IN THE CORONERS COURT
OF VICTORIA
AT BENDIGO

Court Reference: 4793 / 2010

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Lynette Roberts

Delivered On:	14th September 2018
Delivered At:	Bendigo Magistrates Court sitting in the jurisdiction of the Coroner's court
Hearing Dates:	17th October 2016 to 21st October 2016, 16th November 2016 to 18th November 2016 21st November 2016
Findings of:	Jennifer Tregent
Representation:	Sergeant K Connell, Police Coronial Support Unit Ms L. Martin, Barrister instructed by Ms R.Dyall appeared on behalf of the family of the deceased Ms F. Ellis, Barrister instructed by Ms C.Rubira appeared on behalf of Bendigo Health.

I, Jennifer Tregent, Coroner having investigated the death of Lynette Roberts

AND having held an inquest in relation to this death on 17th,18th,19th,20th and 21st October 2016, 16th, 17th, 18th and 21st November 2016

at Bendigo

find that the identity of the deceased was Lynette Roberts

born on 21st of July 1961

and the death occurred on 16th December 2010

at Broadway road, Dunolly

from:

1 (a) Motor vehicle accident related multi trauma including a severe head injury

in the following circumstances:

Background

1. The deceased Lynette Roberts was 49 years of age at the time of her death on 16th of December 2010. Lynette was previously married to Les Lakey and although the marriage did not last they maintained a strong friendship. Les remained committed to assisting Lynette as best he could. Lynette had a child of this relationship Billy Lakey. Lynette came from a loving immediate and extended family as evidenced by the family members who attended the inquest and who showed equal support for Lynette in her life as well.
2. Lynette had a variety of occupations over her life time. Ten years prior to her death she and her then husband Les ran the local fish and chip shop in Dunolly. After the marriage broke down Les left and returned to the Maldon area and Lynette continued to run the shop. Eventually Lynette had to leave the business as her mental health had declined. Lynette was given access to a Disability Support Pension because of her inability to work.
3. It was in 2004 that Lynette experienced her first psychiatric symptoms which were predominantly described as bipolar affective disorder in early presentations. The diagnosis more recently had been schizophrenia. Lynette's first admission to a psychiatric institution was at Bendigo in 2004 summarised by her later treating psychiatrist, Dr Scott Eaton[1], as being due to suffering from depression with psychotic features. There were subsequent admissions to Bendigo psychiatric institutions in January 2010, and March 2010 and whilst in Darwin in May 2010.

[1] MBChB MRCPsych FRANZCP

Summary of most recent admissions

4. On the 2nd of August 2010 Lynette was admitted to the Alexander Bayne Centre (ABC) which is a psychiatric inpatient unit. Lynette remained there until the 21st of August 2010 when she was discharged from the ABC and admitted to Vahland Complex as an involuntary patient on a Community Treatment Order (CTO). As detailed in the statement provided by Dr Eaton, Lynette's acute admission had been precipitated by a relapse of psychotic symptoms such as hallucinations. The hallucinations included command hallucinations instructing her to do things. There were no commands to harm herself and she had no thoughts of this nature. The diagnosis was of schizophrenia.

5. Whilst a patient in the ABC Lynette's treatment included olanzapine 15mg nocte and thyroxine 100mg OD. As her condition had settled the decision was made for Lynette to transfer to Vahland Complex Community Care Unit (CCU). The reason opined for such a transfer, rather than a release to home, was that it was felt that Lynette was at risk of non-adherence to treatment and there were concerns about her vulnerability to exploitation. It was therefore recognised that she was not someone who was free to do whatever she pleased and that there was an expectation of a level of oversighting of her daily living required.

6. It is probably best at this point that some explanation be provided as to what the facilities are at Vahland House Complex. The complex itself is staffed and managed by Bendigo Health hence that organisations interest in this inquest. Associate Professor Philip Tune[2] was and remains the Clinical and Executive Director of Psychiatric Services at Bendigo Health. In that capacity Ass. Professor Tune provided a statement that detailed the facilities available at Vahland Complex.

7. The complex consists of two different facilities supported by one staff group. There is an eight-bed inpatient Secure Extended Care Unit (SECU). This unit provides medium to long-term inpatient treatment and rehabilitation for patients who have unremitting and severe symptoms of mental illness, together with associated significant disturbance, that inhibit their capacity to live in the community. It is a unit which is gazetted to take involuntary inpatients and represents the highest level of care on the continuum of mental health services. As an inpatient unit, all requirements for inpatient units under the Mental Health Act 1986 (Vic) and Bendigo Health Policies apply to the SECU.

8. Co-located with the SECU is the Community Care Unit (CCU) which provides medium to long term accommodation, clinical care and rehabilitation services for up to twelve people with a serious mental illness and psychosocial disability. As noted by Ass.Professor Tune, the facility is located in a residential area, and provides a more "home like" environment than an inpatient unit. It is a place where people can learn or re-learn everyday skills necessary for successful community living.

9. Ass. Professor Tune noted that it is envisaged that while people move through these units to community residential options some patients require this level of **support and supervision** (emphasis added) for several years. As an outpatient service, all requirements for outpatient care and treatment under the Mental Health Act and Bendigo Health Policies apply to CCU. The Vahland Complex is distinguishable from other SECU's and CCU's in that the same

[2] MB BS FRANZCP

staff group provided services to patients who resided in both SECU and CCU. I will comment further on what I regard are the advantages and disadvantages of this shared staffing arrangement later in this finding.

10. At the time of Lynette's admission to Vahland Complex as at the 16th of December 2010 the records showed that all 12 beds in CCU and 8 beds in SECU were being utilised, therefore it was operating at capacity.

11. During Lynette's stay at the CCU her olanzapine was increased due to residual psychotic symptoms and the thyroxine was increased. An application was made to VCAT and a financial administrator was appointed. Lynette underwent other testing and an MRI brain scan returned a normal result. An occupational therapist assessment identified that Lynette could adequately plan meals but did not have the physical skills to cook safely.

12. During this stay at the CCU on three occasions Lynette left the CCU advising nursing staff that she was going to a certain place, then travelled to a different location. On the 3rd of September 2010 Lynette reported that she was going to the bank but was in fact collected some time later from near the IGA Supermarket. On the 5th of September 2010 Lynette left the CCU reporting that she was going to the IGA supermarket and instead took a taxi to Maldon. On the 19th of September 2010 Lynette again reported to staff that she was going to the local supermarket, but she was located attempting to get into the bank.

13. The decision was made on the 20th of September 2010 by Dr Eaton to revoke Lynette's CTO and she was transferred to the SECU at Vahland complex. Dr Eaton noted that Lynette's psychotic symptoms remained, and she was planning to travel to Dunolly to get married in response to her symptoms. Dr. Eaton detailed that Lynette experienced thought blocking and would stare into space focusing on her internal psychotic phenomena.

14. As Lynette's condition was only showing marginal improvement on her treatment with olanzapine it was decided to trial her on clozapine. The decision to trial Lynette on clozapine was discussed by Dr Eaton with family members on the 27th of September 2010. The decision to use clozapine, which is regarded as the most effective drug for the treatment of resistant psychoses, is not made lightly. As stated in the report of Professor Keks[3] prepared for the Court at the request of Bendigo Health, the use of clozapine is associated with serious adverse effects including agranulocytosis, cardiomyopathy, convulsions and weight gain leading to diabetes. As a consequence, a person being trialled on clozapine needs to be monitored closely in the first few months.

15. Dr Eaton discussed with Lynette the possible use of clozapine and with her agreement a trial was commenced on the 22nd of October 2010. The medical notes reflect that Lynette remained quite unwell which manifested itself with poor self-care and lack of insight, while still responding to internal stimuli and talking to herself. The dosage of clozapine was adjusted.

16. Lynette requested that a second opinion be obtained and as a consequence she was seen by psychiatrist Dr Shetti on the 18th November 2010. Dr Shetti concluded that Lynette was suffering from a treatment resistant psychotic illness either schizophrenia or schizoaffective disorder and noted she had been vulnerable to exploitation. Dr Shetti supported continuing on the trial of clozapine and suggested she be trialled in the open ward environment to see how capable she was at looking after herself.

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[3] MB BS MPM PHD FRANZCP

17. In the subsequent days Dr Eaton noted that Lynette's mental state continued to improve with resolution of positive symptoms, only experiencing occasional break through symptoms which Lynette stated she could ignore. Nursing notes indicated that staff were not observing psychotic symptomatology, but the patient continued to dress inappropriately and was dishevelled although apparently attending to self-care. Lynette's insight continued to be impaired.

18. Lynette's overall presentation continued to improve and she had weekend leave and overnight leave with her ex-husband Les. The decision was made to transfer Lynette to the CCU on a Community Treatment Order on the 13th of December 2010. Her regular medications were to be continued.

Expectation of treatment whilst in the Community Care Unit

19. The expectations at the CCU were quite different to the SECU in that Lynette was given much greater freedom, as has been stated time and again by the nurses and staff called to give evidence at this inquest that Lynette could "come and go as she pleased" as she was "living in the community". This observation of independence must be recognised however, as tempered by the expectation that Lynette remained subject to the oversight of the nurses and psychiatrists at Vahland complex. There continued to be the requirement that Lynette took her medication and followed the rules, limited as they might be.

20. It was clear from the evidence of Ass. Professor Tune that there were no strict regulations about the granting of leave and that the term leave did not have the same connotations as required by section 40 of the Mental Health Act 1986 which was applicable to inpatients in the SECU. In contrast patients living in the CCU are outpatients, have a significantly lower risk profile, are expected to co-operate with treatment, are considered to have a significant degree of independence and freedom of movement and do not require a leave of absence approval.

21. Ass. Professor Tune stated that as there was no formality to the granting of leave and there was no leave policy governing the CCU. The usual expectations of residence at the CCU was that, providing they had participated in their rehabilitation program they only need to notify staff if they were going to be absent from the CCU. On notifying staff of an intended absence, clinical judgement was applied as to whether there was any reason to dissuade or stop the patient from leaving.

22. This assessment was based on the patient's most recent risk assessment, the intent and duration of the proposed absence and any other relevant matters. I do note it therefore was envisaged by Ass. Professor Tune that notwithstanding the patient was "free to come and go as please" there was also an expectation of dissuading or stopping a patient from leaving if the circumstances were such as to warrant it. Ass. Professor Tune stated the policy or expectations as to a patient's absence from Vahland Complex was contained in a brochure that was provided to each of the patients for their information.

23. In the statement provided by Ass. Professor Tune he detailed that the Bendigo Health Psychiatric Clinical Risk Assessment Policy outlines that formal risk assessments are to be undertaken and formally documented at least once every twenty-four hours for a patient in the CCU, with more frequent assessments to be undertaken at any clinician's discretion. Ass. Professor Tune stated that, unlike the inpatient units, there was no applicable Bendigo Health Observation Policy. The requirement was however, that patients in CCU would be

sighted by staff throughout the day and generally perform sightings of each patient four times a day. This would usually occur at 7.30am, 12 pm, 5pm and 8pm.

The events in the days leading up to Lynette's death

24. As stated, Lynette was transferred from the SECU to the CCU on the 13th of December 2010. At this time Dr Eaton placed Lynette on a Community Treatment Order that was to run for a period of 12 months.
25. Nurse Elizabeth Wallace (nee Tunn) was working the morning shift on 13th of December 2010 whilst Lynette was still a patient at the SECU. At that time Lynette had not transferred to the CCU but had expressed to Ms Wallace that she was very happy about the transfer. Ms Wallace made a notation that Lynette had been lying in the sun with a blue overcoat on and had complained of feeling dizzy. Lynette was spoken to about this and she changed into a blue cardigan. At the inquest Ms Wallace was asked if this was the first time that Lynette had worn inappropriate clothing for the weather conditions, to which she responded that Lynette always wore inappropriate clothing, which she clarified as meaning it was a daily occurrence. The fact that Lynette's attire was not appropriate for the conditions of the day was a matter of note that was more fully explained in the evidence of Dr Eaton.
26. Ms Wallace stated that she had no further involvement with Lynette on the 13th of December or the days after. On arrival to commence her evening shift at 1.30pm on the 16th of December 2010 Ms Wallace was advised at handover that Lynette had not returned from her walk to the local supermarket. Ms Wallace stated she undertook normal duties and was not involved in responding to Lynette's circumstances.

Events of Tuesday 14th December 2010

27. On Tuesday the 14th of December, being the day after transfer from SECU, Lynette advised nursing staff that she would like to attend the local supermarket a short distance away. Instead she travelled to the home of her aunty, uncle and cousin that was located about 3.5 km from Vahland Complex. At the time Lynette left she was wearing her heavy "ski" jacket which was zipped closed. It was a hot day and as such the clothing was inappropriate for the weather conditions.
28. The cousin Lynette visited on this day was Eric Lakey who provided a statement and evidence to this inquest. Mr Lakey detailed that this was not the first time Lynette had arrived at his parents' house effectively unannounced. He stated at some time during 2010 Lynette had "escaped" from a centre and turned up at his address in a dishevelled state. He stated at the time she was filthy and her feet were bare and bleeding. It appeared that she had been walking for miles. Ultimately as Mr Lakey understood Lynette was placed in a secure facility as an involuntary patient through Vahland House.
29. Mr Lakey stated that around lunchtime on the 14th of December 2010 Lynette came to the back door of his address in Napier Street. He stated his parents were also present at the time. He stated they were shocked by her appearance given it was a very warm day and Lynette was wearing the heavy ski type jacket. He also stated that Lynette's body odour was very strong and it was in his opinion obvious that she had not bathed for some time. Mr Lakey observed that Lynette was wearing thongs and her feet were very dirty. When asked about

how she had come to be at his address she had stated that she had been given leave and that she was "out of that place".

30. Mr Lakey was concerned that, as he described, something was "amiss" and telephoned Bendigo Health and spoke to one of the nurses at Vahland house. Mr Lakey was advised that Lynette was out of the secure unit and was placed in the day unit and as such was permitted to leave the facilities unescorted. The nurse advised that Lynette had stated upon leaving that she was going to the local IGA in Long Gully. When informed that she was in fact some distance from the facility, the nurse acknowledged that Lynette had lied and that someone would come and collect her from Mr Lakey's home.

