IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 1217 of 2008

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the ***Coroners Act 2008***

Amended pursuant to s.76 of the ***Coroners Act 2008*** *on 15 July 2014*[1]

Inquest into the Death of: Mark Bethell

Delivered On:	24 April 2014
Delivered At:	Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	21-24 May and 8 June 2008
Findings of:	Peter White, Coroner
Representation:	Mr J Snowden appeared on behalf of Southern Health Mr R McCloskey appeared on behalf of North Western Mental Health Ms C Smith –Stevens appeared on behalf of the family of Mark Bethell
Police Coronial Support Unit	Sergeant D Dimsey

I, PETER WHITE, Coroner having investigated the death of MARK BETHELL

AND having held an inquest in relation to this death from 21-24 May and on 8 June 2012
at Coroners Court Melbourne
find that the identity of the deceased was MARK BETHELL
born on 25 November 1975

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[1] The amendment was a result of a spelling error.

and the death occurred on 22 March 2008

at Oznam House, Flemington Road, North Melbourne[1]

from:

1 (a) Valproic Acid Overdose

in the following circumstances:

Background

1. Mark Bethell (Mark) was a 32-year-old male, born on the 25 November 1975.
2. In the year 2000 Mark's father, with whom he had been particularly close, passed away. Mark attempted to overdose on two separate occasions following this event.
3. In 2004, Mark attempted to take his own life, by medication overdose. At the time, he was living in a half way house run by the Salvation Army and doing volunteer work in Fyshwick, Canberra.
4. In 2006, Mark suffered a fall at home and hit his head. He was admitted to Hospital. His sister considered that this fall might have caused some long-term damage, as she thought his comprehension was affected and that his speech had slowed from that time.
5. In December 2007, Mark discovered that a former partner had lost a baby which was his. His family also believed that this event contributed to further bouts of depressive illness.
6. During this time, a Dr Hechtman of 56 Church Street, Hawthorn, prescribed Mark with Seroquel, Valproate, Extrosig and Asmol. These medications were prescribed to treat Anxiety, Post Traumatic Distress Disorder and Bipolar Affective Disorder.

Admission to the John Cade Acute Inpatient Unit

7. On 3 March, 2008 Mark was accepted for admission and from March 6 2008, he commenced to reside at Oznam House in Flemington Road, North Melbourne[2].
8. Oznam House is a short-term crisis accommodation for homeless men, situated in North Melbourne. It is run by the St Vincent de Paul Society. It is relevant that prior to this time he had resided in Wollongong NSW, where he was having difficulties with his former girlfriend, and had been evicted from his flat.

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[1] Oznam House is a crisis accommodation shelter run by the St Vincent de Paul Society.

[2] See Oznam House client case notes at exhibit 14(a).

9. I also note that while in Wollongong, over the previous two-year period, Mark had regularly seen a psychiatrist, Dr Almond, and had been diagnosed as suffering from Bipolar Affective Disorder, and Borderline Personality Disorder.

10. On 13 March 2008, at approximately 12.45am, Mark reported to reception at Oznam House that he had taken 50 tablets of Rivotril[3]. An ambulance was called and he was taken to Royal Melbourne Hospital, (RMH) and transferred to the John Cade Unit, the hospital's Acute Psychiatric Inpatient Unit, where he was admitted to the open section of the unit as a voluntary patient[4].

11. On 14 March 2008, Mark attempted to abscond from the unit. He later absconded on 16 March and was seen at Dandenong Hospital the following day. He was escorted to Oznam house by ambulance late in the evening on 17 March 2008.

Dr Mario Carangan

12. Dr Carangan was a Registrar in the Emergency Department at RMH, who examined Mark on 13 March 2008. He reported taking 50 tablets of Rivotril and an unknown quantity of alcohol,

> *'...and highly smelt of alcohol... He was admitted to John Cade centre under the care of the psychiatry team, after he was medically cleared.'*[5]

Dr Veronique Browne[6]

13. Dr Browne saw Mark in the John Cade Unit on 14 March 2008. She had access to his medical history via his hospital file, which included faxes from other units that had managed him in the past.

