IN THE CORONERS COURT
OF VICTORIA
AT BALLARAT

Court Reference: COR 2010 000233

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: LEANNE JOAN HOWELL (nee ZAMPATTI)

Delivered On:	19 September 2013
Delivered At:	Ballarat
Hearing Dates:	9 – 10 October 2012
Findings of:	Ms Michelle Hodgson, Coroner
Police Coronial Support Unit:	S/C Kelly Ramsey
Representation:	Dr Paul Halley (appeared on behalf of Ballarat Health Services)

I, Ms Michelle Hodgson, Coroner,

having investigated the death of: LEANNE JOAN HOWELL (nee ZAMPATTI)

AND having held an inquest in relation to this death on 9th – 10th October 2012
at the Ballarat Coroner's Court

find that the identity of the deceased was **LEANNE JOAN HOWELL (nee ZAMPATTI)**
born on 6 September 1969

and the death occurred on 15 January 2010
at BALLARAT
from: 1(a) HANGING

in the following circumstances:

FINDING INTO DEATH WITH INQUEST

The Coroners Court is different from other courts. It is an inquisitorial rather than an adversarial system. In other words, there is no trial, with a prosecutor and a defendant. Instead, there is an inquiry that seeks to find the truth about a person's death – to establish what happened, rather than who is to blame. The Coroner is more flexible in the evidence that they will accept, but they cannot punish.

When making a finding, coroners carefully consider all the submissions that come before them. Not every issue makes it way into the final report but everything has been weighed up and analysed.

A Coroner investigating a death must find:

- The identity of the person who has died
- The cause of death
- The circumstances in which the death occurred

COMMENTS

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

CIRCUMSTANCES

Background

Ms Leanne Joan Howell (nee Zampatti) was 40 years of age when she passed away. Leanne was he mother of two children.

Leanne had separated from her husband in April 2008. He committed suicide in February 2009.

After this time, her brother, Andrew Zampatti, noticed a significant deterioration in his sister's mental health.

Summary of previous hospitalisations

Ballarat Health Services Hospital records state that Leanne had initially been referred to Ballarat Health Services on 9 August 2009, by St John of God Emergency Department reporting that she did not feel safe at home and had thoughts of suicide.

Leanne was admitted into the Adult Acute Unit for two days at this time and diagnosed with Major depression with Cluster C traits.

On 18 September 2009, Leanne presented to the Emergency Department of Ballarat Health Services due to self inflicted cuts to her arm.

Leanne was admitted to the Adult Acute Unit for four weeks due to depressive symptoms and risk. On 22 September 2009, she was discharged from the Adult Acute Unit and stayed at Eastern View for a period of 11 weeks.

Eastern View is a community care unit providing housing, support and rehabilitation services to people with serious mental health problems participating in a recovery program.

On 16 December 2009, whilst on unescorted day leave from Eastern View, Leanne attempted suicide by taking an overdose of paracetamol and ibuprofen.

Leanne had initially been admitted to Sovereign House, a secure extended care unit on 18 December 2009, however after a further attempt at suicide by cutting her wrists, an involuntary treatment order was made and she was transferred back to the Adult Acute Unit as an involuntary patient.

Admission to such a Unit is only contemplated when treatment in the community cannot be safely provided.

Leanne remained an involuntary patient at the Adult Acute Unit until the time of her death.

Finding of Leanne's body

At around 7.00 pm on Friday 15 January 2010, Andrew Zampatti received a telephone call from the Adult Acute Unit at Ballarat Health Services.

Mr Zampatti was told that his sister had not returned from unsupervised leave at 5.00 pm as had been anticipated by the Hospital.

Mr Zampatti immediately went to his sister's home and discovered her hanging from the roller door in her garage.

He immediately cut her down from the door and rang Emergency services.

Post Mortem Examination

A medical examination of Ms Howell by Paul Bedford, a specialist Pathologist at the Victorian Institute of Forensic medicine found that the cause of death was hanging.

Last Admission to Adult Acute Unit

Leanne's risk of self harm was such that she was nursed in the Psychiatric Intensive Care Area (PICA) until she was able to return to the general ward on 28 December on 15 minute observations.