31. A short time later Nurse Ruth Fisher, who was employed as a registered nurse Division 1 at Vahland complex, attended to collect Lynette. Mr Lakey stated that he was assured by Nurse Fisher that this would not happen again, and that Lynette would not be allowed out unescorted. Mr Lakey was cross-examined as to the accuracy of his recollection of this conversation on the basis that Ms Fisher had no authority to make such a decision. Mr Lakey remained resolute that those comments had been made and I accept that evidence. The fact that Nurse Fisher could herself not revoke a CTO or otherwise prevent unescorted leave is not relevant. As observed by Mr Lakey the comment could have been made to placate him. Mr Lakey also noted that the nurse could report back to those in charge and that this may have had a bearing on the decisions made. This is a fair observation to make as Ms Fisher did have discussions with Dr Eaton when he was next at Vahland complex on the 15th of December 2010.

32. Mr Lakey stated in his evidence that Lynette appeared jittery and nervous speaking rapidly like her mind was going at a million miles an hour. On arrival of a staff member to collect Lynette her demeanour was very calm as she voluntarily got into the car to be taken back to the facility. Ms Fisher's evidence was that she did not observe Lynette to be jittery or nervous or speaking rapidly when she collected her from the home.

33. In the statement provided by Ms Fisher she stated that she was rostered on from 7am to 3.30pm on the 14th of December 2010. During her shift she received the phone call referred to by Mr Lakey as to Lynette's attendance at his parent's house in Napier Street, Bendigo. Ms Fisher stated she checked the notes and they indicated that Lynette had advised staff that she was going to the IGA prior to leaving CCU. Ms Fisher could not recall if it was herself or another nurse who had been informed of this fact.

34. Ms Fisher attended the Lakey home to collect Lynette and noted that she presented as disorganised and had a poor memory. In evidence Ms Fisher stated that this was a reference to Lynette wearing a thick blue jacket and jeans on a very warm day and that her thought process was disorganised as having told staff she was going to IGA and how she was then instead at the address in Napier Street. Ms Fisher could recall that Lynette was not able to comprehend that she needed to notify elderly relatives prior to visiting them rather than arrive at their property unannounced. Lynette posed no resistance to returning with Ms Fisher to Vahland House.

35. Ms Fisher, as Lynette's allocated nurse for this day, completed the risk assessment at 2:35 pm after collecting her from Napier Street. At that time she made the observations as recorded in the medical records "Lynette remains insight less re current situation and conditions of CTO, nil delusional material expressed. Good eye contact, speech normal rate, tone and volume. Orientation was good and memory impaired". The reference to memory impaired was clarified in evidence by Ms Fisher as meaning that Lynette could not remember the terms and conditions of her CTO even though they were explained to her the

previous day. When asked in particular what terms or conditions, Ms Fisher stated, "that she needed to tell staff that she was coming and going and expected, truthfully tell people where she was going and what time she expected to be back". Therefore, I note that even though Lynette was out in the community on a CTO it was recognised that as part of the terms of her CTO she was to keep people informed of her whereabouts and movements.

36. In relation to the further entries Ms Fisher rated Lynette's risk of avoiding contact/ absconding as low. Ms Fisher further stated that the expression of absconding was relevant to people in the secure ward more so than those in the CCU. In relation to Lynette's absence that day she did not regard that as absconding as she was "just off grounds visiting and as a community patient she is at liberty to leave the grounds".

37. Ms Fisher in her evidence agreed that when a patient was relocated from the SECU to the CCU as a matter of practice there would be an increased sense of involvement or awareness with a patient in those circumstances. Ms Fisher stated that nursing staff would be going down to check on patients a little bit more and see how they were coping on transfer to the community units from SECU. It was also not uncommon for patients when they were recently transferred to CCU to still attend the SECU area for meals as occurred with Lynette.

Events of the 15th of December 2010

38. On what was Lynette's third day in the CCU she again stated to nursing staff that she would like to attend the local supermarket. At the time she was assessed by Nurse Margaret (Penny) Armstrong-Goldsmith. At the time of the discussions with Lynette, Ms Armstrong-Goldsmith reinforced what the expectations were namely that she not drink alcohol, take any drugs or attend her relatives' house. Ms Armstrong-Goldsmith stated Lynette confirmed her understanding by repeating them to Ms Armstrong-Goldsmith. Lynette left Vahland House at approximately 11.30am. Once again she was dressed in her heavy jacket and once again it was inappropriate attire for the very hot weather conditions.

39. Ms Armstrong-Goldsmith confirmed in her evidence that she had nursed Lynette on her prior residence in the CCU in September 2010. Ms Armstrong-Goldsmith was aware on two occasions being the 3rd and 5th of September 2010 that Lynette had stated she was going to a certain location and went somewhere else. Ms Armstrong-Goldsmith did not have any actual involvement with Lynette in respect of those matters.

40. On this day the 15th of December Lynette again managed to make her way to the home of Mr Eric Lakey and her aunt and uncle. It was around lunchtime and Mr Lakey expressed his shock of seeing Lynette standing at the back door again. Mr Lakey noted that Lynette was attired the same as the day before and her personal hygiene was unchanged. When asked how she had come to be there Lynette stated that she was "out of that place" and that "if they come for me I'll hide somewhere".

41. Mr Lakey immediately telephoned Vahland House and the woman to whom he spoke said she was sorry and that someone would come immediately to pick Lynette up. The file note suggests that the woman who took this call was Ms Armstrong-Goldsmith but in her evidence Ms Armstrong-Goldsmith did not have a recollection of doing so. Ms Armstrong-Goldsmith did agree the note and the manner it was written supported the conclusion that it was she who spoke to Mr Lakey. Mr Lakey gave evidence that when he asked how it was that Lynette had been let out unescorted for two days running the reply he received was that

Lynette was in the 'open house' and was a member of the community so that they could not keep her in the secure facility. Not long after this conversation Ms Armstrong-Goldsmith attended to collect Lynette. Prior to her arrival Lynette was moving around stating over and over again that she "would hide somewhere if they came to get her". This comment was passed on by Mr Lakey to hospital staff and recorded in Lynette's notes.

42. Mr Lakey stated that he had a conversation with the woman who came to collect Lynette who was Ms Armstrong-Goldsmith. He detailed that he had stated in "no uncertain terms" that it was his opinion that it was wrong for Lynette to be let out unescorted again particularly in light of what had occurred the day before. Mr Lakey stated he was provided with an assurance by Ms Armstrong-Goldsmith that it would not happen again and that she would be speaking with the resident psychiatrist who would be back on duty. Mr Lakey stated that he detailed the reasons for his concerns that Lynette was vulnerable to being taken advantage of.

43. In his statement Mr Lakey said that Ms Armstrong-Goldsmith assured him there would be no repeat of this incident as Lynette would be placed back into the secure facility after being spoken to by the psychiatrist. Mr Lakey was challenged on this point by Ms Ellis who appeared on behalf of Bendigo Health. Ms Armstrong-Goldsmith did not agree she had made such a comment and that further such a comment would not be made as Ms Armstrong-Goldsmith had no authority to make such a pronouncement, it was only the psychiatrists who could. Mr Lakey was adamant that such comment had been made. I prefer Mr Lakey's recollection as it links in with the reference to the psychiatrist being back on duty which was correct. Ms Armstrong-Goldsmith may not have the power to herself bring about the movement of Lynette into a secure facility, but part of her duties is to inform those who do make such a decision.

44. Ms Armstrong-Goldsmith attended Mr Lakey's home and collected Lynette who did not resist a return to Vahland complex. At the time of her collection Ms Armstrong-Goldsmith detected the smell of Jim Beam and on return to Vahland complex Lynette voluntarily took a breath test that returned a reading of 0.04 percent blood alcohol concentration. Ms Armstrong-Goldsmith was not of the view however, that this fact was grounds for suggesting a revocation of Lynette's CTO. Ms Armstrong-Goldsmith was concerned sufficiently to alert Dr Eaton to the circumstances of the previous two days and Lynette attending her relatives' house uninvited and without advising staff of her intended visits. Ms Armstrong-Goldsmith gave evidence that she discussed with Dr Eaton Lynette's vulnerability.

45. On return to Vahland House at 2.30 pm Ms Armstrong-Goldsmith conducted the risk assessment of Lynette. At that time Ms Armstrong-Goldsmith rated the risk of absconding as medium. Ms Armstrong-Goldsmith did note that technically a person cannot "abscond" as such from the CCU. In this instance however, it was being viewed as being absent inappropriately, as she had been somewhere she should not have been.

46. The hospital records reflect that Mr Lakey later that same day at around 2 to 3pm telephoned Vahland house and spoke to Ms Jennifer Sambrooks, a nurse on duty, seeking re-assurance that Lynette would not be allowed to visit his parents again. Mr Lakey stated in his evidence that it was not that Lynette was unwelcome. Mr Lakey was of the view that Lynette should not be allowed to wander the streets in her condition that he regarded as mentally unstable. Ms Sambrooks stated that she reassured Mr Lakey that staff would talk to Lynette and verbally handed over to the evening shift that Mr Lakey had phoned.

47. In her evidence Ms Sambrooks stated that she personally also had concerns that Lynette was not going where she stated she would be and therefore was not being honest with them. Ms Sambrooks stated it was a risk in that they did not know where she was. Ms Sambrooks stated in her evidence that she had spoken to Lynette about Mr Lakey's concerns about turning up at his family home unescorted. Apparently Lynette could not understand how such behaviour presented as a risk to her. Ms Sambrooks explained to Lynette that it was her not telling them where she was going and wandering around that was the risk.

48. Ms Armstrong-Goldsmith gave evidence of the conversation that took place between herself and Dr Eaton. She stated she spoke to Dr Eaton in the SECU and expressed the staff concerns and the family concerns regarding Lynette's tendency to wander. Ms Armstrong-Goldsmith stated that she advised that Lynette had misrepresented where she was going on that day and Dr Eaton was aware of the same situation the day prior. Ms Armstrong-Goldsmith told Dr Eaton that Lynette had consumed alcohol whilst out and further had stated to her family that "if they come to get me I'll hide". Ms Armstrong-Goldsmith was present when Dr Eaton spoke to Lynette and reiterated her leave conditions and that she was not to visit her relatives as they had asked her not to go. Ms Armstrong-Goldsmith stated that Lynette was unhappy and quite upset. Ms Armstrong-Goldsmith confirmed that in the discussions she had with Dr Eaton it was accepted that none of Lynette's behaviour were sufficient grounds to revoke her CTO.

49. Ms Fisher recalls being rostered on that day from 7am to 3.30pm. Ms Fisher recalls seeing Lynette briefly on that day following her return from being collected by other staff again from her relative's house. Ms Fisher stated that she approached Dr Scott Eaton who at the time was having a discussion with Penny Armstrong-Goldsmith about Lynette's circumstances. Ms Fisher stated they advised Dr Eaton of her relatives concerns regarding her wandering the streets and attending their property without being invited. Dr Eaton indicated that he would discuss again with Lynette the conditions of her CTO and reinforce her relatives request that she not visit unless requested to do so. It is to be noted that repeatedly throughout her evidence Ms Fisher stated the reference to "concerns" was a recording of the concerns articulated by the family. They were not concerns that Ms Fisher herself was expressing. In hindsight however, the concerns raised by the relatives were in fact accurate.

50. Dr Eaton's recollection of the conversation with Ms Fisher is at slight variance to her recollection. Dr Eaton referred to the notes recorded by Ms Fisher about concerns for Lynette's safety in light of her absences from Vahland House on the 14th and 15th of December 2010. Dr Eaton in his statement recalled clarifying with Ms Fisher that the locations Lynette was attending were not detrimental to her heath and that she was not wandering aimlessly. In addition there was no change to Lynette's mental state that raised concern such as a relapse of psychosis (such as hearing voices). Dr Eaton stated that Ms Fisher was not able to identify any concerns which would cause him to have grounds to revoke Lynette's CTO. Dr Eaton stated to Ms Fisher that if there was any change, the option to revoke Lynette's CTO could still be considered. Ms Fisher did agree under cross-examination from Ms Ellis that the option to revoke the CTO was always available. Ms Fisher also agreed that she was not able to identify any changes in Lynette's mental state to Dr Eaton that would raise concerns.

51. Dr Eaton detailed that in his conversation with Lynette, following the discussions with the nursing staff, he advised Lynette that as long as she attended her individual program activities she was free to leave the grounds. Lynette was told she would need to make staff aware of her plans to leave and of her time of return. Dr Eaton recalled specifically asking

Lynette why she had not made staff aware of her intention to visit her relatives to which she replied that she did not think she would be allowed to visit. This misunderstanding by Lynette demonstrates to me that to her mind she was not "free to come and go as she pleased". Dr Eaton explained that the need to inform staff was done to ensure that the patient or person being visited was not at risk. Dr Eaton stated that Lynette was accepting of the situation and responded affirmatively that she had understood the conditions of taking "leave" from the CCU.

Events of Thursday 16th of December 2010

52. On Thursday the 16th of December 2010 at approximately 11.30am Lynette attended upon the nursing station in the secure unit and spoke with nurse Jennifer Sambrooks. Ms Sambrooks stated that Lynette's allocated nurse was busy with another patient at the time so she spoke with Lynette instead. Lynette advised nurse Sambrooks that she wanted to go to the local IGA and confirmed her understanding that she was not to go to her aunt or uncle's place. Ms Sambrooks noted Lynette could not understand why she could not visit but agreed she would not do it again. Ms Sambrooks in her evidence stated that she explained to Lynette that her aunty and uncle were frail. Lynette stated she only wanted to go for a walk and would be away for half to one hour. Ms Sambrooks described Lynette's mood as euthymic, she was polite and pleasant and pleased when she agreed that she could go to the IGA. Ms Armstrong-Goldsmith recalled overhearing the conversation between Ms Sambrooks and Lynette and that the conditions of her CTO were detailed to Lynette and she agreed to abide by those conditions.

