted prior to DA's discharge on 9 September 2012 and was this assessment appropriate in the circumstances?

Maclean Hospital – Lismore 8 September 2012

DA was transferred to Lismore Hospital following a schedule by Dr Paul Condon at Maclean Hospital. Maclean Hospital does not have a mental health unit.

The Schedule 1 Certificate reports:

a) DA said he was angry with everything and that he had physically battered another man yesterday for little reason
b) Nurse in Maclean Emergency Hospital told me that DA had said to her that he would" bash" his partner RF. Medical Records of attempted suicide 29 July 2012.

The nurse in emergency at Maclean Hospital was Louise Sheehan, a Clinical Nurse Specialist (Mental Health).

She had first met DA on 9 August 2012 following his discharge from Lismore Mental Health Unit (LAMHU) on 9 August after an attempted suicide. .After assessment at that time she determined to continue care and treatment for DA with follow up in a community setting.

She again saw him on 8 September at approximately 6pm. She recalls he was 'agitated' and 'angry'. He denied suicidal thoughts or intent. His mood was highly changeable and this indicated to her that DA was a risk to himself especially given the previous attempt 6 weeks before. She also considered that DA may be a risk to others given his aggressive and threatening behaviour.

Ms Sheehan's assessment on 8 September is well documented in an 8 page Mental Health Assessment form. She records, inter alia:

> Brought to ED by partner this pm – unable to manage behaviour any longer. Recent increase verbal abuse, property damage and assaulted another male

person yesterday. Family scared. D admits to reduced ability to control anger.
Axis II traits ?depression
D threatening to harm RF whilst in ED. Overheard by security and ED.

Ms Sheehan's evidence is that she was not confidant in allowing DA to remain a voluntary patient due to his changeability. She believed "He was not of sound enough mind to make a decision"

She telephoned Dr Abel, the on – call Psychiatric Registrar at Lismore Hospital to express her concerns. Dr Abel agreed to have DA referred to Lismore Hospital.

Dr Abel

Dr Abel agreed that DA was to be transferred to Lismore Hospital for further assessment and possible admission. DA was received at Lismore at about 9pm. Dr Abel's evidence is that he spent 1 – 2 hours speaking with him.

During that consultation he had access to the assessment form completed by Nurse Sheehan and he 'believed' he had access to the clinical notes concerning DA's admission in July/August 2012 as well as the discharge summary. He stated he relied on Dr Freeman's notes from the time of that admission to assist him form his opinion.

Dr Abel formed the view that there was no basis for him to detain DA as an involuntary patient. He stated that DA was not "voicing any psychotic phenomena and there was no elevated mood". DA denied suicidal thoughts.

Dr Abel was of the view that DA was depressed but there" was no significant depression of mood"

His notes record the following:

"_ Patient has recently had an admission for attempted suicide.

_Still very irritable and partner feels threatened by him.

_Has Depression. Feels overwhelmed. Gets angry easily. Struggling to cope with what is happening around him.

_See notes from Maclean

PLAN
_ start on Mirtazapine 30mg.

_other medications as per chart.

_voluntary admission. May sign himself out.

_He is working with Dr McGowan to increase his dose of Methadone"

Dr Abel's oral evidence is somewhat at odds with the notes made at the time.

In his oral evidence, he stated "I saw no mental health issues only addiction issues".

Nowhere in his notes does he state that he viewed DA's presentation as solely addiction issues.

Nowhere in his notes does he record that his plan, as stated in his oral evidence, was for DA to be referred to Drug and Alcohol Services on the Monday for possible rehabilitation concerning his addiction issues.

Contrary to Nurse Sheehan and Dr Condon, Dr Abel assessed that DA was not at risk.

Also contrary to Nurse Sheehan, Dr Abel did not prepare nor record a Mental Health Assessment.

Curiously, in his oral evidence, Dr Abel stated that he would only document that assessment if DA had been deemed at risk and was to be detained as an involuntary patient.

Dr Abel now concedes that he would document any Mental Health Assessment.

What is clear is the similarity between Dr Abel's oral evidence and the evidence of Dr Freeman.

Dr Freeman saw DA on his first admission in July. His notes at that time refer to DA's intake of **huge** quantities of drugs and "his insatiable drug hunger".

In his oral evidence Dr Feeman stated*:*

"*I don't think I have ever seen anyone who was taking so much prescribed and non-prescribed medication"*

His diagnosis at that time was one of poly- substance abuse but no psychiatric illness.