> *'It was documented in notes provided to us that he had a diagnosis of Bipolar Affective Disorder and Borderline Personality Disorder. (He) was admitted to our inpatient unit as a voluntary patient to the low dependency part of the ward following an assessment in*

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[3] Rivotril (Clonazepam) is a benzodiazepine, which is commonly used as a tranquilizer, or to aid sleep.

[4] The admission of Mark to the John Cade Unit on 13 March 2008, as a voluntary patient rather than as an involuntary patient, was seen as appropriate by Consultant Psychiatrist Dr Veronique Browne (footnote 6), although she appears to have contemplated the possibility that his status might change if he attempted to abscond again. See further discussion concerning the events of 13 March below.

[5] See exhibit 1at page 2. See also the statement of ECATT RPN 4, Frank Harvey, which states that Mark Bethell was transferred to the John Cade Psychiatric Unit shortly after 2 pm on 13 March.

[6] Dr Browne was a consultant psychiatrist employed at the John Cade centre.

She saw Mark in the unit, on March 14, in accord with ward policy, that all new patients are reviewed within 24 hours of admission.

our Emergency Department by ECATT, due to concerns regarding his ongoing risk following an overdose of Clonazepam' [7].

14. Dr Browne further noted that Mark had informed that the overdose had been taken the day before following a relationship break up and that in so acting he had intended to end his own life.
15. He spoke of moving to Melbourne to get his life back together, and that he had become non compliant with his prescribed medication from the start of a new relationship some three months earlier, but wanted to recommence,

    'because he recognised that, they kept him well'.
16. Mark further reported that he attempted to take his own life because he was stressing about job opportunities and accommodation issues, and that the overdose was an impulsive act and denied further suicidal thoughts.
17. Information made available from Wollongong authorities confirmed the above diagnosis and,

    'a history of numerous overdoses'.
18. Mark further described feeling overwhelmed and that he was stressing prior to taking the overdose the day before,

    'but, he did not describe any clear depressive features'.
19. He appeared to have a poor coping style at times of stress.
20. On mental state examination, he displayed reasonable insight into his problems and the need to address them in order to reduce stress.

    'He was agreeable to a psychiatric admission to recommence his medication and to assist him with linking into support services in Melbourne'[8].
21. Dr Browne's management plan was to release Mark over the following week, after she could ensure that he was introduced to psychiatric outpatient and other services, and went back on to appropriate medication. He was placed on hourly observation and was accepting

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[7] See Dr Browne statement at exhibit 3 page 1.

[8] Ibid page 1-2. Dr Browne's review was undertaken with the assistance of an emergency registrar, Dr Dutch who was tasked to follow up with a (further) gathering of collateral history over Friday for the ward round on Monday. See also Dr Browne's evidence at transcript page 28, where she refers to some of the protective features of his presentation, when seen on 14 March. His prior condition of Hypothyroidism, not managed at this time, which can contribute to mental instability, was also taken into account. Dr Dutch was later involved in preparing and signing a discharge note in respect of Mark, this on March 18 following his second abscondence from John Cade Unit, on the afternoon of 16 March.

of her plan, which included review by the Consulting Psychiatrist of his treating team, on the following Monday, and no leave[9].

22. Given his insight and stated willingness to stay on the ward she considered he should be maintained in the unit as a voluntary patient,

> *'but asked that he be reviewed by the On-call Registrar if he was wanting to leave over the weekend, so that his mental state and risk analysis could be reviewed'...*
>
> *'All patients are assessed as to whether they can be managed in the least restrictive environment of the unlocked/open ward area, in keeping with the requirement to manage patients in the least restrictive environment possible to comply with the Mental Health Act. There was no indication at the time of my review for Mr Bethell (for him) to be made an involuntary patient or to be placed in our locked ward , and I was not approached over Friday 14 March, following my review to formulate an interim management plan'*[10].

23. It is also relevant that at the time Dr Browne reviewed Mark, she was aware that he had already attempted to leave the low dependency unit, without permission. This (unsuccessful) attempt had taken place at 6 am on 14 March 2008 when Mark injured his left ankle while trying to jump over a fence[11].