53. Ms Sambrooks gave evidence having undertaken a risk assessment with Lynette prior to her being permitted to leave, but there were no contemporaneous notes made. Ms Sambrooks stated the shift had been very busy and she had forgotten to do the notes prior to leaving herself. There were notes made retrospectively on the 17th of December 2010 when Ms Sambrooks was next rostered on. The recording of these notes was done after it had been discovered that Lynette was deceased.

54. Ms Sambrooks was questioned as to whether, having known that Lynette on the two previous days had misrepresented her intentions of where she was going, had led to any heightened concerns when she sought to leave again on the 16th. Ms Sambrooks stated she believed after having spoken to Lynette about not attending at her aunt and uncle's place and not consuming alcohol whilst out and that she had also been spoken to by Dr Eaton that Lynette had agreed to be compliant with the rules.

55. Ms Sambrooks in her evidence stated that she had been involved in nursing Lynette at the time she was in the SECU. She stated since her medication changes Lynette was more compliant and more settled. She noted Lynette was no longer having auditory hallucinations and on the day of the 16th she seemed coherent and clear, so that was why she was happy to let her go. I suspect the same would have been said in relation to the two days prior when Lynette had sought to leave the complex that she presented as coherent and clear. That in itself though, was not an assurance that she would go where she stated she would. Ms Sambrooks stated in her evidence there was no reason in presentation of Lynette, after having exercised clinical judgement, to dissuade or stop her from leaving.

56. Ms Sambrooks was taken through her assessment notes of Lynette as recorded the following day on the 17th of December 2010. Ms Sambrooks had noted that Lynette was "overdressed for the weather" given she was again wearing the heavy blue jacket. Ms Sambrooks

explained she was not concerned about this fact as it was usual for Lynette to wear the jacket and she had stated she was cold. In Ms Sambrooks observations Lynette was otherwise reasonably dressed, neat and tidy. The fact that Lynette's insight and judgement may have been impaired was not, to Ms Sambrooks view, a reason not to permit her to leave Vahland complex. This was particularly so as she was confident that Lynette was agreeable to doing what was required, namely not visiting her relatives, consuming alcohol and going to the IGA as she had stated she would.

57. At no time did Ms Sambrooks make any observations that Lynette was nervy and jittery. In relation to Lynette's rate of speech it was characterised as normal and affect was "warm", which Ms Sambrooks clarified as meaning engaging, talking with her, smiling and interacting well. There was no evidence of formal thought disorder, namely she was not having strange thoughts or ideas or delusions. Ms Sambrooks stated that this was confirmed by the fact that Lynette could engage in conversation and was not responding to voices. She had good eye contact and her cognition was noted as alert and orientated.

58. Ms Sambrooks stated that she was aware that Lynette had not been sighted for the 12.30 pm rounds and stated at hand over to the next shift at 1.30pm that Lynette was not back. Ms Sambrooks could not recall if she or any staff attended at Lynette's room in the CCU to see if she had returned. It appears no one had actively sought to establish where Lynette was at or around that time.

59. In relation to the assessment where Ms Sambrooks rated as "Low" for risk of avoiding contact / absconding Ms Sambrooks stated she made that assessment based on the conversation that she had with Lynette on that day. Ms Sambrooks was aware of the prior days of "absconding" but Lynette had assured her she would be compliant with the expectations. When Lynette had not returned in the expected time, Ms Sambrooks stated that she thought she had probably been lied to again by Lynette and that Lynette had gone to see the aunt and uncle again. Ms Sambrooks had no idea that Lynette would be going to Maldon. Ms Sambrooks was asked if she had called Mr Lakey to enquire if Lynette was at his home again, but she could not recall.

60. Ms Armstrong-Goldsmith recalls that there would have been general discussion amongst the nurses of the fact that Lynette had not returned from her trip to the IGA and that this information would have been included in the hand over to the next shift at approximately 1.30pm. Ms Armstrong-Goldsmith stated that during the course of her shift no one, that she was aware of, had made any inquiries as to Lynette's possible whereabouts outside of the CCU. Ms Armstrong-Goldsmith confirmed she was the allocated nurse for Lynette for the 16th but had no discussions or interactions with her from the commencement of her shift at 7am until Lynette left the facility at 11.30am.

61. Ms Armstrong-Goldsmith also made the observation in her evidence that Lynette was a member of the community and therefore was free to come and go as she pleased. Ms Armstrong-Goldsmith did agree with my proposition that it may be understood by nursing staff that they had no powers to limit Lynette's movements but Lynette herself may not have been so aware. Ms Armstrong-Goldsmith also agreed that although they regarded the request to leave Vahland complex as a courtesy, Lynette may have regarded it as a mandatory expectation. In this way Lynette would lie if she felt she would not get approval or be permitted to leave if she honestly advised of where she intended to travel.

62. It was said by Ms Armstrong-Goldsmith that Lynette was always happy to return to Vahland complex on collection from her relatives. Ms Armstrong-Goldsmith agreed with the proposition that Lynette may have been operating on a belief that she had no choice and

that if she refused she could be placed back into the secure unit. It was to my mind, highly likely such considerations were influencing Lynette's behaviour.

63. On prior occasions in the month of September when she had travelled to different locations than otherwise advised the outcome was that she was placed into SECU. This misunderstanding by Lynette as to her entitlements of "coming and going as she pleased" was further supported by the fact that she was working under the misapprehension that it was the nursing staff who were saying she could not go to visit her relatives, not the relatives themselves.

64. It was the situation that Ms Armstrong-Goldsmith noted at the time she finished her shift and the next had commenced there was concern developing as to Lynette's whereabouts. On this day Ms Fisher was rostered on from 1.30 pm to 10 pm as the acting shift manager. It was handed over to her at the commencement of that shift that Lynette was nowhere on the grounds as she had gone to the IGA. There were no contemporaneous notes made by Ms Sambrooks or anyone as to exactly when it was that Lynette had left, where she stated she was going and what time she was expected to return.

65. In notes made by Ms Fisher some hours later at 6.50pm it was recorded that Lynette stated she was walking to IGA at 11.30am. In her evidence Ms Fisher stated it took approximately half an hour to walk from Vahland complex to the IGA. Under those circumstances Ms Fisher was not surprised that Lynette had missed the 12 o'clock rounds.

66. At the time of commencement of Ms Fisher's shift Lynette had already been absent for 2 hours. Ms Fisher was asked under cross-examination if she was concerned Lynette was not back given what had occurred in the days prior. Ms Fisher stated that, because Lynette was in the community she was free to make choices and there needed to be a decent amount of time passed before contacting the police. I note however, this is contrast to the fact that Ms Fisher, along with Ms Sambrooks, were concerned sufficiently only the day before to speak to Dr Eaton about Lynette's behaviour.

67. In evidence taken at the inquest Ms Fisher was asked if in light of the previous events of the 14th and 15th of December 2010 whether that raised any concerns for her. Ms Fisher stated she had "done a risk assessment of her two days before and assessed her as being of no real concern … and because she was a community patient it wasn't really that much concern that she wasn't present for that period of time."

68. It concerned me that in formulating her assessment Ms Fisher was relying on a risk assessment that she had conducted two days prior and there had been, in the intervening period, another occasion on the following day when Lynette had again said one thing and done another. The risk assessment completed on the day prior also had elevated risk of absconding to medium and Lynette had consumed alcohol whilst away from the CCU. There was also no current risk assessment noted in Lynette's records to have regard to.

69. At 4.40 pm Ms Fisher asked staff to do an early observation round (usually undertaken at 5pm) to see whether Lynette had returned and was asleep in her unit. Ms Fisher was advised she had not returned and this was now some five hours since Lynette had left the complex. At this point Ms Fisher proactively sought to attempt to locate Lynette. She telephoned the aunt in Napier Street to whom Lynette had visited on the previous two days. The aunt had not seen Lynette that day. At 4.50 pm Ms Fisher received a call from triage at Bendigo Hospital relaying information received from Ms Mackenzie as to the sighting of Lynette in Dunolly. Lynette was seen to be wandering aimlessly down the main street and picking up cigarette butts.

70. Ms Fisher contacted her unit manager at 4.55pm who advised her to call the "on call" psychiatrist to have Lynette's CTO revoked due to concern for her safety and missing her medication that evening. Ms Fisher needed to ring around to find a psychiatrist who was able to authorise the revocation of Lynette's CTO. Ms Fisher managed to contact psychiatrist Dr Chopra. Ms Fisher explained to Dr Chopra Lynette's situation, including her concern for her safety and that she would be non-compliant with her clozapine medication if she did not return. Dr Chopra was willing to provide the revocation of the CTO on the strength of that information. The relevant paperwork was received at 6pm.

71. In between obtaining the documentation to revoke the CTO Ms Fisher had been in contact with Sgt Frazer of the Maryborough police to advise of Lynette's situation. Over the course of the next couple of hours Ms Fisher received calls and made calls in an effort to gather information as to where Lynette may be. Ultimately she was made aware that there had been a motor vehicle accident in Dunolly and a female was deceased. The police could not confirm at that time it was Lynette until they had spoken to her next of kin. Ms Fisher finalised her notes and completed her shift.

72. It was frustrating that when Ms Fisher was asked as to what her concerns were for Lynette, she responded in almost identical terms each time that "she is a community patient and she was at liberty to be absent from the premises". This did not answer the question. The mere fact of being a community patient should not mean that there are no concerns. I am sure that Ms Fisher did not intend her responses to be interpreted that way, but unfortunately that was the manner in which they were received. It is also in stark contrast to the way Ms Fisher conducted herself on the late afternoon / evening of the 16th of December 2010 when she made extensive enquiries in an attempt to locate Lynette, which demonstrates she was concerned.

73. Mr William Roy gave evidence on having seen Lynette around 2.15pm on the day of her death. He stated he was driving with his granddaughter in the car who noticed Lynette walking on the side of the road. He stated that his granddaughter made the comment that the person was walking like a zombie. Mr Roy stated he knew what this meant as the person was walking slowly but staring out in front of her. He stated she gave the impression that she would walk over the top of you if you stood in front of her. On his return trip to Maldon some 10 or so minutes later he realised the person walking was Lyn Lakey from Maldon. Mr Roy had not seen Lynette for about 15 years. He stated that she looked terrible, her face was red and blotchy and he made the observation she had more clothing on than needed, given the warmth of the weather.

74. Mr Roy stated that he turned his vehicle around and spoke to Lynette through the window. She stated she was going to Dunolly so he offered her a lift which she accepted. Mr Roy said that Lynette said she had been in the "rat house" but not much else apart from saying she had sold the shop. When asked about her appearance Mr Roy stated that Lynette physically was extremely clean. He stated he thought the jeans and jacket were virtually new in appearance.

75. Lynette directed Mr Roy to a white house in Dunolly near the caravan park and she got out. Mr Roy watched Lynette as he drove away and she did not enter the white house but turned and walked back towards the caravan park. Mr Roy took note of the time and it was 3pm. Mr Roy estimated that the distance between Bendigo and Maldon was approximately 45 to 50 kilometres. At the time he first noticed Lynette she was approximately 4 or 5 kilometres walking away from Maldon.

76. There is little that is known of Lynette's movements during the day. A statement was provided to the court by Jack Sinclair who was unavailable to give evidence at the inquest. Mr Sinclair had been in a brief relationship with Lynette that ended around 2005/2006. The statement was generally lacking in detail as to locations and times that might have been clarified in the event Mr Sinclair gave evidence. It is of little consequence as it was clear from his comments that Lynette was wandering around Dunolly in search of money to purchase alcohol and cigarettes. Mr Sinclair provided cigarettes, but not alcohol or money as he had neither. It is clear from the blood alcohol reading noted from the pathologist as being 0.16%, Lynette had managed to obtain alcohol from somewhere prior to her death.

77. As noted from the testimony of Ms Fisher, the Maryborough Police were contacted at about 5pm in relation to Lynette's location being unknown. The police officer on duty that day Sergeant Donald Frazer took that call wherein Ms Fisher stated that Lynette was in the main street of Dunolly and there were concerns for her welfare and that she could be a risk to herself. Sgt Fraser was informed that Lynette was an involuntary patient presently on a Community Treatment Order that was to be revoked. He was provided with a general description as to her appearance and that she had been seen walking slowly in Broadway (the main street in Dunolly) picking up cigarette butts.

78. Sgt Frazer passed this information on to Leading Senior Constable Lee, of the Dunolly police, who patrolled the streets of Dunolly from 5.30pm without success. As L/S/C Lee's shift was then complete the responsibility to further patrol the area in search of Lynette was given to Senior Constable Smith. He was also unable to locate Lynette. At approximately 9.30 pm Sgt Frazer became aware that a female pedestrian had been struck by a motor vehicle in Broadway, Dunolly and was deceased. Sgt Frazer along with other police, the local SES and CFA attended the location where Lynette lay.

79. Eileen Mackenzie had known Lynette for 45 years and had seen her approximately 4 weeks prior. Ms Mackenzie was aware that Lynette was in psychiatric care. On the day of Lynette's death, Ms Mackenzie had been informed by a friend that Lynette had left "Psych" services and was in Dunolly. Ms Mackenzie had known that Lynette was not supposed to be in Dunolly and thought that she would look for her. Prior to doing so however, Ms Mackenzie telephoned Psychiatric Services to inform them of Lynette's whereabouts.

80. Ms Mackenzie left her home at approximately 3.30 -4.00pm and drove around Dunolly looking for Lynette for about 20 minutes without success. At approximately 8pm Ms Mackenzie again was driving around Dunolly looking for Lynette when she received a call from Les Lakey stating he had heard over a scanner that a female had been hit by a car. Ms Mackenzie headed to the location where the female had been hit and immediately identified the victim as being Lynette.

81. Ms Mackenzie when giving evidence at the inquest believed she received the information as to Lynette's presence in Dunolly at around 11am and immediately informed Psychiatric Services to this fact. This contrasts with the hospital records that suggest the phone call was received from Ms Mackenzie around 4.50pm. I prefer the accuracy of the hospital records as to the time of the call, as Ms Mackenzie made a number of variations on times in her evidence compared with what was in her original police statement.

