IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 0605

FINDING INTO DEATH WITH INQUEST

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

(Amended pursuant to s76 of the Coroners Act 2008 on 9 July 2015)

Inquest into the Death of: **MALE D**

Delivered On:	6 July 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street SOUTHBANK VIC 3006
Hearing Dates:	1 December 2014 to 3 December 2014
Findings of:	JOHN OLLE, CORONER
Representation:	Mr John Snowdon of counsel for Southern Health
Police Coronial Support Unit	Senior Constable Tracey Ramsey

I, JOHN OLLE, Coroner having investigated the death of **MALE D**

AND having held an inquest in relation to this death on 1 December 2014 to 3 December 2014
at SOUTHBANK
find that the identity of the deceased was **MALE D**
born on 2 February 1957
and the death occurred on 2 February 2009
at Dandenong Hospital, 135 David Street, Dandenong 3175
from:

1 (a) MULTIPLE INJURIES AND IMMERSION LEADING TO HYPOXIC BRAIN INJURY AND PNEUMONIA

in the following circumstances:

BACKGROUND AND CIRCUMSTANCES

1. **Male D** (**'Male D'**) was aged 52 years at the time of his death. A devoted family man, **Male D** is survived by his wife and daughters, with whom he maintained close and loving relationships.

2. A plumber by trade, his wife described **Male D** as a man who could turn his hand to anything. A 'blokes bloke' who "called a spade a spade"; one was never in doubt where you stood with **Male D**. He also had a soft side. He was a very hands on father who loved spending time with his daughters who in turn loved spending time with him. Shortly prior to his death the family completed a treasured holiday travelling Tasmania in a motor home.

3. **Male D** worked hard and ran a successful plumbing business. He conscientiously strove to ensure that individual rights and occupational health and safety issues for workers were paramount.

4. His wife was overwhelmed by the outpouring of support the family received following **Male D's** tragic death. She spoke with pride of the academic pursuits of their daughters and concluded:

> **Male D** was a good man, a hard worker often working six days a week who enjoyed a drink and loved to fish and cook. **Male D** loved his family and we loved him.

CIRCUMSTANCES

5. Y pleaded guilty to the manslaughter of **Male D**. The sentencing remarks noted that **Male D** died on 2 February 2009 as a result of various serious injuries received at Y's hands the previous week. His Honour noted:

> "It is a particularly unsatisfactory aspect of this case that almost nothing is known about the precise circumstances in which **Male D** received his injuries. You claim to have little memory of the relevant events, and given your psychiatric deficits, that possibility cannot be excluded."[1]

6. **Male D** was acquainted to Y and had assisted Y obtain employment. On the day of the assault, **Male D** was in the company of Y and others, drinking alcohol over a number of hours. His Honour noted an absence of any real evidence to demonstrate how **Male D's** injuries were sustained, he stated:

> "I am satisfied that **Male D** did nothing which could have caused his death."

7. For my purposes, it is important to note His Honour considered Y's mental illness was relevant for sentencing purposes, " particularly having regard to your most recent admission to hospital prior to this offending"

8. His Honour noted Y had "little or no insight into this offending and only limited insight into your condition."

FOCUS OF INVESTIGATION

9. My focus is on the medical management of Y whilst an involuntary patient at the Casey Mental Health Service ('the unit') from 30 December 2008 to discharge on 16 January 2009, together with his subsequent management in the community. The suppression order I have made in respect to Y's identity remains in force. Due to the sensitive nature of material subject to my investigation I have made every endeavour to ensure that Y's identity is not disclosed. In a further endeavour to ensure the identity of Y is not revealed, I will refer to members of the clinical team by title only. Through his lawyer, Y was appraised of this inquest and declined an offer to participate.

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[1] Sentencing remarks

10. At inquest I heard evidence from a Consultant Psychiatrist ('the Consultant'), a registered nurse, the manager Casey Community Mental Health Team ('the CCMHT manager'), Y's CCMHT case manager (RN1), the Clinical Director at Monash Health and Professor Mullen.

11. In addition, my investigation has received assistance from Mr Paul Smith, Deputy Secretary, Mental Health, Wellbeing and Ageing, Department of Health though his reports dated 5 November, 2014, 10 February 2015 and 26 March 2015.