Leanne's risk of self harm was such that she was nursed in the Psychiatric Intensive Care Area (PICA) until she was able to return to the general ward on 28 December 2009, on 15 minute observations.

At the inquest, Andrew Zampatti described his sister's distress at being in the PICA including her intimidation by the presence of another patient in the PICA. This is reflected in the nursing notes.

Until 5 January 2010, Leanne was on 15 minute observations.

Following a review of Leanne on 5 January 2010, conducted by Dr Praveen Thottappilil (referred to as Dr Praveen during the Inquest) and Beth Fernandez, nursing observations were reduced to half hourly.

A Clinical Risk management Plan was discussed on 6 January 2010.

Leave Arrangements

It was reported that Leanne's condition was improving and that successful day leave would lead to her eventual discharge.

One of the problems facing mental health staff in assessing the suicide risk of a patient and for public mental health services that develop risk assessment tools is finding the right balance between what the patient tells staff and how much weight this is given in making a clinical assessment of risk. It is also unclear as to what is reasonable through clinical assessment for a mental health professional to know in the way of assessing the possibility of self-harm and suicide.

A Leave Plan should incorporate features that decrease the risk of adverse events occurring.

It is important for protective features to be documented, communicated and complied with in any grant of leave.

The Ballarat Psychiatric Service Protocol[1] regarding leave for inpatients from the adult inpatient units outlines the emphasis on risk assessment, communication of leave arrangements to family and client and documentation requirements. This is in line with the *Mental Health Act* 1986 (Vic).

It states clearly that all inpatient decisions should occur with

(a) Consideration of the

i. Risks and anticipated benefits, and

ii. Of the rights of the client, their family and carers.

[1] Client Leave from Inpatient Units Mental Health Services – PRO/C044 2009 Ballarat Psychiatric Service

In relation to documentation the protocol states clearly that

> All clients should have **clearly documented risk assessment and risk management plans** which are considered and references in the documentation of all leave decisions.
>
> The leave plan, approval of the leave by the authorisedpsychiatrist or his or her delegate, negotiation of this plan with client and accompanying adult, and the departure and return times of the client, should be clearly documented.
>
> **Any issues arising in the course of the client's leave should be noted.**[2]

A Leave of Absence form (MHA21) must be completed for all involuntary clients granted leave.

Agreement to commence graduated day leave was reached at a family meeting with Leanne, Andrew Zampatti, Ballarat Psychiatric Staff and Dr Praveen Thottappilil on 6 January 2010.

The mental state examination (MSE) is a core assessment tool for specialist psychiatric staff. The mental state examination collates information about the client's physical, emotional and cognitive state, is a systematic appraisal of the appearance, behaviour, mental functioning and overall demeanour of a person and it reflects a "snapshot" of a person's psychological functioning at a given point in time. A mental state examination is an important component of the assessment of a patient.

Dr Praveen Thottappilil stated that he had conducted a mental state examination and that

> *Leanne was well groomed, reactive, euthymic, normal speech, not expressing any thoughts of self harm and that her depressive symptoms were under control.*

How did the leave progress and how was this recorded?

Whilst Dr Praveen Thottappilil approved leave escorted by staff on 7 January 2010,[3] encouraged, it did not occur.

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[2] Emphasis added

[3] MHA21 – Leave of Absence form Ballarat Psychiatric Service Clinical file

This appears to undermine the aim of graduated leave.

In correspondence to the Chief Psychiatrist dated 20 January 2010, Dr Praveen Thottappilil stated

> *As part of the discharge plan, it was decided to start with day leaves.* ***It started with an escorted leave with the staff which went very well,*** *and then progressed to unescorted leave to her home.*

In fact ***no escorted leave*** had taken place and in evidence before me, Dr Praveen Thottappilil stated that he was aware of this at the meeting of 12 January 2010, and he had determined to progress with unescorted leave although the escorted leave had not occurred.