24. In an additional statement, Dr Browne added that it was felt that further information was required from Dr Moore, his general practitioner in Melbourne, and Dr Almond, his NSW based psychiatrist. Dr Browne planned that Mark should recommence his usual medication regime once Dr Dutch was able to confirm that history with his earlier carers via Dr Almond and Dr Moore[12]. I note that this did not occur prior to Mark's abscondence from the unit during the afternoon of 16 March 2008[13].

25. In response to a question from the Court as to why, in the face of his known history and attempt to leave the unit without permission he hadn't been made an involuntary patient

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[9] I note that Dr Browne later changed the no leave direction, to one of no leave without registrar review and approval.

[10] See exhibit 3(a) at page 2-3, where further advice concerning the inquiry undertaken by Dr Dutch, with details of the materials so received, is also set out. See also Dr Dutch statement at exhibit 18 page 6(d).

[11] See transcript page 36, and exhibit 18, page 6(d), the statement of Dr Dutch who also treated Mark's injured ankle. The low dependency section was the open part of the unit.

[12] Dr Almond (with whom contact could not be made over the weekend), was a Consultant Psychiatrist who had seen Mark in NSW. His GP in North Melbourne, Dr Moore, had seen Mark on one occasion only, and did not assist.

[13] See transcript page 36-37 and the statement of Peter Kelly at exhibit 5, paragraph 5.

over the weekend, Dr Browne stated that this would be a question for the Registrar if Mark had sought to leave the open part of the unit again[14].

Peter Kelly-a summary of clinical notes[15]

26. On 15 March 2008, Mark requested leave, which was granted after review by Psychiatric Registrar Dr Nilumi Ziffer.
27. He returned to the unit two hours after the agreed leave time and admitted to staff that he was intoxicated, having consumed a bottle of wine and an overdose of prescribed medication. On later review, again by Dr Ziffer, he denied suicidal ideation[16].

    'Nursing staff were informed that Mr Bethell was not to have further unaccompanied leave from the ward and that if he attempted to leave he may need to be placed under the Mental Health Act'[17].
28. He was again medically reviewed the next day with no further orders made.
29. As above, on 16 March 2008 at 2.45pm, Mark was noted to be missing from the low dependency unit. The unit and surrounds were searched without success. Oznam House was notified and their staff reported that he had been sighted there at 1pm.
30. The on-call Psychiatrist Dr Anasson and on-call Acute Services Manager were also notified and the former requested an urgent CATT review at Oznam House.
31. Oznam House staff were informed of this plan and informed that Mark had left; he was believed to have gone to Frankston.
32. The Frankston CATT service was therefore also alerted.
33. At 3.15am on 17 March 2008, the Dandenong Hospital Emergency Department contacted the John Cade Unit and advised that Mark had been found semi-conscious following an overdose of prescription medication and alcohol.
34. The John Cade Unit clinical notes record that a Dandenong Hospital Psychiatric Registrar would contact the unit in the morning to discuss,

    'possible transfer... to the John Cade Inpatient unit'.

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[14] See transcript page 38-39.

[15] Peter Kelly is the Director of Operations at North Western Mental Health. He prepared a summation of events based upon his review of relevant clinical notes. His notes should be read in conjunction with my findings at page 12 below

[16] Mark told Dr Ziffer that he had consumed 25 tablets of Zanax, together with the bottle of wine. See discussion at transcript page 60.

[17] See statement of Dr Ziffer at exhibit 18, page 7. Reference by Dr Ziffer to informing nursing staff about placement under the Mental Health Act, is a reference to the placement of Mark in the closed section of the Acute Assessment unit, as an involuntary patient.

35. A further entry states that Mark was to be discharged from Dandenong Hospital back to Oznam House. This entry was made at 9.40pm and refers to,

'review in the morning re possible discharge'

36. The next entry refers to Mark being discharged from the John Cade Unit at 11.30am 18 March 2008[18]. This entry, according to Mr Kelly, may have reflected that a clinical judgement had been made at Dandenong that Mark was fit for discharge from their Emergency Department.