12. Consultant psychiatrist, Professor Paul Mullen, was engaged by the court to provide an independent expert opinion on the appropriateness of the clinical decision to discharge Y, the discharge plan and the medication regime.

THE EVIDENCE

13. This finding is based on all the investigation material comprising the coronial brief of evidence, all material obtained after the provision of the brief, the statements and evidence of witnesses who appeared at the inquest and any documents tendered.

14. It is important that I make clear that it is not part of a coroners role to lay or apportion blame. As Calloway JA espoused in *Keown v Kahn* (1999) VR 69:

> In determining whether an act or omission is a cause or merely one of the background circumstances, that is to say a non-causal condition, it will sometimes be necessary to consider whether the act departed from a norm or standard or the omission was a breach of a recognised duty, but that is the only sense in which paragraph (e) mandates an inquiry into culpability. Adopting the principal recommendation of the Norris Report, Parliament expressly prohibited any statement that a person is or may be guilty of an offence. The reasons for that prohibition apply, with even greater force, to a finding of moral responsibility or some other form of blame: the proceeding is inquisitorial.[2]

15. Callaway JA observed that it is the Coroners role to seek to establish the facts, set them out and for others, if they wish, to draw legal conclusions. The amendment to *Coroners Act 1985* (Vic) repeals the requirement to make a finding as to persons/other entities who "contributed" to the death, due to the connotation that had attached to that concept; a

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[2] *Keown v Kahn* (1999) VR 69, 76.

connotation of fault, blame or culpability. I have assiduously sought to follow His Honour's direction.

Y's psychiatric admissions to Casey Hospital from 6 December 2008 and discharge on 16 January 2009

16. The consultant had managed Y on each of his four admissions since 2006, and reported that Y suffers from schizo-affective disorder characterised by both manic and depressive episodes as well as psychotic symptoms; namely persecutory delusions and auditory hallucinations, which responded well to depot anti-psychotic medication. He also has an alcohol dependence disorder.

17. Y re-presented to Casey on 6 December 2008 reporting paranoid thoughts and hearing voices, and wanted to re-start his depot. He was discharged on 12 December 2008 but was re-admitted on 30 December 2008, following a lengthy siege at his parents home triggered by their concerns for his deteriorating mental state and aggression. The CAT team was called and upon their attendance at the residence, in the company of police, Y refused to see them and took his parents hostage. Ultimately with the assistance of Special Operations Group the siege was resolved and Y was transported to Casey Hospital.

18. Upon his admission, Y was extremely abusive, hostile, intimidating and paranoid and was admitted straight into seclusion. Y came out of seclusion on 1 January 2009 but remained irritable and hostile. At clinical review on 5 January 2009, Y was noted to be slowly improving and was prescribed his regular dose of Zuclopenthixol Decanoate, a long acting antipsychotic injection administered every two weeks. Y was reviewed on 7 January 2009 and the consultant felt he needed more time in hospital. They started working on discharge planning, which involved seeing the social worker to investigate accommodation options and meeting Y's parents. Y saw the social worker on 7 January but did not want any offered accommodation in the Casey Cardinia area and wanted to find a house with his partner and her children.

19. On 8 January 2009, Y's consultant met Y's parents, who conveyed that they had 'reached the end of their tether' and were unwilling to take him back at the granny flat at their residence. Y was in attendance for the meeting and was very abusive toward his parents, such that the meeting had to be curtailed. Given his behaviour and irritability the consultant added Olanzapine 10mg twice daily.