82. At the scene of the collision Sgt Frazer spoke with Raymond Mills who was the driver of the vehicle that had struck Lynette. Sgt Frazer conducted a preliminary breath test on Mr Mills which produced a negative result to the presence of alcohol. Mr Mills was interviewed as to his involvement in the collision. Mr Mills later provided a formal statement for the brief of evidence. Mr Mills stated he was familiar with Broadway in Dunolly as he operated a

business in that street and travelled the road at least twice a day for the previous three and half years. The area where the collision occurred was a 60 kph zone. It was poorly lit with no street lighting.

83. Just prior to the collision Mr Mills was aware of headlights from a vehicle approaching him from the opposite direction. The headlights were on low beam and therefore there was no impediment to Mr Mills' vision. He estimated his speed to be approximately 60kph. He was looking straight ahead and saw nothing on or near the road. As the approaching vehicle passed he heard and felt a loud bang and saw something dark, almost black hit the front right lower windscreen pillar and glance from the vehicle.

84. Mr Mills executed a U-turn and got out to see what he had hit with his car. It was at this point he became aware of a person lying on the side of the road. The other car that had been travelling on the road also stopped and the driver, Tom Aczel, came to assist. Mr Aczel also made a statement to assist in the investigation. Mr Aczel placed the time of the collision as being around 9.10pm. He noticed that a person had been hit by the other vehicle and came to provide assistance. Mr Aczel was a volunteer St John Ambulance First Aid Officer so was able to provide immediate care. He performed mouth to mouth whilst Mr Mills did compressions. It was apparent from the statement provided by Mr Aczel that Lynette had died almost instantly from her injuries.

85. It is clear from the evidence of both Mr Mills and Mr Aczel that no one saw Lynette prior to her being struck by Mr Mills' vehicle. Sgt Cunningham undertook an investigation into the circumstances of the collision and concluded that Mr Mills was not at fault. It was on all accounts a tragic accident. Sgt Cunningham also spoke to other members of the community at Dunolly who had seen Lynette earlier in the day but they were unable to add anything to how it was that she came to consume alcohol, just that she was seen in the town at different times through the afternoon.

86. Mr Lakey spoke of receiving a telephone call from a person at Vahland complex at what he estimated was approximately 2pm. He stated the woman he spoke to queried if he had seen Lynette at all that day or if she had been to his address. They were unaware at that time of Lynette's whereabouts and were concerned for her welfare. Mr Lakey stated at the time he was almost speechless that Lynette had been let out unescorted again and expressed as much to the nurse he spoke to. He stated the response he received was that Lynette was a "member of the community" and could not be kept in a secure facility. Mr Lakey commented to this nurse that "even a layman could see that Lynette was not in her right frame of mind and was at risk being allowed to wander the streets". He stated the reply he got was that her supervisor had made a "judgement call" to let Lynette out unescorted again. Mr Lakey stated he suggested other avenues of enquiry and had been informed the police had been notified.

87. Mr Lakey was challenged on his recollection of the timing of this call having been 2pm in the afternoon. Mr Lakey in his evidence went into a fair amount of detail as to how he recalled the timing of the call. It was put to Mr Lakey in cross-examination that nurse Fisher was the person in charge of making enquiries as to Lynette's whereabouts on the 16th of December and that the police were only notified at 5pm. The suggestion therefore was that Mr Lakey was incorrect as to the time of the call. It is important to note however, that Ms Fisher made comprehensive notes as to who she spoke to on that afternoon/ evening and there is no reference to having spoken to Mr Lakey. It is to my mind, as suggested by Mr Lakey, that he was telephoned at 2pm and spoken to by a different nurse and that the reference to the police being notified was possibly said in order to placate him.

88. Mr Lakey stated the following day he was notified that Lynette had been hit and killed by a car in Dunolly the previous evening. In response he telephoned Vahland complex and was put through to the Supervisor who had let Lynette out unescorted from the facility the previous morning. The response by Ms Sambrooks was that she was sorry for their loss but that she had made a judgement call to let Lynette out of the facility unescorted as "she appeared to be so happy and cheerful". When Mr Lakey queried how it was that the day prior he had been assured that Lynette would be returned to the secure facility and not let out unescorted, the response was that Lynette was a "member of the community" and they could not simply put her back in the secure facility.

89. I assume what was meant by this comment or observation was that while Lynette remained on the Community Treatment Order until such time as it was revoked she remained free to do what she pleased. Ms Sambrooks in her evidence could not recall having a conversation with Mr Lakey the following day and felt it was unlikely she would have used the expression "happy and cheerful".

90. Mr Lakey made the observations that having himself been a police officer for a significant period prior to retirement he had dealt with a lot of mentally unstable people. Mr Lakey was of the opinion that even a lay person could plainly see Lynette was suffering from mental instability and was in no way a suitable candidate for unescorted release from the institution in which she was placed, particularly after her wandering of not one but two previous occasions. Mr Lakey noted he spoke for Lynette's extended family when he expressed the belief that well intentioned, but nonetheless grievous error in supervisory judgement had been made on the day of Lynette's unfortunate death. It was the firm belief of the family that Lynette would still be alive if that error in judgement had not been made. I will comment further on this observation later in this finding.

Timing of decision to start to search for Lynette

91. The timing of when it was regarded as necessary to attempt to locate Lynette was in many ways crucial. The decision-making process attendant with that is as important in many respects as decisions made to allow further absences from Vahland to attend upon the IGA and also if and when to revoke the CTO. It was clear from the evidence of Ass. Professor Tune that there was no formalised plan or guideline setting out what exactly was to be done and when, if a patient had failed to return from an outing whilst in the CCU. The response to a situation where a patient was identified as missing when they failed to return from a planned absence or they were found to be absent without having notified staff was guided by clinical judgment (depending on the assessment of risk).

92. As stated by Ass. Professor Tune staff may be guided by the "Reporting of Missing or absconded Psychiatric Patients from Inpatient Units" policy which is applicable to patients in the SECU. This policy requires staff to contact a range of people, including the relevant unit manager/shift manager, the patient's medical officer (or duty doctor after hours), the next of kin, police and the Psychiatric Triage Service as well as completing relevant paperwork. It is clear these steps were largely undertaken in the search for Lynette. The question remains one as to timing of that process. Ass. Professor Tune stated that the expectation of how staff would respond would be governed by how dangerous they thought the behaviour may be. In this respect Ass. Professor Tune noted that on the days prior the behaviour engaged in of visiting relatives, was not dangerous behaviour.

93. Ass. Professor Tune was asked what, in his view, was a reasonable period of time to wait before being more pro-active in ascertaining where a patient may be if they had not returned within the time frame they had set. Ass. Professor Tune responded, "an hour or two at the most". It is recognised the decision and timing is, as stated, one of clinical judgement and subjective to the immediate circumstances as they present. Ass. Professor Tune did concede that an earlier response of ringing some of the relatives would have been appropriate. Ass. Professor Tune was asked if the timeliness of action by staff was identified in the internal review, to which he responded that it was not.

94. It was put to Ms Fisher that when her shift commenced at 1.30pm on the 16th of December 2010 her decisions as to when to actively look for Lynette were based on the exercise of clinical judgement. That clinical judgement was formed having regard to the risk assessment she undertook on the 14th of December 2010, the risk assessment undertaken on the 15th of December and the hand over information provided by nurse Sambrooks on the 16th of December. Ms Fisher agreed with this proposition and added to the information also the knowledge that the day prior Lynette had spoken with her treating psychiatrist. It must be recognised there were no notes from the assessments undertaken by Ms Sambrooks. Ms Fisher was referred to those notes that were written subsequent to the events and stated they would not have altered her decision of when to start searching for Lynette.

95. It appears someone was concerned however, as a call was made by a member of staff to Mr Lakey at what he estimates to be around 2pm. Ms Fisher was clear this was not her, but I accept the evidence of Mr Lakey that the enquiry was made of him. Whoever did make that call did not make a note in Lynette's file or pass the information on to Ms Fisher who was then the nurse in charge. Ms Fisher also placed emphasis on her decision making not only on the basis that Lynette was mentally settled, but also as she was in the community stating, "so there was no real urgency to act because she is technically an out-patient in the community". That may be correct in the sense that there is no mandated time of return for Lynette, but that does not alter the fact that other matters may come into consideration that urgency should be applied. It may be said that Lynette was mentally stable in terms of her condition but that does not mean she is without risk if she were consuming alcohol and otherwise wandering the street, which as it turned out she was.

96. Ms Fisher stated that it was on a directive from her unit manager, Ms Helen Steel, who she had spoken to that afternoon in respect of Lynette's absence, that the psychiatrists were approached to request consideration of the revocation of Lynette's CTO. It was put that one of the primary concerns was that Lynette may be non-compliant with her medication being clozapine. Ms Fisher had given evidence that she was the clozapine co-ordinator for Vahland complex which enabled her to provide extra information in the proceedings. It was put to Ms Fisher that missing one dose of clozapine would not have an immediate reaction. Ms Fisher agreed stating that what they go on is three missed doses. In this regard Lynette was regarded as having missed a dose when she had vomited whilst on weekend leave. This was however, on the Saturday prior. There is nothing to suggest she had missed any other doses, as the next dose of clozapine on the 16th of December 2010 was not due until 8pm that night.

97. Dr Eaton in a statement provided to the court was specifically asked what the outcome would be if a patient misses taking their dose of clozapine and his response was "If a patient takes clozapine ceases this medication they are at an increased risk of a relapse of psychotic symptoms, but such a relapse would not occur immediately. A relapse following non-adherence to medication develops over a period of weeks rather than hours and symptom development is usually subtle and patient specific." The reality to my mind is that it was not

ideal that Lynette may miss a dose of clozapine, but that in itself was not determinative of the need to act to revoke the CTO. It was the other alive factors of the events of the proceeding days which were well within the knowledge of all those responsible for her care that was the reason for alarm to be raised and the ultimate revocation of her CTO.

The co-location of the SECU and CCU- an advantage or disadvantage?

98. The observation was made early on in this finding that the setup of Vahland complex was unique in that the SECU and CCU were co-located. This meant that although the buildings the patients stayed in were separated they were located on the same site. The otherwise separate facilities shared the same nursing staff and at times the CCU patients would attend within the SECU area to meet medical staff, undertake meals or activities, receive medication and have a risk assessment conducted. As noted by Ass. Professor Tune this was a definite advantage when patients transitioned from SECU to CCU as having the same staff group meant the nurses were already familiar with the patient's, making the transition easier. I would agree, as it would no doubt also provide a benefit in the accuracy of risk assessments and generally making observations as to how a person was coping as they would have a comparison on which to base those assessments.

99. The staff were physically located in the SECU area. This raised concerns to me as to exactly how much over sighting of patients in the CCU there really was, given the nature of the lay out of the premises and the splitting of responsibilities between high care patients and lower care. The first impression I made at the time of undertaking a visit to the facilities prior to the inquest commencing, was the relative isolation of the CCU to the nursing stations and staff contained in the main building. In order for patients to be able to enter the SECU they would present at the door and have themselves "buzzed" through. This was understandably a requirement as the location they were entering was a secure zone and therefore care had to be taken to avoid involuntary inpatients from being able to leave.

100. It was clear from where the nursing staff were located they would have no idea who was coming or going from the units unless they went physically out of the building. In addition the only way to ascertain if someone had returned from an outing was for that person to have physically or by phone advised of such or a check by phone or attendance at the patients' unit. The evidence of Ms Wallace on this point was that it was usual for the patient to attend the SECU at which time they would have a chat with their allocated nurse. If they were heading out for the day they would advise of where they were going. Ms Wallace stated it was not a requirement for them to advise of their return. Ms Wallace did say it was a general practice that the nurse allocated would attend the units or ring to see if the patient was back. There would of course always be the checking of patients at the "sightings" times detailed earlier.

101. Ms Fisher gave evidence that to her knowledge Vahland complex was the only CCU in this state that was co-located on the same grounds as the Secure Extended Care Unit. Ms Fisher had visited other facilities in Ballarat, St Vincent's Hospital and the Austin Hospital. Although the new Bendigo Hospital was close to completion at the time of our visit to Vahland complex in 2016 the SECU and CCU were still fully operational. Evidence was given that the expectation was the SECU would move to the location of the new hospital and the CCU would remain in its current location. The effect of this as described by Ms Fisher is that the CCU would have a cohort of nurses dedicated to the CCU, which Ms Fisher described as beneficial for them.

102. Ms Armstrong-Goldsmith when giving evidence was asked if having knowledge of Lynette's conduct on the 14th and 15th of December whether that meant that a greater degree of attention needed to be placed on her. Ms Armstrong-Goldsmith stated that "whether it did or didn't, I still have to do the tasks allocated in SECU first because SECU is the secure environment and when you move into the community units, even though there are reasons to be concerned about people in the community that does not mean they come above and beyond the SECU clients". In clarification Ms Armstrong-Goldsmith was asked if SECU tasks and patients took priority over those associated with the CCU, which she agreed was the case unless there was a major calamity that occurred.

103. It may be somewhat academic as to whether the advantages of co-location such as occurred at Vahland complex outweighed the disadvantages. It is my opinion that having individual staff on site, where their sole responsibility was the care and supervision of the patient's in the CCU is the preferable set up.

Considerations as to what is "leave" in the setting of a CCU and staff responsibilities

104. As stated earlier I found it almost to be the mantra of Bendigo Health care staff that Lynette was "a member of the community and could come and go as she pleased". There must be recognised that sensibly there were limitations on that expectation. The facility was not a hotel. It was staffed by qualified nurses and overseen by psychiatrists. There were clearly responsibilities to ensure for the welfare of the patient. If that meant dissuading them from undertaking a certain course of conduct, here leaving the facility for a claimed trip to the supermarket, then that was what was to be undertaken. The mere fact that they could not physically restrain a patient is to view the responsibilities from a different perspective.

105. It was clear that the concept of leave is quite different depending on if a patient is an involuntary inpatient in the SECU compared with a person in Lynette's situation, as of the 13th of December 2010 who was an outpatient subject to a Community Treatment Order. As noted by Ass. Professor Tune in the statement he provided to the Court, an inpatient is physically restricted to the unit, has a higher risk profile and are required under section 40 of the Mental Health Act to have a formal "Leave of Absence" document completed and signed by the authorised psychiatrist or his or her delegate.