37. I note here that the evidence of the Dandenong Senior Psychiatric Medical Officer, Dr Eric Thomas, does not support this interpretation of the discharge from Dandenong Hospital[19]. During the morning shift on 17 March 2008, Mark was seen by ECATT RPN Wright at the Dandenong Hospital Emergency Department, but could not be interviewed as he was regarded as,

'medically unfit for interview.'[20]

38. This was apparently the result of his intake of medication and alcohol, following his abscondence from the John Cade Unit[21]. According to Dr Eric Thomas, he saw then Mark on the afternoon of 17 March 2008 and found that his Bipolar Affective Disorder condition was in remission but his Borderline Personality Disorder was complex and that,

'the patients highest chance of avoiding eventual suicide is to encourage at every opportunity, to be responsible for their own safety.'

39. According to Dr Thomas a plan was in place, to which Mark agreed, that he go back to Oznam House,

'a highly supportive environment,... and then to the RMH Blueler ward. (I believe this is a reference to the Low Dependency ward within the John Cade Unit*), which plan was communicated to staff at the RMH'* [22]

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[18] On the morning of 18 March 2008, Mark was discharged from the John Cade Unit in his absence. He did not receive discharge medication. It is also the case that this discharge was signed off, without a risk analysis or the use of a risk assessment tool. See the contra requirements of exhibit 3(e) the Continuum of Care protocol, and the concession by Counsel for NW Mental Health Service, at transcript page 230-31, where he informed that a risk assessment was not undertaken at this time.

[19] Dr Thomas was the reviewing Senior Psychiatric Medical Officer at the Dandenong Hospital.

[20] See exhibit 7.

[21] See statement of DCATT RN Sab, at exhibit 8.

[22] See exhibit 6 page 3. See also the Oznam House Client notes at exhibit 14(a) which again reflects that Dandenong Hospital, Oznam House staff and ECATT staff at the John Cade Unit, were understood to be accepting of this arrangement.

40. Dandenong Hospital Emergency Department CATT faxed a copy of their assessment documents to RMH. The fax number was 93424023, which is Blueler Ward at RMH, John Cade Unit and the same number John Cade Unit staff had faxed information to Dandenong Emergency Department at 3.02pm on 16 March 2008. This further supports the conclusion that the John Cade Unit staff were aware of Mark's discharge from Dandenong Hospital and the plan that he return to Oznam House overnight, and the plan for his reappearance to the RMH John Cade Unit the following morning.
41. An after hours triage contact was made by Oznam staff on the afternoon of 18 March 2008, stating that Mark had been transported back to Oznam House and wanted medication and wanted to come to the RMH Emergency Department.
42. According to Mr Kelly the ECATT triage nurse checked his *discharge medication* and advised Mark that he would not be prescribed benzodiazepines but was welcome to come to the Emergency Department[23].
43. Again, according to Mr Kelly, Mark later attended the RMH Emergency Department at 9pm on March 20. No medications were prescribed and he was described as,

    'not currently at risk'.
44. His principal diagnosis on discharge was described as, *'anxiety'.*
45. He left the Emergency Department at 10pm and was believed to have returned to Oznam House[24].

Psychiatric Caseworker Fiona Alexander[25]

46. Between 4 March 2008, i.e. prior to his taking up residence, and 13 March 2008, Ms Alexander had several meetings with Mark. These focused initially on Mark's medication needs and then on his mental health, substance and alcohol abuse, and accommodation and employment possibilities. On March 6 2008, Mark secured a place at Oznam House. Her overall impression at this time was that Mark was well presented, alert and rational.
47. On 13 March 2008 at 12.45am, Mark informed Oznam House staff that he had taken an overdose of Clonazepam and alcohol. He was taken by ambulance to RMH Emergency

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[23] On the morning of 18 March, Mark was discharged from the John Cade Unit, in his absence. He did not receive discharge medication. See further discussion at footnote 18.

[24] See exhibit 13(a) at folio 1.

[25] Fiona Alexander was a Psychiatric Disability Worker employed by Oznam House, with a history that included 4 years employment in that position. She was the case worker for Mark following his arrival at the accommodation, on March 6 2008. Oznam house is an alcohol and illicit drug free environment.

Ms Alexander is now employed at another facility within the St Vincent de Paul Society.

Department where he was seen by Dr Carangan. At around 12.00 pm he missed an appointment at Oznam House and as a result, Ms Alexander discovered that he had been taken to RMH[26].