20. From 9 - 16 January 2009, Y was reported to be generally settled and did not require close nursing observation or placement in the Acute Medical Area or seclusion. He continued to be angry when his needs were not immediately met but this behaviour was managed by nurses using firm boundaries. On 14 January 2009 a plan for case management referral to Casey Continuing Care Team (CCCT) was made and as part of the referral document a risk assessment was conducted. It was reported that Y's verbally aggressive and hostile behaviour decreased during his admission and his documented risk assessment by staff was subsequently decreased to a medium risk of harm to others. At the time of the referral he was being nursed on a 1:60 level of nursing, meaning direct observation on an hourly basis, which is the lowest level of nursing observation. In considering and utilising the information that was before the clinical nurse educator, she assessed Y as at medium risk to others: 'Whilst Y had not been physically aggressive, his tendency to become verbally aggressive and hostile when his perceived needs were not met had the potential to be a risk to others.'[3]

21. On 16 January, the day of Y's discharge, the consultant reiterated to Y the need for him to see a psychologist. Y was made aware of the IVO from his parents. Due to his recent unsuccessful discharge from hospital and history of being on community treatment orders (CTO) it was decided that Y be treated on depot medication on a CTO and a case manager referral was made.[4]

22. Consultant psychiatrist reviews and the fact that Y was on basic nursing level observations the week prior to discharge indicated to the consultant that Y was not psychotic or manic and could be discharged. The consultant was aware of Y's agitated behaviour on inpatient units, damaging his workplace and IVO's from his family, however he did not believe Y posed a risk to others at discharge. Y was in the pre-contemplative phase of his substance addiction and on discharge remained a high risk of abusing substances. However, the consultant stated that beyond the psycho-education approach they used, there was no proven intervention that could have negated the risk.[5] In relation to Y's threatening behaviour, the consultant stated that he had known Y for three years and felt he could discern what behaviour was related to paranoia and what was his 'normal belligerent, caustic manner'. He

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[3] Report of clinical nurse educator, dated 21 November 2012.

[4] Report of Consultant psychiatrist, Casey Hospital, Southern Health, dated 1 November 2012.

[5] Report of Consultant psychiatrist, Casey Hospital, Southern Health, dated 1 November 2012.

was confident at discharge that Y was back to his baseline level of function. [6] In evidence, upon review of the progress notes, the consultant acknowledged he was not aware of Y's level of instability in the approximate week, prior to discharge.

23. Olanzapine 10mg bd and Diazepam 10mg tds were stopped at discharge because: the depot medication had kicked in and the consultant did not want to over-sedate Y as he adjusted to life in the community; Given Y's predilection to abuse substances, diazepam was always going to be a short term treatment; there were questions as to whether Y would take the medication if it were prescribed; If Y took the medications they would likely increase his sedation if he returned to drink or illicit drugs; and stopping the drugs abruptly theoretically might cause a withdrawal syndrome.[7]

24. At Inquest, the consultant gave evidence that although he can't be sure of anything, he was confident of his decision to stop the two drugs because Y had been well for many weeks in 2008 on a much lower dose of zuclopenthixol 100mg, and the nature of a manic disorder, the agitation and aggression aspect, can be treated very quickly, 'or in his case certainly he seemed to get better quickly in his history, at least five or six admissions had been short. So the acute aroused stage can be treated quickly' and he thought the other prescribed medications would be enough. However, upon reviewing the progress notes at inquest, the consultant acknowledged when assessing the appropriateness of discharging Y, he had not appreciated the level of instability exhibited by Y in the week or so, prior to discharge. He had inadvertently understood Y to have been stable throughout that period.

25. The consultant stated that he had the responsibility to treat Y collaboratively and in the least restrictive environment and within those two parameters he felt that Y being seen on 23 January, a week later, was sufficiently containing for Y.[8]

CCCT Post-discharge follow-up and review on 23 January 2009

26. On 20 January 2009 the case manager contacted Y's home and spoke to his mother, who informed that Y was not home. He relayed details of an appointment for Y to see a doctor; a message which she said she would pass on. Later that day Y rang the case manager and told him his depot injection was due on 23 January 2009. An appointment at 8.30am on 23

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[6] Ibid.

[7] Report of Consultant psychiatrist, Casey Hospital, Southern Health, dated 1 November 2012.

[8] Coronial transcript of evidence, 158-9.

January was made for administration of Y's injection and to explain his obligations under the case management model.