106. In contrast patients living in the CCU (on a CTO or on a voluntary basis) are outpatients, have a significantly lower risk profile, are expected to co-operate with treatment, are considered to have a significant degree of independence and freedom of movement and are not required by the Mental Health Act to have a "Leave of Absence" form completed. These are the legal distinctions of managing patients in the care of the SECU or CCU.

107. Ass. Professor Tune further noted that as leave is not formally granted for patients residing in the CCU or required to be formally granted, there is no leave policy governing the CCU. In fact he stated "leave" is not a term which should apply to people residing in community-based facilities. I note however, that the term leave does appear in the Vahland complex brochure that was tendered into evidence. Under the heading "Leave" it is stated that:

> "While admitted to Vahland complex, patients may take leave from the grounds. Within reason and providing staff have no legitimate concerns, voluntary patients have the freedom to come and go during the day providing they have attended their programs and have informed staff of their plans."

108. In his statement Ass. Professor Tune commented that providing patients had participated in their rehabilitation programs, they were to notify staff of an intended absence from the complex and the staff would use clinical judgement as to whether there is any reason to dissuade or stop the patient from leaving. This judgement was based on the patient's most recent risk assessment, the intent and duration of the proposed absence and any other relevant matters.

109. I canvassed with Ms Fisher that the conditions of leave do import some ability of the staff to curtail a patient's expectation of leave given the staff must exercise clinical judgement as to whether there are any legitimate concerns such that they should attempt to dissuade a patient from leaving the site. Ms Fisher responded that in the event a staff member was to advise a patient that they were not to go, the staff member cannot lock them up and they are free to leave. I did note however, there were still limitations and in the event the staff member was significantly concerned then steps could be taken, as they were with Lynette, to have the CTO revoked and so too therefore their freedom. Ms Fisher agreed but felt these comments were better to be directed to Ms Sambrooks who had undertaken the morning shift and by implication it was her who had made the decision to permit Lynette to leave.

110. When Ms Fisher was under cross-examination Ms Ellis provided a hypothetical scenario on which to comment. That scenario was that if a patient had stated they were planning on a trip to Dunolly to meet friends for lunch, if that person otherwise presented as mentally stable with no outward concerns they would not be advised not to go. In response to this Ms Fraser stated that staff would enquire as to the means by which a person was proposing to travel the journey to Dunolly and assist where they could with time-tabling and lifts to the public transport. Ms Fisher did say that they would advise against a person leaving if they did know how they were getting to their location or if they did not think it was safe the method they were using. The conduct by nursing staff in this manner by intervening was to my mind commensurate with the responsibilities of the care team, not merely that they are a member of the community and can do what they want, when they want and how they want.

111. In addition the "patients", as the term reflects, still undergo a level of supervision that would not exist if they were simply in the community at large. They have nurses who attend to them and do regular rounds throughout the day to confirm their whereabouts, they ensure that they are maintaining a certain level of hygiene and tidiness of accommodation, that they are participating in programs and taking medications. In relation to this latter aspect they are required to attend at the nursing station to confirm that such is occurring. They are also subject to regular mental health and risk assessments and are monitored to ensure that adverse symptoms to mental health are not placing them at risk. The nurses and psychiatrists continue to review the mental welfare of the "patient" such that if a change in treatment is required, such as revocation of a CTO, this will take place.

112. Dr Eaton confirmed as much were the expectations regarding the care of a person in the CCU. Dr Eaton was asked if in his professional opinion Lynette had adequate supervision from the 13th to the 16th of December 2011 to which he responded "yes". Dr Eaton was asked questions in relation to the expectations of the Community treatment order. Dr Eaton described such an order as being where a person is detained under the Mental Health Act but they can still be at home or in the community. They are treated and managed by mental health services in the community. Dr Eaton noted that there was provision, as at 2010, to include within a CTO a residential condition. This requirement was not made with Lynette, as there was the expectation that she would reside at CCU where her mental state could continue to be monitored. Dr Eaton stated that residential conditions were seldom included in

CTO's for reasons I need not canvass and he did not feel the outcome with Lynette would have been any different if one had been included. I agree with that observation.

Treatment plans attached to Community Treatment Orders

113. Dr Eaton agreed that there was an expectation under the Mental Health Act 1986 as applicable in December 2010 that a treatment plan would be prepared when a patient was on a CTO. Dr Eaton was referred specifically to section 19A (1) which stated:

"The authorised psychiatrist must prepare, review on a regular basis and revise as required a treatment plan for each patient."

Dr Eaton agreed at the time Lynette was placed on a CTO on the 13th of December 2010 there was no treatment plan prepared. When asked to explain why there was not, Dr Eaton explained that the standard practice was that it was prepared by the junior doctor within a few days of the CTO being made. Based on this time-tabling Dr Eaton expected the plan would have been prepared before the next ward round that would have been the Monday following Lynette's death.

114. Dr Eaton explained that a treatment plan would identify what are the aspects of management for any particular patient and identify the treatment and monitoring physical health or identifying accommodation or improving rehabilitation skills. Dr Eaton stated that at the time Bendigo Health also would develop an Individual Service Plan (ISD) that covered many of the same issues which were subject to review every 8 to 12 weeks. Dr Eaton stated such an individualised plan was completed for Lynette on the 13th of October 2010 prior to discharge on the CTO.

115. Dr Eaton was taken to section 14D of the Mental Health Act at the relevant time which detailed, and I paraphrase, that one basis upon which consideration may be given to the revocation of a CTO is if the patient was not compliant with the treatment plan. Dr Eaton was asked if the non-existence of a treatment plan from 13 to the 16th of December 2010 for Lynette made the decision to revoke for non- compliance impossible. Dr Eaton responded that what would have been included on Lynette's treatment plan, such as detailing the medication she was to take or attending upon an occupational therapy assessment was not such that it would have altered the situation. Dr Eaton stated it would not be usual as part of a treatment plan for them to be attending the CCU.

116. Dr Eaton was also questioned by Ms Martin, who appeared on behalf of Lynette's family, in relation to the efficacy of completing the treatment plans in a timely manner. Dr Eaton was provided with the Chief Psychiatrist's guidelines for treatment plans. In those guidelines it is stated that the initial treatment plan should be prepared at the same time that the CCO is made and later a more comprehensive plan should be produced in collaboration with the patient, their family and carers. Dr Eaton agreed that was, as stated, in the Chief psychiatrists guidelines.

117. There was located in Lynette's medical file a copy of the treatment plan as it related to the earlier CTO that was generated on the 16th of July 2010. The treatment plan stipulated that Lynette was required to continue to take her oral medication as prescribed by the psychiatrist or a general practitioner. It also had a requirement for Lynette to attend a psychiatrist for review every three months and to attend appointments and have home visits with a case manager as requested. It spoke of the expectations of the case manager in relation to certain

matters and responsibilities in terms of monitoring Lynette's mental state and liaison with the psychiatrists. It also spoke generally of Lynette's rights and that she was aware the CTO could be revoked if she failed to comply with the plan or became unwell.

118. Dr Eaton was referred during his evidence to the individual treatment plans referred to as ISP that were completed in relation to each patient and largely mirrored what would be covered also on a treatment plan prepared for a CTO. Such an ISP was prepared at the time of Lynette's admission to the CCU on the 21st of August 2010. There was provision for family members and carers to contribute to the ISP and that Kelvin Robert (Lynette's brother) had made such a contribution. There were other matters covered in the ISP in terms of priority needs to be addressed as they related to Lynette being finances, activities of daily living and accommodation. This ISP was subject to review as noted previously every 8 to 12 weeks.

119. Dr Eaton was also shown another ISP that was created on or around the 9th of October 2010. It again had a reference to Kelvin Roberts being a contributor to the discussion surrounding Lynette's welfare. This document was therefore generated six or seven weeks after the first, consistent with Bendigo Health's internal guidelines. It was clarified that the Chief Psychiatrists guidelines on treatment plans recognised that the original plan would be fairly simple and may only include sufficient information to enable the patient to engage in treatment with a community-based service. Thereafter a more comprehensive plan was to be developed in collaboration with the patient and family carers.

120. Dr Eaton was asked by Ms Ellis that now having seen what was contained in the treatment plan of the 16th of July 2010 and also the two ISP's that these latter documents accord with the sentiment expressed by the chief psychiatrist in the guideline. Dr Eaton responded that involving the patients and covering all aspects that are important for the care they did, but he recognised that it did not satisfy the legal requirement of the completion of treatment plans.

121. Professor Keks also gave evidence in terms of the timeliness of the preparation of treatment plans. Professor Keks stated that it was usual practice in the community unit that such a plan would take one to two weeks to formulate and anything earlier would be, in his opinion, undue haste. He stated that it was for the whole team to eventually generate a sensible plan based on careful observation, evaluation and treatment planning. I pointed out to Professor Keks in Lynette's case she had been treated, observed and evaluated over a significant period of time by the "whole team" whilst in the SECU and prior to placement on the CTO. Notwithstanding those facts Professor Keks maintained that the usual procedure of gradualness and informed assessment in the CCU would remain appropriate. I note this opinion runs contrary to the current practice developed by Bendigo Health with the need for such plans to now be completed within 72 hours of placement on a CTO.

122. I do not propose to take the matter of the treatment plans as it relates to the evidence of Dr Eaton much further. The timing of the preparation of treatment plans is canvassed in the evidence of Ass. Professor Tune. I did express to Dr Eaton that it appeared the expectations of the legislation was the treatment plan would be prepared contemporaneous with a person's release on a CTO and such an outcome would be preferred to ensure that such a plan was compiled in a timely manner. The failure to have a treatment plan in existence in no way altered the question as to whether Lynette's CTO should have been revoked sooner or otherwise had any impact on avoiding the outcome of her death.

Risk assessments

123. It is clear that a primary responsibility of the nursing of psychiatric patients is to regularly undertake risk assessments. At the time of Lynette's admission to the CCU it was only a requirement that this be undertaken once a day and that was usually by the person who was the patient's allocated nurse for the morning shift. The assessment itself involves going through a series of questions and ticking the box as to the most appropriate assessment of the patient with the option to apply some limited free hand commentary.

124. I confirmed with Ms Fisher that the usual practice when completing risk assessments is that the paper work would be done at the time the assessment was undertaken. A patient would need to be asked questions such as "do you feel at risk of self-harm" and logically the form would be completed in response to those answers. Ms Fisher stated however, that the risk assessment document and notes generally on the patient may not be completed until some hours after the interview or engagement with the patient.

125. Ms Fisher stated part of the explanation for not undertaking the recording of the risk assessment in the presence of the patient was that they did not like nurses making notes in front of them. In addition the current practice is for the notes on a patient to be placed on the computer and Ms Fisher stated that at the time of giving evidence in 2016 the computer resources were limited. It was clear from my questioning that I had concerns as to the accuracy of records if not contemporaneously made. Ms Fisher was asked by Ms Ellis if it was possible that there could be a confusion of the recording of one patient's information against another under such circumstances. Ms Fisher stated that "it could quite easily happen" but when asked if it had ever happened to her before she responded, "not to my knowledge".

The effectiveness of the treatment of Lynette's psychotic symptoms

126. There are what are termed positive and negative symptoms of mental illness associated with a diagnosis of psychosis. Ms Fisher described some of those positive symptoms being the hearing of voices, people touching you, experiencing strange smells and tastes. In order to assess if a patient is experiencing positive symptoms a mental state examination is undertaken. This is of course dependent on asking the patient if they are experiencing any of these symptoms.

127. The expression of negative symptoms of mental illness, Ms Fisher characterised as including a lack of enthusiasm being manifest with not wanting to get out of bed, to wash, to eat properly or to maintain a tidy house. It was also confirmed by Dr Eaton that the decision by Lynette to wear her heavy blue jacket, notwithstanding the weather, was also consistent with being a negative symptom of mental illness.

128. Dr Eaton gave evidence of Lynette commencing her trial on the clozapine medication on the 22nd of October 2010. Due to the side effects of taking such medication the dosage was very low to start and gradually increased. The medical records recorded that as of the 3rd of November 2010 a notation saying, "Almost completed induction of clozapine, still psychotic". Certainly by the 26th of November 2010 with the increasing dosage the observation was that Lynette was "improving with clozapine' and it was at that time that

planning and thinking about discharge occurred. Dr Eaton stated that even patients who are still experiencing psychotic symptoms can be treated in the CCU. In addition, it is not uncommon for a patient not to have reached the maximum dosage level of clozapine prior to discharge providing they are showing a good response to treatment, which is what Lynette was.

129. When describing how outwardly Lynette appeared to have benefitted from clozapine, Dr Eaton noted that she had gone from being very floridly psychotic, experiencing multiple hallucinatory phenomena and having many delusions. Lynette would just sit in the room and not really communicate with you because of those psychotic experiences. The change was that Lynette was observed to be somebody who was warm, able to think and plan more about things and interact in a much better way. In addition, Lynette had successfully had overnight and weekend leave with her former husband Les, albeit she had vomited her medication on one such occasion. It was all these factors that enhanced the decision to transition Lynette into the CCU.

130. Dr Eaton was referred to the mental health assessment he conducted on the 13th of December which was the day he approved Lynette's placement on a CTO and transfer to the CCU. He noted on the record that Lynette was well kept, good eye contact, calm, soft clear speech and euthymic being of normal mood, no abnormal thoughts, alert and insight good. There were no signs of hallucinations, delusions or thought disorder. Based on all these observations Dr Eaton had no reluctance in taking the course he did to release Lynette from the secure environment of the SECU.

131. Dr Eaton stated that part of the reason for Lynette to transfer to the CCU as distinct from home was to continue to monitor her Clozapine levels and ensure she was compliant with her medication regime. The fact of being in the CCU was that it also allowed for Lynette to take meals in the SECU, as the task of cooking for herself she would be unable to achieve at that time. I accept the decision to trial Lynette on clozapine had resulted in a very positive result in the change to Lynette's mental state that had not otherwise been achieved by other medications. The decision to undertake such a change was supported, not only by Dr Eaton, but also by Dr Shetti from whom Lynette had sought a second opinion.