48. Ms Alexander phoned the Hospital and spoke with Mark, who stated that he hoped the medication would kill him and that he was feeling poorly, and depressed and hopeless. He also informed her that he had taken a further 15 tablets while waiting for transfer to the John Cade Unit.
49. On 14 March 2008 she rang again and was told that he had been placed at the John Cade Unit within the hospital. She was also informed that he had tried to abscond and didn't succeed, and had then been given leave and had not returned.
50. Late on 17 March 2008, Mark was escorted back to Oznam House from Dandenong Hospital by ambulance[27]. Ms Alexander contacted the CATT team triage unit because she considered that Mark was at imminent risk of self-harm. Mark had told her that he was becoming unwell and was pushing the limit with his medication, and wishing to push the boundaries and overdose.
51. At this time Ms Alexander spoke with IWCATT Clinical Psychologist Monica Lizarazo and reported that Mark was dishevelled and sweaty, with slurred speech and was substance affected. She further reported her knowledge of his history and of his wish to access more prescription medication.
52. Ms Alexander was told that because Mark was a voluntary patient he was not regarded as being an imminent risk and they will note the phone call but were not likely to respond. Monica agreed MB sounds like he needs to be assessed, but he had left the John Cade Unit and thus his behaviour might not be psychiatrically driven.
53. This conversation took place at approximately 3.13pm. Monica Lizarazo was the intake rostered clinician at RMH Inner West Area Mental Health Service, and as I understood the evidence, was located in Moonee Ponds at the time.
54. Ms Alexander further stated that she felt,

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[26] See admission notes of Dr Kathryn Loon at exhibit 18 page 100, and her note at page 101 that he should be admitted to John Cade LDU as a voluntary patient, but be, '*recommended if he tries to leave*'.

[27] See transcript page 103.

MB is at risk of another overdose, when he collect meds from facility ... care to ensure he is taking prescribed amount should be maintained.'[28]

IWCATT Intake Clinician Monica Lizarazo[29]

55. According to Ms Lizarazo, at the time of this conversation there was no information on file or hard drive about Mark, apart from a record that on 16 March he had left against medical advice from John Cade. I note here that her later evidence (transcript page 220) was that she could ascertain that he had been having contact with CATT since 2001 and that he had attracted a diagnosis of bipolar effective disorder, borderline personality disorder and benzodiazepine and alcohol dependence, and that he had a history of self harm.
56. I further note that the use of the description 'left against medical advice' was misleading as Mark did not seek advice or converse with either a Dr or RPN, before either of his unauthorised departures on 14 and 16 March 2008. The underlining is mine.
57. It is relevant that the Continuum of Care Protocol Ex 3(e), then applicable, (evidence of Dr Browne) refers to absence without leave concerning *'In Patient Units'*, which I accept is a reference to both the Low Dependency and High Dependency sections of the John Cade Unit.
58. Ms Lizarazo further agreed that this was a significant issue because if it had been recorded that he had *'absconded'*, there would have been the need for an urgent risk assessment under this protocol when, or soon after, that abscondence was determined.
59. We know from other evidence that this did not occur.
60. I note however that it is also the case that in her writing up of the contact with Ms Alexander in the Computer screen dumps, that Mr Lizarazo herself referred to Marks *'abscondence'* [30].

19-22 March 2008

61. On the following day 19 March 2008, Ms Alexander cautioned staff about Mark's, *current state.*

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[28] Statement of Fiona Alexander at exhibit 14 page 4 and exhibit 14(a) her client notes at page 3 of 9, and discussion of this matter in her evidence from transcript page 247.

[29] See statement of Monica Lizarazo, at exhibit 10.

[30] See exhibit 10(b).