27. On 23 January Y was late for his appointment and was initially irritable when was not seen immediately. Unfortunately the medical officer due to see Y this day, was absent through illness. According to the case manager, a vastly experienced clinician, Y initially presented, 'like many other clients', as 'unhappy and irritable at being case managed'. Y's demeanour was described as 'stand overish' at times, however he became more amenable during the interview and the case manager 'quickly built a good rapport with him'. During a mental state assessment he was found to be delusional, mentioning that 'coffin cheaters were out to get him'. When the case manager discussed this with Y he found that Y did have some insight into his mental illness as he expressed doubt about his delusions regarding coffin cheaters and the brotherhood. Y then discussed his living arrangements and further, social supports, his family, his CTO requirements and Y being served with several IVO's. Y scored 19 on the Health of Nation Outcome Scale, a medium score which showed that he was 'relatively unwell'. The main area of interest was that Y's hallucinations and delusions were still present and real to him. He also displayed depressive symptoms, was not sleeping well, had mild distortion in his cognitive ability and was at times agitated. The case manager reported that Y's risk assessments showed he did present with irritability and hostility but was able to de-escalate very quickly and was rational in his thinking and boundaries. Y discussed good coping strategies such as calling his case manager, seeing a GP, calling his mother or CCT if he was feeling unwell or felt he would hurt someone. He reported using minimal amounts of marijuana and alcohol (3 cones or a couple of bourbons one or two days a week). The case manager determined from the assessments that Y was sometimes threatening in manner but not suicidal or a risk of harm to others at the time. There were no major risks evident to warrant Y returning to Casey and he was complying with his CTO conditions.[9]

28. At inquest, the Community Team Manager, acknowledged that in hindsight if he was conducting the assessment on Y and was faced with the same matters as those raised by the case manager in his assessment with Y, he would have probably looked at instigating the CAT team and if the medical officer was present he thinks the medical officer would have sought advice from a psychiatrist. He thought the most concerning features of Y's

[9] Report of Registered Nurse, Casey Continuing Care Team, dated 27 March 2013.

presentation were that some of the delusional elements about the brotherhood and coffin cheaters were still there.[10]

29. At inquest the consultant stated that patients can have delusions but it just depends how much it impacts on their behaviour.

30. So if you have this delusion as [Y] clearly seems to have at this appointment with the case manager, it's how much he's attached to it...if your psychosis or your delusions are so preoccupying that they direct your behaviour, that is problematic. Very problematic. But if you have these delusions because you've had them for so many years as I think must have been the case with [Y], you can go in and out of them in how much you believe them. You could still work...work...and have this belief, this delusion, but it's not something that will impact on his day-to-day life except maybe occasionally when he's going to sleep or whatever.[11]

31. The consultant stated that if he was conducting the assessment on Y and was faced with the same matters as those raised by the case manager, it is difficult to say if he would want Y in the community. He would be more interested in the ability for Y to have doubt into his delusions. If the doubt is strong enough and the case manager and doctor can work with that patient he would not necessarily admit the patient. However, it has to be in the context of his behaviour and what impact that is having in his life.[12] He acknowledged that on the information, if he assessed there were hallucinations, persecutory delusions, paranoia, he would not want him in the community; he would take action. He also stated 'if there was some working relationship you could say to the case manager 'look, I'm not sure. Can I see you tomorrow'... You don't have to at that moment bring them in.' He would put it in context but if there are troubling delusions and hallucinations then he would need them to come in.[13]

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[10] Coronial transcript of evidence, 28-30.

[11] Ibid 210.

[12] Coronial transcript of evidence, 211-12.

[13] Ibid 213.

PURPOSE OF THE CORONIAL INVESTIGATION

32. The primary purpose of the coronial investigation of a reportable death[14] is to ascertain, if possible, the identity of the deceased person, the cause of death (interpreted as the medical cause of death) and the circumstances in which the death occurred.[15] An investigation is conducted pursuant to the *Coroners Act 2008* (Vic)[16] and the outcome of this part of my investigation is included in this finding.

33. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[17] This is referred to as the 'prevention role' of the coroner.