Dr Peter Whetton, in an expert report dated 2 September 2014 opines that DA's case was a case of dual diagnosis; that is both an addictive problem and a mental health problem.

In his opinion the decision to change DA's status from involuntary to voluntary on 8 September 2012 was "inappropriate". His view was that DA's history revealed a man who was disturbed by alcohol and drug abuse as well as significant mental health issues as evidenced by the previous suicide attempt and aggressive behaviour with self- harm.

Dr Whetton is also critical that no consultant psychiatrist was contacted prior to that change in status being made.

An alternative opinion has been expressed by Dr Matthew Large, Psychiatrist, in an expert report dared 17 May 2015. Dr Large expressed the view that DA could not have been detained as a mentally ill person on 8 September 2012.

He writes in his report of three pre-conditions which must be met for an involuntary admission under the Mental Health Act (MHA),

a) A condition appearing in S.4 of the Act including, relevantly to this case "severe disturbance of mood". Dr Large agrees that DA was demonstrating a disturbance of mood but believes "*there were good grounds for Dr Abel to consider that the threshold of a 'severe' disturbance of mood was not met"* This was especially so, in his opinion because of Dr Freeman's previous assessment of DA as having a" moderate depression".

b) S.14 of the Act requires an opinion by the Medical Officer that detention is necessary for the person's own protection from serious harm or the protection of others from serious harm. Because the conditions in S.4 were not met, Dr Large stated in his report that this criterion need not be considered in detail.

c) S.12(b) requires that a Medical Officer must be of the opinion there was "no other care of a less restrictive kind". Given DA's consent to voluntary admission, Dr Large states that Dr Abel "could not have admitted DA involuntarily".

Similarly, Dr Large stated that Dr Abel could not have detained DA as a Mentally Disordered person pursuant to S.15 of the Act, given the fact that a voluntary admission was reasonably available.

It is not possible to determine conclusively whether the change in status was appropriate and whether the decision to admit DA as a voluntary patient was reasonable in the circumstances.

Certainly, according to Dr Freeman, there are times when a patient expresses a wish to be admitted voluntarily, but circumstances may dictate that such a decision would be unreasonable. So the fact that DA agreed to a voluntary admission should not have been the determining factor. All the other indications pertaining to DA's presentation needed to be considered.

The major difficulty in this matter is the paucity of clinical notes and the absence of a documented Risk Assessment which would have provided some evidence to support Dr Abel's thought processes on 8 September 2012.

Without such documentation I can only rely on Dr Abel's oral evidence which does not reflect the notes made by him in the progress notes.

His progress notes make no mention of the diagnosis being one of poly substance abuse and no mention is made of the lengthy conversation that Dr Abel maintains he had with DA concerning the question of rehabilitation and the need to connect with Drug and Alcohol services. In fact his oral evidence very much mirrors that given by Dr Freeman who had seen DA at the previous presentation but not in September 2012.

Notwithstanding DA's previous suicide attempt only 6 weeks before and his increasing level of aggressive behaviour, Dr Abel chose to change his status from involuntary to voluntary. He did not consult with a consultant psychiatrist before making that decision.

It may have been that if the risk assessment had been appropriately documented and if a consultant Psychiatrist had been notified the decision may have been the same. That remains an unknown.

What is known is that DA was able to discharge himself on the following morning with tragic result.

Discharge on 9 September 2012

There is little doubt that the discharge of DA on 9 September 2012 was not appropriately carried out.

Dr Abel had written in his notes from the day before that DA "may sign himself out".

In the morning of 9 September 2012 DA asked to be discharged. Mr P. Ribton – Turner ultimately dealt with that request. Mr Ribton – Turner at that time was a registered psychiatric nurse.

As there was no Psychiatric registrar on site over the weekend, Mr Ribton – Turner said the practice was to contact the on –call Registrar about this request.

Mr Ribton –Turner made the following notes in the clinical notes at 10.25.:

"Patient requesting discharge – pc to Psychiatry Registrar on duty – has OK'd D/C. Patient found with a lighter in court yard – lighter removed – patient demanded discharge. Given possessions and escorted out. Patient unhappy about placement in HDU and not in A1 – otherwise appeared superficially settled"

Mr Ribton – Turner agreed he made no contact with DA's partner assuming that the person who was picking up DA was his carer. In fact, DA's partner had no notice of DA's discharge.