Emergency Department physician Dr Fiona Nicholson[31]

62. On 20 March 2008 at 9.05 pm, Mark presented at the RMH Emergency Department, where he was seen by triage nurse Douglass who notified ECATT to come and conduct a review, otherwise known as, *'ECATT fast track'*[32]. Later according to the *'Treating Doctor'*, Dr Nicholson, Mark left the Emergency Department before that review could occur.
63. According to hearsay information then obtained by Dr Nicholson from an unnamed ECATT staffer, Mark had earlier rung ECATT and been informed by the officer that they would review him if he presented but that he would not be provided with medication.
64. (Despite her record indicating that she had actually reviewed Mark), I accept her evidence that she did not in fact see him. I also accept that the same ECATT officer informed her that Mark had come to and then left the Emergency Department before the ECATT staffer had time to review him[33].
65. In these circumstances, as I understand her evidence, Dr Nicholson used information supplied by the ECATT staffer, which included Marks telephone presentation to form the basis for her recorded notes that includes the opinion that he was suffering from *'anxiety'* and was *'not currently at risk'*[34].
66. I also note that her further evidence was that she did not review Mark's medication for his Bipolar Affective Disorder or his Borderline Personality Disorder, or obtain advice as to whether he had received such medication since his arrival in Melbourne[35].

The Oznam House Client record-further excerpts

67. On 21 March 2008, Mark advised Oznam House staff that he needed prescription medication and needed to see a GP at a medical centre immediately and that if he did not get his medication he would start fitting.
68. Staff advised him to go to the Emergency Department at RMH.

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[31] See her statement at exhibit 13 and the documentation somewhat misleadingly suggesting her review of Mark at exhibit 13(a).

[32] See transcript page 224.

[33] This occurred at approximately 9.52 pm when Dr Nicholson recorded that she saw Mark

[34] I note however the possibly conflicting evidence, found in the Oznam House client notes suggests, in fact that the call to the ECATT staffer referred to only as *'Jim'*, was made at 6.30 pm by Oznam House staff rather than by Mark.

'At 6.30 pm MB came to reception and requested advice as to how to get a prescription for Clonazepam, as he had run out. (The) writer rang ECATT at RMH and spoke to Jim who suggested that MB present at ED'.

See RMH triage record at exhibit 13(a).

[35] Dr Browne had earlier stated that getting him back onto an appropriate medication regime was part of her management plan, when she saw him on his arrival at the John Cade Unit.

69. Mark began to argue and was advised that staff could not assist him further[36].

70. At approximately 11am on Sunday 22 March 2008, a staff member at Oznam House checked on Mark and found him in his room. At approximately 4.40pm another worker, Michael Callaghan, received a call from Mark. Shortly thereafter, Mr Callaghan went to Mark's room and found him lying on his bed in an unconscious state. Ambulance officers attended and found that Mark had died. Empty packets of prescription medications were found nearby.

71. A subsequent autopsy established that Mark had died of Valproic Acid Overdose[37].

Findings

1. Based on his extensive history of self harm and suicidal ideation, the evidence of his caseworker Fiona Alexander, as well as the clinical notes referred to by Mr Kelly concerning Mark's immediate past history as further explained by Dr Thomas, I am satisfied that on 18 March 2008, Mark was in a poor state and was at imminent risk of self-harm.

2. It is relevant to this consideration that against a background of his earlier diagnosed mental illness, Mark had displayed little ability to cope with difficulty and a tendency to act impulsively and self harm in stress related situations[38].

3. It is also relevant that on the occasion of both of his earlier disappearances, on 14 March 2008 and 16 March 2008, that the Continuum of Care Protocol was not complied with[39].

4. I also find that on 18 March 2008, when Oznam House caseworker Fiona Alexander sought assistance from the John Cade Unit through a triage telephone service provided by IWCATT, she was informed that as Mark had absconded,

> *'his behaviour might not be psychiatrically driven. She was also advised that he was a voluntary patient and not considered to be an imminent risk. She was further informed that the call would be noted, but they were unlikely to further respond'*[40].

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[36] Exhibit 14(a) ibid. I am satisfied that his response to this advice almost certainly had to do with his view that he would not be supplied with prescription medication if he returned to RMH.

[37] Valproic acid is indicated in the treatment of epilepsy mania and as a preventative agent in Bipolar Affective Disorder.

[38] See discussion of impulsiveness issue by Dr Ziffer, at transcript page 57 and 66. See also Mark's claim to Ms Alexander about wanting to push the boundaries and overdose, in the Oznam House client notes, exhibit 14(a) page 3 of 9.

[39] See exhibit 3(e) and footnote 42 below.