Overview of evidence

34. All members of clinical staff gave full and frank evidence. With hindsight, individual and systemic short comings in respect to Y's admission were acknowledged, however in the context in which they worked, I do not find their management of Y unreasonable. Clearly, all clinical decisions were made in Y's best interests. Although hindsight has revealed that poor clinical decisions were made, I endorse the opinion of Professor Mullen:

> "I'd be very distressed if my report gave the opinion that I was being critical primarily of the clinical skills, or care, provided by the consultant and his team. What I tried to do in the report – and it may be that I failed to do this – was to point out that they had to work within constraints placed on them by the nature of our mental health services. And the reason that the care, in my view, of Y was suboptimal is entirely due to the nature of the Mental Health Services as provided in Victoria at the moment. It is not – I mean I'm terribly sorry if you read that as critical of the professionals involved, it is certainly not meant to be, that's why I tried

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[14] Section 4 of the *Coroners Act 2008* (Vic) requires certain deaths to be reported to the coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death includes all deaths that appear 'to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury. Mrs Mulqueen's death falls within this definition.

[15] *Coroners Act 2008* (Vic) s 67.

[16] Hereafter referred to as 'the Act'.

[17] *Coroners Act 2008* (Vic) ss 72(1), 72(2) and 67(3).

to separate it. I mean I think the decisions were not good sometimes, but the decisions were not good because they couldn't be anything else than what they were. And as the consultant said – "I'm not in the business of treating patients – don't have the facilities, or the time or any of those things. Now that's a terrible situation to put a doctor in."[18]

35. Professor Mullen is deeply troubled by Victoria's mental health service, which in his view, measures it's quality of service, by the number of separations (discharges of patients from acute settings). Professor Mullen is concerned that shorter admissions result from a system which encourages an increase in separations. The gravamen of this focus is that consultants see their role as making seriously unwell patients, less unwell as opposed to treating the illness. The consultant agreed with Professor Mullen that the system does not allow consultants to treat patients in acute mental health settings in Victoria.

36. Under cross examination by counsel for Casey, the following exchange occurred:

Q: One of the comments that (the consultant) made yesterday was that as a reality he believes the role of an acute unit such as his at Casey, is to make very unwell patients less unwell, and when they are sufficiently less unwell to be able to go back into the community to be able to discharge them back into the community. He says that he did not believe that it was possible to make them well "in that environment" – is that something which you'd agree?

A: That's a very honest response. I don't think you need to make people well, I think you need to make them a lot better and able to function a lot better, that is the case with most people discharged from an Acute Psychiatric Unit. I agree with him entirely, and he is forced to say this, to be honest and say this is a tragedy."[19]

37. I consider the inability of the consultant to access specialist forensic psychiatric support, made clinical decision making extremely difficult in respect to Y. The consultant and members of the acute community treatment teams spoke of lessons learnt and improvements at Casey. In hindsight, sub optimal clinical decisions occurred in a context of unavailability

[18] T – 370

[19] T - 363

of a specialist forensic support, which the consultant stated in evidence, if available, it would have been appropriate.[20]

38. Sadly, there is a marked over representation of persons who suffer serious mental health illness, in the commission of serious crime, including homicide, in Victoria[21].

39. Consultant Forensic Psychiatrist Dr Danny Sullivan, in his role as Assistant Clinical Director at Forensicare, provided a report to assist my investigation. I thank Dr Sullivan for his assistance.

40. Dr Sullivan stated that the Forensicare Community Forensic Mental Health Service offers primary and secondary consultation to assist referrers, predominantly area mental health services, to assess and manage mentally disordered patients who pose a significant risk to others. The service is funded by the Department of Health.

41. Primary consultation involves a risk focused clinical assessment, generally by consultant psychiatrist and provision of a written consultation report with recommendations for management.

42. A secondary consultation involves discussion, face-to-face or by telephone, with treating staff and brief correspondence to assist services with management planning, ideally to reduce risk of violence or offending.

43. After reviewing the material relevant to Y's case, Dr Sullivan noted that on the available information Y would have clearly been eligible for primary and secondary consultation to assist the treating team with risk management issues.

44. However, Dr Sullivan explained:

> The Community Integration Program (CIP) of Forensicare has had shifting eligibility criteria and capacity over the years depending upon funding. In January 2009 there was a limited capacity to provide clinical input to patients of Area Mental Health Services (AMHS) who were managed in the community. This was generally reserved for people with both serious mental illness and serious past offences, and involved co-case management alongside the AMHS for a period of weeks to some months. Only a small number of patients across Victoria, certainly less than 20,

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[20] T - 225

[21] Prof Mullen – T - 338

were able to receive such a service at any given time and the CIP staffing levels were relatively low, precluding large caseloads.