Dr Praveen Thottappilil stated that he inadvertently made that error in his reporting to the Chief Psychiatrist.[4]

The Clinical Risk Management Plan (for her discharge) dated 12 January 2010 was signed by Leanne, Dr Praveen Thottappilil and Beth Fernandez, a provisional psychologist.

Ms Fernandez stated that she did not participate in the decision making process to grant leave.

> *I attended the meetings on 12 and 14 January 2010 during which Leanne was approved for unescorted day leave. As I was new to the role I did not contribute opinions or make recommendations to the decision-making process for granting leave, although I was welcome to do so. I may have answered questions of any attending family members present who would have been welcome to comment during these meetings.*
>
> *Ultimately, it is the consultant psychiatrist who makes the final decision whether or not leave is granted. Dr Praveen made that decision on 12 and 14 January 2010, and I did not question this judgment.*

It is unfortunate that Ms Fernandez did not contribute as she had had a lengthy involvement with Leanne, one of her roles being that should be her treating clinician, meaning that when she was discharged home, she would treat her at home as required.

Ms Fernandez was also aware of Leanne's particular vulnerabilities having conducted a number of assessments on Leanne previously.

I note that Leanne was one of her first patients.

[4] Letter to Coroner's Assistant dated 4 March 2013 from Dr Praveen Thottappilil

Andrew Zampatti did not agree with the Clinical Risk Management Plan prepared for discharge, and was unprepared to sign it.

Despite what is recorded in the document, he stated clearly at the time and in evidence that he was unable to stay overnight with Leanne due to his own family commitments and responsibilities.

Dr Praveen Thottappilil's notes of 12 January 2010, disclose that Andrew was apprehensive about the granting of unescorted leave, however he ultimately gave his support for following the planned leave.

It was agreed at that meeting[5] that Andrew Zampatti would be contacted before Leanne left the Unit on leave and that the leave would be for short periods of 2 to 3 hours, a mental state examination and risk assessment was to be conducted and that if there were any problems, Leanne was to return back to the Unit.

The Leave of Absence form of 12 January states:

- *To start with unescorted day leave to her house.*
- *Staff to do MSE before her leave.*
- *If any crisis to return back to AAU.*

Leanne was released unescorted on leave on 13 January 2010, for a period of almost five hours according to the nursing notes.

Dr Praveen Thottappilil states in his correspondence to the Chief Psychiatrist that Leanne "went home for the first time on 13th January 2010, for a period of 2-3 hours. That leave went reasonably well without any major problem."

The nursing notes of Michelle Ainsworth in contrast, disclose that Leanne had thoughts of self harm on her leave but was able to be distracted.

Dr Praveen Thottappilil stated in his notes of the review on 14 January that there were no thoughts of self harm by Leanne during that period of leave.

Leanne also declined leave that day spending it in her bed complaining of a sore ear.

[5] Although not recorded in any of the Hospital's notes

Deficiencies in documentation and communication

The documentation in relation to Leanne's leave, particularly the Leave of Absence form is deficient.

It omitted critical information that were conditions on her leave. The information was critical because they were protective factors structured and designed to decrease the risk of an adverse event[6] occurring on Leanne's leave.

Specifically, it was not recorded that the leave was to be 2 to 3 hours, or that her brother Andrew was to be notified.

When Leanne was released on 13 January it was for a period of 5 hours and no contact as made with Andrew upon her release from the Unit.

Upon becoming aware that Leanne had been given leave on 13 January for a period of 5 hours, Andrew telephoned Dr Praveen Thottappilil on 14 January to advise that the conditions of leave had not been complied with.

Dr Praveen Thottappilil stated in evidence that he received that call from Andrew and stated that he telephoned the ward to tell them the terms of Leanne's leave.

Dr Praveen Thottappilil stated that he does not recall who he spoke to on the ward and he did not take a note of this telephone call.

The nursing notes do not record any call to the ward recording this conversation nor was any documentation altered or amended either by Dr Praveen Thottappilil or nursing staff to ensure that this error did not occur again.

In particular the notes of the review of the leave on 14 January 2010, make no record of this non compliance with conditions imposed on the granted leave.