In his oral evidence, Mr Ribton – Turner stated he would have asked DA to remain long enough to be seen by the psychiatrist but as DA insisted on leaving he could take the matter no further.

Dr Seifken was the on – call Psychiatric Registrar at the time. It was his practice to attend to ward rounds sometime in the morning and attend other times during the day as required. He was able to be contacted by telephone at all times.

He noted that DA had been placed in the High Dependency Unit which on all of the evidence was an inappropriate place for someone with DA's presentation but at the time was the only bed available.

He also noted that DA was not permitted to smoke. This issue of smoking was a recurring issue in this inquest, Dr Freeman stating that the ban on smoking was a "disaster". Dr Seifken agreed, especially given the highly addictive nature of nicotine and the high number of patients admitted to the Mental Health Unit who have this addiction. Dr Seifken gave oral evidence that he regularly takes patients out of the hospital grounds to have a cigarette as this can have a therapeutic impact on their mental well-being.

On the basis of what he was told, Dr Seifken did not consider DA to have a major mental illness, nor did he believe him to be suicidal. He made a retrospective entry in the clinical records on 11 September 2012:

"On Sunday 9/9/12 I received a call from the nursing staff in HDU indicating that DA had requested discharge. They informed me that he was a voluntary patient and that

it was documented that he could sign himself out if requested. Nursing staff reported that he was sufficiently settled. As I was off site at the time, and given the above circumstances, DA was allowed to leave"

Dr Whetton is particularly critical of the way in which DA was discharged, there being no significant discharge planning or contact with family. There is no record of consultation with the Consultant Psychiatrist'

He concluded that as there was no proper risk assessment carried out, the decision to discharge DA without examination was **not good clinical practice.**

Dr Seifken, in his oral evidence said that things have now changed and there is now a clinical handover to the on-call Registrar. He stressed that this situation would now be unlikely to occur, as every admission and discharge would need a face to face encounter and before discharge a patient must be seen by a Consultant Psychiatrist.

Mr Warren Shaw, Network Manager – Richmond Clarence Health Services Group
Wrote an extensive report and gave oral evidence to the court.

In his report, Mr Shaw outlines a range of improvements that have now been made in relation to patient safety since DA's death. These include a number of strategies to improve risk assessment and management by clinicians. In particular and relevant to this inquest:

Suicide risk assessment training for both mental Health staff and medical staff working in EDs in Lismore Base Hospital.

Mental State Examination training

NNSWLHD Mental Health Services has added risk assessment stickers and guidelines to ensure that off – going / oncoming staff has handed over/ received appropriate information. A sticker is required to be signed by *both* the off-going and oncoming staff members and is used to prompt the routine recording of information including risk assessment.

Senior staff have been sent to complex Risk Assessment training carried out by Justice Health

Greater accountability of Junior Medical staff is now in place for them to discuss admissions and discharges with the consultant on call.

In addition it is now required that *all admissions are to be discussed with the on call Consultant Psychiatrist prior to a definite decision to admit.*
After the first review with the Consultant Psychiatrist, clinical issues must clearly be noted as they form the basis of the care plan.

Further, there is now a *requirement to have patients reviewed personally by a registrar or consultant prior to discharge.*
All pending discharges are to be discussed with the Consultant Psychiatrist prior to discharge from LAMHU.

Any discharge out of business hours must now include *a face to face assessment for any unplanned discharges with either the after -hours Consultant, or by the Registrar, or by the CMO in consultation with the on call Consultant.*

Of particular significance to this inquest are the changes to liasing with next- of –kin which are designed to ensure that wherever possible the carer will be included in any decision making.

I accept the recent changes made by the Local Health District in relation to the way patients are assessed, admitted and discharged and the recognition of the increased need for greater communication with carers will mean a greater level of care and attention will be afforded to patients like DA.

I am satisfied that further recommendations are presently unnecessary.

Whilst recognising the need to balance the least restrictive care against the risk posed to the patient, if followed, these changes may go part way to avoiding a similar tragedy as that which occurred on 9 September2012 concerning DA.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was DA

Date of death

died on 9 September 2012

Place of death

died (street number and name redacted), Yamba, NSW

Cause of death

The death was caused by Neck Compression due to Hanging

Manner of death

Self inflicted with intention to end life

I close this inquest.
H.Barry
Coroner
Glebe

Date 14 July 2015