Thus, although he may have been eligible, depending on the limited resources it is unlikely that Y would have been perceived to require specific forensic input at that time. This is predominantly due to the fact that he did not have a significant prior offending history. Had he been referred in January 2009 prior to discharge from the inpatient unit, it is likely that he would not have been perceived to meet the threshold for serious offending.[22]

45. Professor Mullen addressed this aspect:

> The quality of the assessment of Y's risk of acting violently in the short or long term was, in my opinion, poor. It was, however, no worse than that which occurs in most acute psychiatric units in Victoria. Those with the knowledge and skills to carry out such assessments adequately are thinly spread in the public mental health services. Most of such expertise is concentrated in Forensicare's Community Services. There was a time when Forensicare provided a consultation service to acute psychiatric services around the state. The funding and resources are no longer available to provide such a service. No criticism can therefore be directed at those caring for Y for failing to avail themselves of a now discontinued service.[23]

46. I consider the inability of the consultant to access specialist forensic psychiatric support, was a significant impediment to optimal decision making. In hindsight, sub optimal clinical decisions occurred in a context of unavailability of a specialist forensic support, which the consultant stated in evidence, if available, it would have been appropriate.[24]

47. In emphasizing the need for consultant's to receive specialist forensic psychiatric support, Professor Mullen explained that a forensic psychiatrist has a totally different set of priorities than a consultant.[25] He explained that in fairness to general psychiatrists, "to be fair to their training, and their approach to their patients, do not put the risk of violence as a very high priority.....If you see every one of your patients as the embodiment of future violence, that is not good for treatment.....and this is why it seems to be so important that we have the

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[22] Statement Dr Danny Sullivan

[23] Exhibit 10 Professor Mullens statement

[24] T - 225

[25] T - 330

specialist who can approach their patients in that way, or approach other people's patients in that way to carry out assessments...a forensic psychiatrist a greatly different set of principles."[26] Professor Mullen explained a forensic psychiatrist would have placed great weight on:

- The significant 7 hour siege which led to Y's admission;
- Y's threats to kill;
- That Y's parents who had offered him life long support, and his former partner had reached the end of their tether. They were so frightened of Y, they were no longer prepared to support him and intended to take out intervention orders against him;
- Y's level of intimidation and instability in the ward;
- That he could not be discharged until sufficient time for anti-psychotic medication to take full effect;
- That olanzapine and diazapam would need sufficient time for reduction (not cessation the day prior to discharge);
- That the delusions and hallucinations exhibited at the 7 day review post discharge should have resulted consultant review and potential re-admission;
- The need to formally involve the community treatment team in all discharge planning meetings and
- The need to carefully monitor the likely return to drug and alcohol upon discharge.

48. In respect to the role of the consultant, Professor Mullen stated the above are "immediately in the forefront of the mind of a forensic psychiatrist. They are not and they shouldn't be in the forefront of the mind of someone like the consultant."[27]

49. I note that Casey has made significant improvements since 2009. Notably, in the context of this case:

- discharge hand-over is from consultant to consultant;

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[26] T - 331

[27] T - 332

- Community team case manager is formally involved in discharge planning;
- Forensic clinical nurses are now available and fully utilised in cases such as Y; and
- PARC (Prevention and Recovery Care) and three SECUs (Secure Extended care Units) in Victoria which offer long term voluntary and involuntary therapeutic care[28] SECU is not ordinarily offered after an admission.[29] It is a long, slow rehabilitation with expected stay of at least a year.[30] Professor Clarke did not suggest Y would be a candidate for placement in either unit.