Changes in practice subsequent to Lynette's death

132. At the time of Lynette's admission to the CCU risk assessment and note taking of observations of the patient would only occur once per day and were not done at any particular time. Ms Fisher stated that the current practice is that any new admissions to the community units have a twice daily risk assessment and detailed notes are taken in the morning and afternoon for the first two weeks that they are residents in the CCU.

133. At the time of Lynette's stay at the CCU there was not always a note made by the person who was told of information about when a person was leaving, where they were going and at what time they were expected to return. This information was largely shared in the hand over at shifts and subsequently recorded in the notes as to the patient's daily activities. Ms Fisher stated that now there is a board, presumably in the Nurses station, that details where a person may be going, if they are escorted or not, expected time of return and what they are wearing. This latter aspect is extremely important as it was Ms Fisher who had to ring around the nurses from the earlier shift to ascertain what clothes Lynette was wearing to pass that information on to the police who were searching for her. Ms Fisher cannot recall when this initiative was introduced, but it must be regarded as a welcome one.

134. The expectation now, as it was at the time of Lynette's attendance at the CCU, was that a person who is leaving the site would either attend the nursing station in person or telephone to say they were going out. They now are also expected to advise on their return. As Ms Fisher observed at times some residents would return and go straight to their unit without advising anyone. Under this approach it was therefore very "hit and miss" as to whether or when it would be, as with Lynette, that it was noticed that someone had not returned within the time they advised. It would only have been something that was clearly established at one of the times the "sightings" were undertaken, which could be hours after their advised time of return. The lack of any documentation as to where people advised they were going and how long they intended to be absent was always most unsatisfactory. It meant that a clear notation as to exactly when someone left to then pinpoint their expected return time was not made. In addition, the fact of someone leaving or where they were going might only have been communicated to one person and therefore not shared with other nursing staff.

135. In questioning Ms Fisher it was clear that at the time of Lynette's death there was no defined procedure to follow in the event a patient in the CCU was unaccounted for at the time of Lynette's death. Ms Fisher stated in her evidence that there is now a tick sheet as to who to phone and where. The protocols are of course quite different depending upon if the patient is on leave from the SECU which is psychiatrist approved or absent from the CCU. Patients from SECU have a specific time they must have returned by. In relation to CCU patients the test is more subjective. The fact there is clear guidance on how to handle absent patients is clearly advantageous, but it is somewhat surprising such did not exist in 2010.

136. There also was a paucity of note taking as it related to what I regarded must have been the engagement between Lynette and whoever her nominated nurse was for the day. I was told that patients, although in independent living, would be provided with assistance if they requested, or may be encouraged to undertake activities such as cleaning or personal hygiene such as showering. Ms Fisher stated some nurses took such notes and some did not. I commented that if a person was demonstrating a low-level of care to their hygiene and their appearance this might that have been symptomatic of becoming mentally unwell. Ms Fisher agreed with that proposition. Evidence was given that each nurse was generally assigned 5 patients each to oversee. Under those circumstances I would have thought it would not be too onerous a task to make more comprehensive notes of engagement with patients, even if it was quite basic in description.

137. Ass. Professor Tune stated that Bendigo Health undertook a review of Ms Robert's death to identify any issues, particularly systemic issues, which may have contributed to her death and which could be addressed to reduce the risk to patients in similar circumstances in the future. Ass. Professor Tune stated that the "team" could not identify a critical event which led to Ms Robert's death. He did state that issues were identified where practice could be improved, particularly in relation to the completion of treatment plans. As a result, there is now an endorsed policy with clear expectation regarding the timely completion of Treatment Plans. A copy of that policy was tendered into evidence.

138. I accept that a review was undertaken, to which Ass. Professor Tune speaks, but I am concerned as to the breath of issues that may have been canvassed. I say that, as I enquired of each of the nursing staff who attended the inquest to give evidence as to whether they were ever part of a discussion or meeting or analysis as to what took place or if there was any debriefing following Lynette's death. The answer to that question was no, apart from Dr Eaton whose views were canvassed. I do not see how a comprehensive overview can have been appropriately undertaken if the majority of the staff who dealt first hand with Lynette's

care were not asked for their input. Ass. Professor Tune conceded that it was inadequate, as part of the internal review, that the nurses involved in Lynette's care were not interviewed.

139. In response to my clear criticism of the manner in which the internal review known as a "Root Cause Analysis" was conducted I was advised by Ass. Professor Tune that changes had been implemented subsequently. He advised there was a new Chief Medical Officer at the hospital who had formed the view fairly quickly that the current processes were not as good as required and improvement in this area was to be undertaken. In addition, "Root Cause Analysis" methodology training had been supplied to many of the senior staff with the intention of strengthening the process considerably.

140. The concern I clearly had in my criticisms of the internal review is that many aspects such as the decision-making process of the nursing staff to permit Lynette to leave, the timing and manner in which the search for her was undertaken and the manner in which notes were not recorded in a timely manner should all have been aspects of the internal review. A reliance solely on the notes of the nurses was inadequate.

141. It is disappointing that the only significant change or matters for which rectification was sought related to the timely completion of treatment plans which, as conceded by all, played no relevance or import into Lynette's untimely death.

Evidence of the Psychiatrists

142. Dr Scott Eaton was a Consultant Psychiatrist employed with Bendigo Health Psychiatric Services at the time of Lynette's treatment at the SECU and Vahland House and it was he who was in responsible for her psychiatric care, along with other health professionals. Dr Eaton's credentials are that he is a Fellow of the Royal Australian and New Zealand College of Psychiatrists and a Member of the Royal College of Psychiatrists. (UK). Dr Eaton was the consultant psychiatrist at Vahland Complex from 2002 until February 2013.

143. It was from the statement provided by Dr Eaton that much of the information contained in the finding as to Lynette's prior diagnosis and treatment in SECU and Vahland Complex was obtained. Dr Eaton gave evidence that, with the exception of Lynette's time at Vahland Complex, he had not otherwise been involved in her treatment. As a consequence Dr Eaton was unable to comment on prior episodes of wandering and Lynette's symptoms generally, prior to his own involvement, apart from what he had gleaned from Lynette's medical records. This is not a criticism of Dr Eaton, it is what happens in every occasion that there is a change in professional care. It also had no impact on Lynette's treatment as Dr Eaton had made a thorough appraisal of Lynette's psychiatric history.

144. Dr Eaton when preparing his statement for the Court was asked to provide an opinion as to whether the occurrence of Lynette's death could be associated with suicide. Dr Eaton was not of that view, as he stated at no time during Lynette's spell at Vahland complex had there been evidence that Ms Roberts experienced depressed mood, thoughts of life not being worth living or developed any ideas of ending her life. Dr Eaton noted that Lynette had not been impulsive or emotionally volatile and the treatment with clozapine is known to decrease the incidence of suicide in those at risk. At the outset of the inquest I made it clear that suicide was not something I contemplated as needing to explore. I find such a possibility is not a causal factor in Lynette's death.

145. Dr Eaton was asked to comment on the effects of alcohol. He stated that alcohol along with clozapine are known to have a sedative effect. This impacts on cognitive function (slowing of

thinking) and motor function (poor coordination). Dr Eaton was aware of Lynette having a blood alcohol reading of 0.16 at the time of her death. In his opinion Lynette's cognitive and motor function would both have been significantly impaired.

146. Dr Eaton was extensively cross-examined by all representatives at the inquest. Dr Eaton confirmed that his first engagement with Lynette was when she was released from the Alexander Bayne Centre and transferred to the CCU at Vahland complex. This occurred on the 21st of August 2010 after Lynette was placed on a Community Treatment Order on the 20th of August 2010 by Dr Barbosa. At the time of first admission at the CCU Dr Eaton noted that Lynette was experiencing many positive symptoms of her mental illness. These included experiencing hallucinations, delusions and thought disorder. Dr Eaton indicated positive symptoms are responsive to medication.

147. Dr Eaton also noted that Lynette would experience negative symptoms at times also and these were characterised by a lack of drive or failure to attend to normal daily care routines. These latter symptoms were not responsive to antipsychotic medication but were issues they were attempting to address with rehabilitation strategies at Vahland complex. Dr Eaton stated the negative symptoms may be ongoing and lifelong.

148. The CTO was subsequently revoked by Dr Eaton on the 20th of September 2010. Dr Eaton gave evidence that the revocation of the order was because Lynette was mentally unwell and at risk. He expanded on this by noting that Lynette was floridly psychotic and responding to hallucinations and she had delusions. Lynette believed, for example, that she needed to go to Dunolly to marry her ex-partner Gary Steel. As such Dr Eaton was worried that Lynette would be leaving the CCU and act on her delusions. It was also in the context that she had lied in relation to her leaving the Vahland complex on the three occasions of the 3rd, 5th and 19th of September as detailed earlier.

149. It was from the 20th of September 2010 that Lynette became an inpatient at SECU and on an involuntary treatment order. On the 13th of December 2010 Lynette was again placed on a CTO this time signed by Dr Eaton, commensurate with her discharge into the CCU. Dr Eaton was questioned in relation to what changes had occurred over the three month period whilst in the SECU. Dr Eaton stated that on admission to SECU Lynette remained unwell on the treatment she was on at the time and the medication levels were increased to the maximum level without effect. It was recognised that Lynette needed to trial clozapine which is for patients who suffer from treatment resistant schizophrenia.

150. Dr Eaton observed that Lynette improved on the clozapine. She was less disturbed and was no longer experiencing the psychotic symptoms that she had been experiencing before. She was more settled and she was having time away from the ward which was going well. On the basis of these positive outcomes the plan was to transfer Lynette to the CCU where she could have more freedom and the ability to work on rehabilitation skills.

151. Dr Eaton was asked to comment on aspects of Lynette's medical records. He confirmed he was aware of the events of the 3rd, 5th and 19th of September 2010 when Lynette left Vahland complex and went to places other than advised. He could not make any further observations outside what was contained in the records.

152. Dr Eaton was also taken through the risk assessments in Lynette's file subsequent to her admission to SECU. There were a number of entries where the word absconding was underlined and a rating attributed as medium. There was also the narrative at times of "tries to abscond on several occasions. Staff need to watch the front door of people coming and going as Lynette could come to harm if she manages to get out" which was from an assessment conducted at 3pm on the 22nd of September 2010 and risk of absconding rated as

medium. The next nurse to undertake an assessment of Lynette on the same day at 7pm makes the observation "trying to exit SECU frequently" but nominates risk of absconding as low. Such a variance in the outcome of the assessments indicates how subjective the compilation of the results will be.

153. It was certainly a factor noted that Lynette had a history of absconding and the staff at the time of her immediate admission back to SECU rated that risk variably as low, medium to high. As Dr Eaton noted, the longer Lynette was in the SECU and her psychotic symptoms were resolving, her drive to abscond disappeared and the risk of absconding was rated as low. Ms Ellis clarified with Dr Eaton, that of the 165 risk assessments that had been conducted over the period from the 2nd of November 2010 to the 12th of December 2010 there was no recording of immediate or acute risk of absconding. Dr Eaton stated that toward the latter part of Lynette's stay, the risk was clearly static and low compared with her earlier admission.

154. Dr Eaton was questioned in relation to Lynette's prior history of wandering from her admission in September 2010, her conduct in SECU and subsequent release whether it was considered that a specific plan be implemented should similar behaviour occur again. Dr Eaton did not believe that such a plan was warranted as Lynette's history of wandering was associated with psychotic symptoms and as her psychotic symptoms had diminished, so too had the risk.

155. The factors relevant to Lynette over the period of the 13th and 14th of December where she did not go to the IGA as advised but attended upon her relatives and that on the latter date she had a low alcohol reading were, in the opinion of Dr Eaton not such that it was then appropriate to take the "draconian" step of revoking Lynette's CTO. If such had occurred the outcome would have been Lynette's immediate return to the SECU. This further stay in the SECU could possibly have been for some months and in Dr Eaton's opinion that outcome would be too extreme in the context of what the conduct had been.

156. The fact that Lynette had lied to staff about where she was going also did not present as a matter for significant concern to Dr Eaton, as Lynette's motivation to lie had been due to believing that the staff would not let her go to her intended location. Dr Eaton stated her behaviour was not regarded as inappropriate wanderings, it was purposeful in that she wanted to visit with relatives. Dr Eaton gave evidence that there was a very big difference in the manner in which Lynette was thinking in relation to the September incidents and the December incidents. The motivation for leaving the facility was very different to September where she was behaving in response to command hallucinations, which were no longer present in December.

157. When asked what would have been the determinative factor to make the decision to revoke the CTO, Dr Eaton stated the being absent from the CCU daily and therefore not attending groups or activities or starting to travel further afield as she had on the day of the 16th of December 2010, were matters to be considered in revocation of the CTO. Dr Eaton noted that if Lynette has missed a single dosage of her medication this would not have resulted in a decomposition of her mental health but would be concerning that such may occur again. Dr Eaton felt the extended periods of absence, as were starting to occur, was posing a risk to her medication regime. In the event Lynette missed three days of medication she would have to return to the starting levels of clozapine due to risks to her health. This fact could compromise her mental well-being.

158. Dr Eaton was asked to comment on whether Lynette's habit of being inappropriately attired, namely wearing her heavy overcoat in hot weather was something for which he

should have considered revocation of the CTO. Dr Eaton explained such behaviour in people who have a diagnosis of schizophrenia has nothing to do with psychosis but may be due to autonomic dysregulation within the autonomic nervous system that helps control body temperature or could be an affectation of the person to choose to dress in a particular way.

159. In terms of vulnerabilities to risk Dr Eaton placed much emphasis on the risk of financial exploitation to be limited by virtue of the fact Lynette's finances were, from October 2010, being administered by State Trustees. In this way Dr Eaton was of the opinion that a lack of finances would limit someone's ability to travel very far as they did not have access to cash. It appears this limitation however, on available cash did not prevent Lynette travelling long distances or accessing significant amounts of alcohol.

160. As noted in the course of this finding I have made reference to the evidence of Ass. Professor Tune who appeared as the representative for the Bendigo Health. Ass. Professor Tune has years of experience, having been employed by Bendigo Health since 2006 and as such was asked to make comment on and express opinion into the management of Lynette's care and the appropriateness of the procedures and operation of the SECU and more particularly the CCU.