Death of Leanne on leave outside terms upon which it was agreed to occur at the Case Plan Meeting

On 15 January, with no record of these conditions, Andrew Zampatti's concerns proved prophetic and on leave taken outside the terms that were agreed to at the case plan meeting, Leanne took her own life.

[6] In particular self harm

Role of Family Members

Andrew Zampatti was committed and caring regarding the treatment of his sister. He was also vigilant.

Significant weight should be placed on the opinions of family members as part of any case management plan.

The Ballarat Health Services "Risk assessment and Risk Management Guidelines" emphasises that "great weight should be given to information and opinion form those who know the individual well, whether they are family, friends or staff."

Whilst this was accorded recognition in the clinical case planning (ie notifications and short periods of leave) it was simply not acted upon because it was not recorded or communicated to nursing staff either initially in documentation or even after it was bought to Dr Praveen Thottappilil's attention by Andrew Zampatti.

Ms Ainsworth stated categorically that she was unaware of those conditions on Leanne's leave.

It was not until 5.30 pm the evening of her death that it was noted that Leanne had not returned from leave.

It was not until 7.00 pm that evening that Andrew was notified that Leanne had had leave and that she had not returned.

I note that in his correspondence with the Chief Psychiatrist Dr Praveen Thottappilil stated that Andrew was notified at 1700 hours. This is incorrect, and in any event, some two hours after Leanne was due to return from the leave she had taken outside of what had been granted.

Deficiencies in Documentation and Reporting

There are significant issues with the documentation kept by the hospital.

Critical information is not recorded and therefore not communicated.

Reviews that purportedly last for 40 minutes are documented by a handful of lines in point form. Correspondence to the Chief Psychiatrist falsely records the path of Leanne's leave.

The lack of accurate information being provided to the Chief Psychiatrist is of concern. It is the data upon which the Chief Psychiatrist informs themself in order to review in patient deaths and to identify deficiencies in practices which need to be identified so as to achieve improvements in practice and issues relevant to the mental health system.[7]

The integrity of that data should be scrutinized, if it is sought to be relied upon.

All the errors made in correspondence to the Chief Psychiatrist created a more favourable picture of clinical decisions and communications than what in fact was the case.

Conclusion

Though a matter of speculation whether the outcome would have been averted, the risk to Leanne would have been substantially decreased if her brother had been contacted and leave occurred in accordance with the plan of graduated leave initially formulated.

[7] See Recommendation "Chief Psychiatrist's investigation of inpatient deaths 2008-2010"

RECOMMENDATIONS

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

(1) To prevent suicides from patients granted leave from Acute Inpatients Units, I recommend:

(a) The Department of Health and Human Services ensure there is clear and consistent process, documentation and communication for Leave Plans. Any changes are to be made only after suitable discussion and consideration and such variations recorded and communicated.

(b) In addition to Recommendation 1A, the process and documentation of Leave Plans should incorporate supervision and accountability to ensure compliance by all mental health professionals involved in the granting and implementation of leave plans.

(c) That there be a process for ensuring the accuracy of information provided to the Chief Psychiatrist.

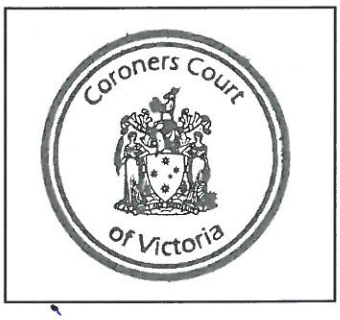
(d) Implement Recommendation 15 made in the report titled "Chief Psychiatrist's investigation of inpatient deaths 2008-210" that

> "That the Chief Psychiatrist convene a panel every three years to inquire into inpatient deaths over that time to consider overall practice improvements and issues relevant to he mental health system."

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

- Mr Lance Wallace, Acting Secretary Department of Health.
- Dr Mark Oakley Browne, Chief Psychiatrist.
- Ballarat Health Services.
- Mr Andrew Zampatti.
- Coroner's Prevention Unit.

Signature:



Ms Michelle Hodgson
Coroner

Date: 18.9.2013