Issues of Concern identified by Professor Mullen

50. In respect to PARC and SECU, Professor Mullen explained that the nature of Y's mental illness, would exclude him from these placement options:

> "I have no problem with these units – they're necessary, but they're not units for Y. They're units for people who have a multitude of problems, and really can't cope in the community – the difficulty you see is that what we have to change is the environment in the acute treatment units."[31]

51. Though commending the development of PARC and SECU, Professor Mullen explained Y needed a longer admission in an acute setting, which encompassed a step down or recovery unit, which is an option, not available in Victoria. Professor Mullen stressed the importance of continuity of care and strongly advocated the need not to split acute and non acute settings. In his view the nature of an acute setting needed fundamental change. His major concerns with the current system of provision of mental health in Victoria is capsulated as follows:

- Far few acute care beds to provide adequate care. Most psychiatric beds are available in private sector don't admit grossly disturbed patients like Y. The number of beds in public facilities drop by over half.
- The threshold for admission is so high that only severely disturbed persons are admitted into acute care.

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[28] T - 254

[29] T - 255

[30] T - 256

[31] T - 343

- There is more stress and pressure to discharge on clinical staff in acute settings.
- The length of stay in acute settings is too short.
- There are need to have forensic specialists available to access risk of violence. The CAT teams are over stretched in the community.

52. Mr Smith rejects Professor Mullen's assertions above. However, it is common ground that the demand for mental health services is significant and the capacity to meet the demand remains challenging. I note Mr Smith's response[32] to the following question posed by **Male D's** wife:

> Q: Professor Clarke concurs that that the inadequacy of availability of beds is the environment we work in and it puts a constant stress on the system" He also states the total number of beds per 100,000 population is considerably less in Victoria than elsewhere in Australia."

53. Mr Smith replied:

> "Victoria was the first Australian state to embrace deinstitutionalisation in the 1990s and has embedded a philosophy of the requirement to provide least restrictive care for someone accessing public mental health services into its legislation and policies. Rather than rely solely on acute inpatient care, investment has been made in provision of a wide range of alternatives both in acute and community settings. As such, the number of acute inpatient beds per population is below that of other states, whereas the number of less acute options is considerably greater. For example, Victorians can more readily access step down care in Prevention and Recovery Centres for up to four weeks per admission and have greater access to community based care than people in other states."[33]

DHS response to Professor Mullen's concerns

54. Professor Mullen acknowledges the useful role performed by forensic nurses as a result of the 2010 initiative, however bemoans the unavailability of forensic psychiatrists to assist and support acute mental health clinicians[34] Mr Smith asserts in response:

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[32] Letter to Court dated 26 march 2015

[33] Statement Paul Smith 26 March 2015

[34] T - 338

- Forensicare has not had funding reduced
- Specialist acute care is available and accessible at all times
- The 2010 new model created new forensic clinical specialist positions to provide expert consultation and advice services to access and manage risk

55. Mr Smith has identified the endeavours of successive governments to "deliver a system where acute inpatient services can be accessed when clinically indicated, but one in which less secure and acute alternatives are also available." He explains there are "200 beds in Prevention and Recovery Centres (PARCs), which operate predominantly as step down care to assist people to re-establish themselves after a period of mental illness but can also provide early intervention care and reduce the likelihood that an inpatient stay will be required...There are also beds in Community Care Units and Secure Extended Care Units. ... SECU provide secure inpatient treatment and care for people with severe symptomology and behavioural disturbance who require an extended period of sustained treatment and rehabilitation in a secure environment. There are currently 132 SECU beds in Victoria, ... a further 12 beds are being built as part of the Bendigo Hospital redevelopment....PARC beds which provide sub-acute care for up to four weeks, have increased from 90 in 2009-10 to 200, with a further 30 in the pipeline. All these options assist to reduce demand for adult acute inpatient services...Notwithstanding the range of services available for people with a mental illness, demand in the state system is consistently high."

56. Professor Clarke stated that the inadequacy of availability of beds is the environment we puts a constant stress on the system. Mr Smith explained that Victoria has less acute inpatient beds per population than other states due to investment in a wide range of alternatives both in sub-acute and community settings. "As such, the number of acute inpatient beds per population is below that of other states, whereas the number of less acute options is considerably greater."

57. Professor Mullen spoke of the era in which mental health in Victoria was deinstitutionalized in the early 1990's, and his support for the change. Further, though commending the creation of PARC, CRU and SECU and acknowledged the useful role they provide in the provision of mental health services in Victoria, he steadfastly advocates they are only part of the solution, and are not an option for a patient such as Y.