161. As part of that enquiry Ass. Professor Tune was asked about the preparation of treatment plans and the timeliness of such. Ultimately after much questioning it was recognised and conceded that the individual service plan (ISP) was not a treatment plan as required under the then applicable Chief Psychiatrist's guidelines and section 19A(4) of the Mental Health Act 1986. The 13th of December 2010 Community Treatment Order had no associated treatment plan. At the time of Lynette's care there was no clear policy directing when it was that such treatment plan needed to be completed by the psychiatrist or delegate.

162. In 2012 a policy was implemented by Bendigo Health where the expectation was that the treatment plan would be completed within one week of entry to a community service. The policy in other respects largely mirrors the expectations as outlined in section 19A of the Act. The latest Bendigo Health policy of 2015 now speaks of such treatment plans to be completed within 72 hours of admission and an ISP within a week. Ass. Professor Tune gave evidence to confirm that an audit had been conducted in the last 18 months that demonstrated a 100 percent compliance with the policy at Vahland complex.

163. I do not intend to further canvass the debate as to whether or not the ISP served as an equally applicable document as a treatment plan or on the failures or short comings of the preparation of the treatment plan for the reasons advanced previously. It did however demonstrate poor documentary work practises, particularly in light of the Chief Psychiatrists stated expectations. It is encouraging that a review as to compliance with the current policy of treatment plans being prepared within 72 hours demonstrated that in the previous 12 months it had occurred 100 per cent of the time. It is clear that such internal reviews are imperative in ensuring that policies are being followed and maintained.

164. As Ass. Professor Tune was effectively the spokesperson for Bendigo Health he was asked to comment on certain aspects of Lynette's treatment and care notwithstanding not having any direct involvement with such. Ass. Professor Tune was informed that Lynette's family had not been notified of the fact that Lynette had moved from SECU to the CCU on 13th of December 2010. Ass. Professor Tune agreed that hospital staff should have ensured that the family or at the very least, her next of kin were notified of such a movement.

165. The final witness called at the inquest was Professor Nicholas Keks, a highly qualified psychiatrist who had been engaged by Bendigo Health to provide an expert liability report. As Professor Keks experience and expertise was without challenge he was more than aptly

placed to be in a position to provide opinion evidence in his statement and in testimony at the inquest. The report provided by Professor Keks detailed a comprehensive summary of the ongoing diagnosis of Lynette's mental illness, how it had developed and manifested over time.

166. Professor Keks was of the opinion that Lynette's acute risk had returned to near baseline levels by early December 2010. In relation to Lynette's static or long term risk, due to her cognitive dysfunction, he was of the opinion there could be an argument that she needed to be protected from herself and restricted in her movements in order to prevent inappropriate behaviour. In this context Professor Keks noted that some decades ago the mechanism of institutionalisation was available to achieve long term "asylum" for persons cognitively impaired due to chronic psychoses.

167. Professor Keks stated that the current accepted psychiatric practice stresses recovery, rehabilitation and return to the community for patients with chronic mental illness. Professor Keks noted that these principles are embedded within the Mental Health Act that the requirement for treatment be in the least restrictive environment. He stated only a minority of patients with chronic mental illness remain in secure long term placement on the basis of very high static risks. In his opinion the ongoing static risk posed by Lynette's mental state did not justify long-term secure hospitalisation in terms of current practice and probably would not have constituted grounds for institutionalisation even some decades ago.

168. Professor Keks concluded that Lynette was treated appropriately for her acute psychotic exacerbation, which settled after a period of treatment on clozapine. It was his opinion that Lynette was then appropriately managed with respect to her recovery process and progress to return to the community through the transition mechanism of the CCU. As Professor Keks noted the key issue in this case was whether, given the events of the 14 and 15th of December 2010, the clinical situation existed for Dr Eaton to revoke Lynette's CTO and have her re-admitted at that time to SECU.

169. Professor Keks noted that nursing staff and Dr Eaton were appropriately concerned about what had occurred on the 14 and 15th of December and had taken reasonable and appropriate steps to try to manage the situation. Professor Keks noted the risk assessment conducted by nursing staff had elevated the dynamic risk of absconding and vulnerability to exploitation from low on December 14th to moderate on December 15th. It was put to Professor Keks that the risk assessment for the 16th of December as documented retrospectively was low for absconding. Professor Keks was asked to comment on whether that was appropriate in the circumstances. Professor Keks stated that the difference between the two is of no clinical or practical significance. I could not understand Professor Keks evidence that on the one hand it was appropriate to notate an alteration in risk and on the other hand it was somewhat irrelevant.

170. Professor Keks also noted that Dr Eaton had interviewed Lynette and reinforced the rules and expected behaviour whilst at the CCU. That may be correct that Dr Eaton did speak to Lynette and I suspect, short of revoking her CTO, there was not much else he could have done. The reality is that Lynette continued to behave on the 16th of December in the manner she had on the previous days, namely lie to the nurses about where she was going, consuming alcohol and not returning as advised.

171. Professor Keks stated that analogous behavioural difficulties to those manifested by Lynette would be a common occurrence in patients proceeding through the recovery process from psychotic illness. In the opinion of Professor Keks, the tragic outcome of Lynette's death was not reasonably predictable from clinical assessment or dynamic risk assessment. In addition

while there was a degree of elevated static risk given the patient's negative state/ cognitive dysfunction due to chronic psychosis, in his opinion there were no reasonable clinical grounds to affect a transfer of Lynette to secure hospitalisation. In his opinion the decisions made by Dr Eaton were not only appropriate, but consistent with the expectations of the Mental Health Act for patients to be treated in the least restrictive means available.

172. Professor Keks was of the opinion that having regard to Lynette's illness trajectory and progress on clozapine that it was timely and appropriate for her to be transferred to the CCU on 13th of December 2010. In his opinion there was an argument for the transfer to the CCU to have occurred somewhat earlier than it was actually was undertaken. I also agree that it was an appropriate course to adopt, as it was supported not only by Dr Eaton but also encouraged and recommended by the second opinion obtained by Lynette from Dr Shetti.

173. Professor Keks was asked to comment on whether given Lynette's psychiatric condition as at 14th of December and then again on the 15th of December and the obligation of Bendigo Health pursuant to the Mental Health Act regarding the overarching obligation to treat in the least restrictive means whether it was reasonable to allow Lynette to remain on a CTO and residing in the CCU. In relation to both days Professor Keks responded in the affirmative. Professor Keks was asked if the management of the deceased by the hospital on 16th of December 2010 was appropriate to which he responded, "Yes it was".

174. Professor Keks was also asked to comment on whether the steps taken by the hospital in response to discovering Lynette had not returned to the CCU on the 16th of December 2010 were appropriate. It was Professor Keks opinion the hospital's response was appropriate. He noted Lynette was last sighted at the CCU at 11.30 am but concern about her prolonged absence was not noted until 4.40pm. He stated in the context of the CCU (in contrast to an inpatient unit) such timing is not unreasonable. Professor Keks stated that when information concerning the observation of the deceased wandering aimlessly in Dunolly was received at 4.50 pm immediate action was undertaken.

175. I made the observation to Professor Keks that I felt that his responses and observations had primarily been focused on Dr Eaton's engagement and treatment of Lynette and he was not more broadly concerned with her management generally. Professor Keks conceded he had focused on the psychiatric aspects of Lynette's care.

176. Professor Keks was taken through the medical file by Ms Ellis. The change in Lynette's presentation after commencement of treatment on clozapine was noted to be an improvement in minimising positive symptoms of her mental illness. Professor Keks stated that the use of such medication does not necessarily lead to an improvement in negative symptoms, such as dressing inappropriately or being dishevelled and malodorous and not appearing to be looking after themselves very well. Professor Keks stated that the existence of these negative symptoms was not a basis to vary or prevent a move to a CCU from SECU.

177. Professor Keks was taken to Section 19A of the Mental Health Act that covered the need and expectation of what was to be contained in a Treatment plan. He was then taken through the individual service plans that were created in collaboration with Lynette and her family. Professor Keks agreed that much of the information captured in those documents was what was referenced to in section 19A of the Mental Health Act. I do not doubt that in reality everyone was aware of the projected outcomes and manner in which the treatment was to be administered to Lynette. It still does not alter that Bendigo Health and most particularly Dr Eaton were not compliant with the expectations of the legislation and the Chief psychiatrists' guidelines on the compilation of Treatment Plans, notwithstanding how dismissive Professor Keks was as to their utility.

178. Professor Keks made the observation that Lynette still had very significant negative state manifestations and possibly minimal positive state or some positive state manifestations which she was now suppressing largely so that they were not obvious to staff. Professor Keks stated there was still "very, very, significant illness operating". In relation to the observations of Dr Eaton as to the fact Lynette did not have any positive symptoms of her mental illness Professor Keks qualified that, in his opinion, the absence of positive symptoms really meant the absence of the expression of positive symptoms and observation of things like the person hallucinating or manifesting obvious pathological behaviour.

179. Professor Keks agreed with the management of Lynette in not revoking her CTO on the 15th of December 2010. Professor Keks was asked if it was possible for Lynette to have decompensated between Dr Eaton's assessment on the afternoon of the 15th and the morning of the 16th. Professor Keks stated originally that it was exceedingly unlikely but then qualified it to state "except if she got very drunk for instance or had illicit substances that would do it".

180. Professor Keks further on the point as to the effects of the consumption of alcohol agreed that it had a sedative affect, as did the use of clozapine. He stated that it was dose dependant and that alcohol would also be somewhat disinhibiting depending on how much you had. Professor Keks added that you could be drunk and wandering in the middle of the street and not really be aware of it. Professor Keks commented that he had not been aware of the alcohol in Lynette's system until giving evidence.

181. I enquired of Professor Keks what the significance was of the fact that Lynette lied on the 16th of December saying she was going to the IGA in the context of her discussions with Dr Eaton the evening before. Professor Keks stated that such behaviour was not suggesting major safety danger issues but was suggesting she was still unwell. I asked Professor Keks if the use of the explanation again of the visit to the IGA should have been a "red flag" to the nursing staff to keep an eye out for Lynette's return and be proactive in checking on her return to which Professor Keks agreed. Professor Keks stated it was a very subtle red flag and he did not think it would be reasonable to expect the nursing staff to pick that up. I do not agree with such an observation. To my mind it was somewhat telling the use of the expression by Lynette that she was going to the IGA would not necessarily be a truthful one. The behaviour may be perseverative as stated by Professor Keks, but that does not mean it should necessarily be ignored.

182. It was put to Professor Keks that Lynette having stated again that she was going to the IGA whether this would be a basis to call the psychiatrist with a view to consideration being given to revoke the CTO. Professor Keks said it would not. I agree with this sentiment that that in itself would not be sufficient, but there does not appear to have been any further conversation with Lynette undertaken to confirm that such an intention was in fact true.

183. That concludes a summary of the evidence of the inquest.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with Lynette's death:

Submissions received on behalf of the parties

184. As is usual practice the parties were invited to provide submissions to the Court to make any comment or observation of the evidence and provide suggestions as to how improvements in practice might be achieved. I propose, where appropriate, to incorporate aspects of those submissions into my conclusions. I will deal with the distinct topics I highlighted earlier noting that there will be a degree of overlap.

Leave policy

185. In the evidence of the witnesses, most particularly Ass. Professor Tune, there was no strict leave policy as such for the CCU patients as compared with those in the SECU whose leave requirements were governed by the limitations outlined in the Mental Health Act. There was an expectation that the patients would attend the nurses station in the SECU to advise of their intentions, but this was regarded by staff as a courtesy more than a mandatory expectation. That is contradicted however, by the evidence that the staff are encouraged to dissuade a patient from leaving if it is not felt appropriate. I anticipate such may occur if at the time of undertaking a risk assessment a safety related risk is nominated as high.

186. As noted in the submissions filed on behalf of the family it was clear Lynette did not understand the leave policy and that she believed she was required to attend the SECU nurses to obtain approval for leave. This was demonstrated by the "made up" stories Lynette told staff in order for permission to be granted.

187. It was further a point emphasised in the submission by the family and a point that I have re-iterated in relation to the expression of "members of the community". Although legally free to "come and go" as they pleased from the grounds of the CCU there was a greater expectation than that, in the duty of care owed to these patients. They were still patients of a mental health facility and were under supervision to ensure medications were taken, usual household tasks performed, meals prepared or taken, personal hygiene attended to and programs completed.

188. I agree with the submission on behalf of the family that it should be a mandatory requirement when a patient leaves the CCU grounds that they attend upon the nursing staff to inform them of their proposed absence. In addition a formalised leave policy document be prepared that could be provided to the staff and patient so that each was aware of the expectations. As some patients would struggle to necessarily read the formalised document it would be helpful to them at the time of transfer into the CCU that an oral explanation be provided with a requirement they articulate back what their understanding of the policy is.

Decision to release Lynette from SECU and place on a CTO

189. It is always easy to opine that a different decision could have been derived at from the known matrix of facts. In matters involving discretion and clinical assessment it is not helpful to conclude a different decision should have been made, unless there is some clear and significant departure or demonstrable error in judgement that has occurred. As much applies in the legal system of the review by higher courts of decisions based on the exercise of discretion by judicial officers.

190. It was submitted by the family that the decision to place Lynette on a CTO and release her from the SECU was premature in light of Lynette's history of wanderings, going to different places than advised and being a lonely and vulnerable lady who sought out company and interactions that were not always appropriate.

191. I do not share that view. The factors relied upon by Dr Eaton in exercising his judgement in the way he did was that he had noted significant improvements in Lynette's mental health after being placed on clozapine. In addition Lynette had been subject to that new medication regime since the 22nd of October 2010 and there had been observation of a marked improvement in overcoming the positive symptoms of her condition. These improvements were noted in the Lynette's medical records.

192. The decision to "trial" Lynette in a more open environment had also been supported by Dr Shetti who provided a second opinion as requested by Lynette. There was also evidence given by Dr Keks that many patients, who also suffer from treatment resistant schizophrenia, may trial the use of clozapine entirely whilst in the community and not in a SECU or CCU. It is for all those reasons that I do not believe the movement of Lynette from the closed environment of the SECU to the CCU was premature or inappropriate decision to have been made at the time.

Treatment Plans

193. There was much discussion about the consistent failure by the hospital in relation to the preparation of a treatment plans as is required pursuant to s19A of the Mental Health Act 1986 and in accordance with the Chief Psychiatrist's Guidelines. The hospital sought to rely upon the fact that although treatment plans were not in existence there were Individual Service Plans and these effectively fulfilled much of the same expectations of a treatment plan. The fact of the existence of ISP does not overcome the stated requirements that such a plan should be prepared.

194. The hospital also sought to rely upon the fact that the Mental Health Act and the Chief Psychiatrists guidelines did not specify a particular time by which the treatment plan should be prepared by. It was suggested that had it not been for the intervening circumstance of Lynette's death that a treatment plan to attach to her CTO would have been prepared in the following few days. It must be noted that Bendigo Health also failed to have a treatment plan in existence as it related to the CTO of the 20th of August 2010.

195. In the preparation of a treatment plan the authorized psychiatrist must take into account the wishes of the patient as far as they can be ascertained (s19A(20(a)) and unless the patient objects, the wishes of any guardian, family member or primary carer who is involved in providing ongoing care or support to the patient (s 19A(20(b)).

196. It was submitted on behalf of Lynette's family that they were not given an opportunity to have their wishes reflected as to her treatment. It would have allowed them, on knowing she was subject to a CTO and out of the secure facility, to provide additional support.

197. The follow on from this is the failure to otherwise inform the next of kin or other family members at all of the transfer of Lynette out of the SECU and into Vahland complex. The evidence of overnight visits taken with Les and the nomination of next of kin and others on medical documentation confirms Lynette had family support and interest in her well-being. It could be supposed if family were aware of the ability to more readily attend upon Lynette in the more open environment, it would not have been necessary for Lynette to leave the facility herself in search of company.

198. I do not propose to make any recommendations on these matters as the expectations as to what is required are contained in the Mental Health Act both then and now. There are the clear guidelines issued by the Chief Psychiatrist as to what is expected. It is clear from all the Chief Psychiatrists guidelines, not just those in relation to CTO's, that the expectations are that patients and their family or carers will be consulted prior to decisions being made.

The decision not to revoke Lynette's CTO earlier

199. It was submitted on behalf of the family that subsequent to the events of the previous days on the 14th and 15th of December 2010, the decision should have been made at that time to revoke the CTO. This was because Lynette had twice lied about her intended leave plans, had stated that if people sought for her to return to the facility she would "hide", she was recognised as being lonely and vulnerable, had a history of absences and false explanations in September 2010 and increased risk factors having consumed alcohol on the prior day. Mr Lakey had made observations of how Lynette appeared to him to be nervous and jittery and in a dishevelled state. Lynette was speaking rapidly, that to his mind evidenced that Lynette was mentally quite unwell and should not have been permitted to leave the hospital facilities, particularly unescorted.

200. It was submitted on behalf of the hospital that, as noted by Ass. Professor Tune, a lay person's point of reference when it comes to assessing mental un-wellness is with somebody who is mentally well. The point of reference for mental health professionals might be where that person is, at a given time, having regard to the spectrum of their un-wellness. This would account for the difference in assessments between the mental health professionals and Mr Lakey. The fact that Lynette was prone to wearing clothing that was inappropriate to the weather conditions and having poor standards of hygiene was not regarded by any of the psychiatrists as something to support a conclusion of a deterioration in Lynette's mental health. These features were more akin to the negative symptoms associated with schizophrenia, which is the subject matter of rehabilitation, not medication.

201. It is clear however, that Lynette's behaviour over the previous two days had heightened the concerns of those charged with her care. Ms Fisher and Ms Armstrong-Goldsmith specifically spoke to Dr Eaton of those concerns and the concerns raised by the family. The nurses who had conducted the risk assessments had elevated the risk of absconding to medium. In response Dr Eaton had spoken directly with Lynette to confirm that she was aware of her responsibilities on the CTO. Dr Eaton stated that as there were no identifiable changes in Lynette's mental state or any other concerns raised which would cause him to revoke the CTO he did not do so.

202. Dr Eaton did not regard the trips to her relatives as of significant concern as they were not wanderings, in the psychotic sense, in that they were planned, organised and purposeful and not driven by auditory and command hallucinations. As noted, Dr Eaton exercised his clinical judgement and discretion in the decisions he made and there was no demonstrable error in his reasoning.

203. What Lynette's conduct did highlight for me, was that a greater vigilance should have been exercised to monitor Lynette's movements thereafter and an attempt to dissuade her from leaving the grounds of Vahland complex on the 16th of December 2010. This was particularly so given she provided, yet again, the explanation of the planned destination as being the local IGA. It could have been suggested that someone would go with Lynette on this journey.. Evidence was given during the inquest that staff had been required to leave the facility to accompany patients to appointments, so such an objective could have been achievable. I appreciate that the level of supervision and engagement is not what would normally be expected in a facility such as Vahland, however given the concerns raised from the previous days it may have been a pragmatic step to take, at least in the short term.

Timing of decision to commence the search for Lynette

204. As stated in the submissions filed on behalf of the family the evidence was that the alarm was not raised with respect to Lynette's failure to return until after 4.40pm and proactive measures to locate commenced at 5.10 pm. This was five and a half hours from Lynette's "leave" request before any formal efforts were made. It was submitted this timing was too slow given the events of the days prior and Lynette's history generally. I agree with that submission. As stated earlier the staff should have been more vigilant in monitoring Lynette's failure to return and then reacted more quickly.

205. It was submitted on behalf of the hospital that the timing of the search being initiated was not inappropriate. It was noted at 1.30pm by nurse Sambrooks to the afternoon staff that Lynette had not returned from her outing. Ms Armstrong- Goldsmith gave evidence that when a resident failed to return to the CCU within the expected time frame the staff allowed a reasonable lapse of time before commencing a ring around. By 3.30pm Ms Armstrong-Goldsmith was concerned about Lynette's whereabouts, but was not panicking.

206. It was submitted that the decision by Ms Fisher, the nurse in charge of the afternoon shift, to not escalate the search for Lynette earlier was based on the exercise of clinical judgement. That clinical judgement was influenced with Ms Fisher having had her own observations of Lynette and undertaken risk assessments and mental state examination. Also she was aware Lynette had been assessed by the treating psychiatrist the afternoon before and Lynette had not been engaging in high risk behaviour. There were no concerns expressed to her at handover, Lynette was on a CTO and she was in the habit of telling staff untruths about where she was going..

207. These observations fail to note that Ms Fisher in undertaking risk assessments had elevated the risk of absconding to moderate and had been sufficiently concerned about Lynette's behaviour in the days prior that she spoke of it to Dr Eaton. Ms Fisher was aware Dr Eaton had then spoken to Lynette as to the expectations on her, but clearly by her conduct in not returning in the time specified she had not followed those instructions. In addition, I do not agree that Lynette could not be said to have been engaging in high risk behaviour. As was known to Ms Fisher, Lynette had the ability to travel long distances and procure alcohol even without the benefit of financial assistance. Given these facts were known to Ms Fisher and

the other nursing staff in the morning and afternoon shifts, the search for Lynette should have commenced earlier.

208. Ass. Professor Tune conceded as much in his evidence. Ass. Professor Tune stated that the expectations of staff as to how they would respond would be governed by how dangerous they thought the behaviour would be. In exercising a "judgement call" the staff would be basing it on the fact that the previous two days behaviour in which Lynette was engaged was not dangerous behaviour. It was nuisance behaviour to the family, but it was not judged as dangerous.

209. It was strongly emphasised in the evidence of Mr Lakey and the submissions filed on behalf of the family, that they never viewed Lynette's attendance on the home of her cousin and aunty and uncle as nuisance behaviour. They were concerned only for Lynette's wellbeing. It was further submitted by the family that when Lynette was told not to visit relatives the outcome had been that her "safe haven" of being at this location had been withdrawn. There is strength in this submission in that a staff member had at some point earlier in the day telephoned Mr Lakey to see if Lynette had visited. As it was clear that Lynette was not there, concern should have been heightened as to exactly where she was.

210. The hospital submitted that it was not possible to conclude that had there been earlier notification to the police this would have averted the tragedy because even when the police were notified at 5pm and tasked to search for Lynette she could not be found. It was some 4 hours later that she was tragically struck by the motor vehicle. I do agree in part with this observation but not entirely. If the authorities had been alerted sooner, as too her family, a more comprehensive search could have been undertaken. In addition, if Lynette had been located earlier her level of intoxication would not have reached what it had at the time she was walking along the road. It is clear the effects of the excessive consumption of alcohol had a direct causal connection to Lynette's death.

211. There was no clear policy on what to do once a patient had failed to return to the CCU as compared to the SECU. Notwithstanding that fact however, once concern had reached the point that a search should be instigated Ms Fisher was very thorough in undertaking enquiries with the relevant authorities, bringing about the revocation of Lynette's CTO and documenting extensively what had been undertaken. As noted previously her efforts would have been assisted by provision of extra details such as what clothes Lynette had last been seen in. This information is now recorded on a white board and is an improvement in practice that has been instigated since Lynette's death.

Risk Assessments

212. It is clear that little needs to be said to conclude that it is undesirable that notation of risk assessment outcomes are not made at or proximate to the time that they are undertaken. I accept that patient's feel a level of anxiety if, during the assessment notes are being taken of them, but that does not alter an expectation that such an assessment will be recorded independent of the patient a short time later. In many respects, for no other reason than ensuring the results are fresh in the mind of the assessor. In addition, as a tool used in the management of patients with psychiatric conditions, it is important for others involved in the patient's care at the same time to have access to that information.

213. The failure of nurse Sambrooks to make that recording until the subsequent day had no bearing on the ultimate outcome and I suspect it was certainly not something that commonly

occurred with Ms Sambrooks or other staff. The difficulty where the notes are not recorded contemporaneously, particularly in circumstances where events of significance intervene, it casts doubt on the reliability of the recorded observations.

214. It is clear that all psychiatrists and nurses working in the area of mental health must have been trained on how to conduct a risk assessment. It must also be recognised that they are very subjective assessments and in part reliant on accuracy of reporting by the patient. They have limitations but are still a necessary tool in the treatment and supervision of patients.

215. The comments were made in the submissions provided by the family, that Ms Sambrooks assessment of Lynette's risk of absconding categorised as "low" was contrary to facts of relevance when making such an assessment. There was the day prior a recording of medium risk, Lynette again going to a different location than she had previously advised, Lynette's comment she would "hide" from staff and the fact she had taken alcohol in the day prior. I agree that it is incongruous with this factual background, without some change, to lessen the risk to "low". The only alteration was that Dr Eaton had spoken to Lynette in the intervening period, but it is unclear if Ms Sambrooks knew of that conversation anyway. I therefore disagree with the observations of Dr Eaton that the adjustment from moderate to low was "reasonable" and the observations of Ass. Professor Tune that it was "justified".

216. I agree with the submissions on behalf of the family that there needs to be ongoing training and education around the preparation of risk assessments. I would anticipate that there has been a lot of research in this area, in part referred to by Professor Keks in his evidence. The outcome of the findings of this research should be shared with those who undertake such assessments. It is also not an unreasonable expectation that prior to ending a shift the responsible staff member completes all documentation required on a patient's record. This should be a mandatory requirement.

Review of hospital procedure

217. Ass. Professor Tune gave evidence that an internal review, described as a Root Cause Analysis, was conducted by Bendigo Health subsequent to Lynette's death. Ass Prof Tune outlined that the only matter of significance that was found where the hospital may be regarded as lacking was the timely preparation of Treatment plans.

218. It was clear that the extent of this internal review was completely inadequate. Ass. Professor Tune was asked as to whether the timeliness of the search for Lynette was subject to review and he conceded it was not. It is unknown exactly what was the substance of the internal review as it related generally to Lynette's supervision, care and the events leading up to her death. I suspect very little if no substance was given to those considerations as the only person who gave evidence of having participated in such a review was Dr Eaton. I was quite careful to enquire myself of each of the nursing staff to identify if they had been involved or received any follow up subsequent to Lynette's death and the answer was no.

219. As noted in the submissions filed on behalf of the family that it was issues as to the clinical judgment exercised by nursing staff that were clearly relevant for a RCA review. I agree with that submission and conclude any review that was undertaken was grossly inadequate. It is encouraging however, that the new Bendigo Health Chief Medical Officer has recognised the shortcomings of the past and has implemented a system of additional RCA methodology training.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

1. There should be produced for the CCU patients a clear policy as it relates to the expectations of staff and patients as to what is to occur in the event a patient leaves the grounds of Vahland complex. This policy should be not only provided in written form to the patient but a verbal explanation provided to them at the time of entry to the facility. The relatives and carers should also be informed where appropriate of the expectations of such a policy so they can assist in compliance.
2. That at a minimum of 24 hours before the patient is moved from the SECU to the CCU their next of kin or nominated carer is informed of what is to occur to allow them to provide input into the decision.
3. That staff are provided with regular and refresher training on the how to conduct risk assessments to ensure uniformity in approach.
4. That nursing staff be required to make comprehensive and contemporaneous patient notes prior to the conclusion of their shift.
5. Training for all staff, not limited to psychiatrists, as to what is expected practice as dictated in the Chief Psychiatrists guidelines particularly as they relate to communication and engagement with relatives and carers.

Finally, I wish to note that the staff, be they the nurses or psychiatrists who were involved with Lynette's care were genuinely concerned for her best interests. I anticipate had they had the benefit of hindsight the decisions they made may have been different. It is unhelpful however to speculate on a different outcome.

I also wish to express my condolences to Lynette's loving and extended family for their loss. I thank them for their patience and commitment throughout the process of this enquiry.

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

1. The family of Lynette Roberts
2. Les Lakey
3. Bendigo Health Care Group
4. Chief Psychiatrist Ruth Vine
5. Sgt Karen Connell
6. Snr Sgt Steven Cunningham

Signature:

Coroner's name: Jennifer Tregent
Date: 14th September 2018