58. The only solution, according to Professor Mullen, is to ensure acute wards offer a two phase environment. Firstly to manage the crisis which precipitated the admission. Once stability

has been achieved, transfer the patient to a step down or recovery unit, which offers a positive and therapeutic environment, suitable for treatment of the underlying serious mental health illness. In my opinion, the logic is compelling. Surely patients who as so unwell, to require admission to an acute psychiatric unit, should receive treatment for their illness. At the very least, consultant's should have the option of a recovery unit to utilise as deemed clinically warranted. The consultant who cared for Y, agrees with Professor Mullen that the current system in Victoria, does not allow a consultant to treat a patient admitted to an acute psychiatric unit, such as Casey. Rather, make the patient less unwell, and discharge. Professor decries this clinical scenario.

59. In general medicine, it would be unacceptable if a patient was discharged into the community, from an intensive care unit. Why is it not equally unpalatable in a mental health setting. Professor Mullen explained treatment in an acute setting, which constitutes a therapeutic and positive environment, is treatment we would be proud to offer a family member suffering a serious mental health illness, and not a violation of the legislative requirement to provide treatment in the least restrictive environment.[35] In my view, the requirement to treat in the least restrictive setting, does not require discharge immediately a crisis is lessened without the underlying illness being treated. In my view a step down/recovery ward which enables clinicians, in appropriate cases, to treat their patients in a therapeutic setting, prior to discharge, should not constitute a failure to treat in the least restrictive setting. I consider such an option in a case such as Y, an appropriate clinical option.

60. Clinical staff in acute mental health settings perform a valuable and often, thankless task. They deserve community respect and unstinting support. A step down/recovery unit within an acute psychiatric setting would provide an invaluable treatment option.

61. The evidence satisfies me the medical management and care provided by the Southern Health was not unreasonable or inappropriate, in the circumstances, having regard to the complexities involved and system in which they worked.

62. I acknowledge the difficulty for health clinicians to manage and treat individuals suffering serious mental illness. The complexity of assessing Y at discharge and post-discharge, in particular in light of his longstanding history with Southern Health and his consultant psychiatrist – and the inability of accessing specialist forensic psychiatric assistance.

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Further, there is little or no evidence as to Y's conduct and/or mental state in the period prior to the fatal assault.

63. I acknowledge the endeavours of Southern Health to implement measures designed to assist it's clinical staff in the performance of their onerous duties.

64. I acknowledge the sad loss suffered by **Male D's** family, and note the dignity exhibited by them, in particular their determination to avoid blame but seek improvements in Victoria's mental health service.

65. I am satisfied that no further investigation is required.

66. I find that **Male D** died at Dandenong Hospital, Dandenong on 2 February 2009 and that the cause of his death is multiple injuries and immersion leading to hypoxic brain injury and pneumonia.

COMMENTS

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

67. My investigation has been greatly assisted by Mr Paul Smith. His passion, commitment and determination to provide the best mental health service for Victorians, is evident. Demand for mental health service is extreme and budgetary constraints a reality. I applaud initiatives his department has implemented in recent years, and I acknowledge the benefits derived by many Victorians who suffer serious mental health illness. However, I consider it imperative:

- that clinical staff in acute psychiatric settings have the ability to transfer a patient, in appropriate circumstances, to a recovery/step down unit, where treatment of their illness can be undertaken to facilitate their safe return to the community; and.
- that consultants are able to access forensic psychiatrists at Forensicare to receive appropopriate and timely expert assistance when required as deemed appropriate.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death, directed at the Department of Health and Human Services:

Recommendation 1

> Without undermining the important role of PARC, CRU and SECU, I recommend consideration be given to adapting acute mental health units to incorporate a step down or recovery unit, within the acute setting which offers a therapeutic environment which enables clinicians to treat the underlying serious mental illness, before safe discharge into the community.

Recommendation 2

> Without undermining the important role of Forensic Nursing clinicians, I recommend consideration be given to creating a forensic psychiatric specialist service along the lines of the former Forensicare Community Integration Program.

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

The family of **Male D**;

The Investigating Member; and

Interested Parties.

Signature:

JOHN OLLE
CORONER
Date: **9 July 2015**

Coroners Court of Victoria