[40] See exhibit 14(a) the Oznam House client notes at page 3 and the evidence of Fiona Alexander at transcript page 242-43, which I note was not put into dispute.

5. Moving to 20 March 2008, I find that on that evening Mark attended in the RMH Emergency Department of his own volition and was briefly seen by an Emergency Department staffer who triaged him fast track, to be seen by ECATT[41]. Later Mark appears to have left the Emergency Department before that review took place.

6. We also know that subsequent to that event an ECATT staffer provided Dr Nicholson with advice, which Dr Nicholson used as the basis for her later record as to his presentation at that time.

7. I find that the appraisal so provided by the ECATT staffer, which led to the preparation of documentation, suggesting that Mark was suffering from,

   'anxiety' and ' was not currently at risk' [42],

   was both superficial and dismissive, and was fundamentally inconsistent with what was known about him at that time.

   I further find that in the circumstances in which she found herself, Dr Nicholson should only have recorded that Mark had left the Emergency Department before she could review him.

8. I also find that such an appraisal was unsatisfactory because it did not include a reasonable risk analysis concerning Mark's present potential to self-harm particularly as it related to self-administration of medication and alcohol, and that this was required given his earlier history of (symptomatic) impulsive behaviour and abscondence.

9. In these circumstances, I consider that clinical advice provided by Dr Anasson earlier on 16 March 2008 (on the occasion of an earlier disappearance), to the effect that ECATT staff should go to Oznam House to review Mark, was particularly pertinent. In my view this suggestion should have been followed by ECATT (on 20 March 2008), i.e. before contrary advice was given to Dr Nicholson[43].

It is also relevant that on 15 March, Mark had tried to abscond and injured himself in the process, and had later that day then left the Unit with permission, but did not return at the time and in the condition promised. Thereafter, on the afternoon of March 16, and despite further warning by Dr Ziffer, Mark absconded for a second time.

I also note that Marks earlier diagnosis of Borderline Personality Disorder, often carries with it a high risk of suicidal behaviour and persistent impulsive behaviour.

[41] See the evidence of Dr Nicholson, referred to above.

[42] See exhibit 13(a).

[43] See footnote 44.

10. Further, the comments made at that time by various senior clinicians (including Dr Anasson) and the need to provide Mark with a review to establish a medication plan appropriate to his needs should also have led to a more thorough examination of his condition[44].

11. I also further find that his past and recent history, coupled with his earlier self-harm and ideation, combined to establish by the evening of 20 March 2008, a strong case that he was at imminent risk, which called for his admission as an involuntary patient to the John Cade Unit [45].

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[44] See statement from Dr George Anasson, the on-call Consultant Psychiatrist at RMH, on 16 March 2008, who was consulted over the phone about Marks disappearance and directed ECATT to go to Oznam House to see and review Mark, which advice was recorded presumably by an ECATT staffer. (Exhibit 20 page 1).

It is also relevant that at this time (i.e. on the occasion of his re-appearance at the RMH on March 20 2008, and also earlier on March 17 when John Cade Unit staff were informed of the plan by Dandenong Hospital to return him to Oznam overnight, and for Mark to attend at the John Cade Unit on 18 March), that Mark had not been seen in accord with Dr Browne's earlier management plan. This plan had reasonably been to seek to re-establish appropriate medication and assist him with linkage to organisations, which might help him with accommodation and employment, the primary cause of his earlier stress and suicidal ideation.

While this could not occur because of Marks self imposed absence from the John Cade Unit, it remained an unresolved and significant issue, which was a dynamic risk that was always likely to re-emerge as a significant stressor.

I further find that the earlier direction of Psychiatric Registrar Dr Ziffer, to ECATT staff at the John Cade Unit, on March 15 concerning the possibility of placement under the Act, (see f/n 17 above and exhibit 18 page 7), and Dr Kathryn Loon's similar comments on March 13, (see f/n 26 above and exhibit 18, page 101), were also relevant.

I find then that all of these contacts with senior clinicians and the arising clinical notes referred to, should have prompted the responsible ECATT staff to initiate a discussion with a Consultant Psychiatrist on the occasion of Marks re-appearance in the Emergency Department, on March 20 2008, (if not before).

A full risk analysis and RPN review either at the Emergency Department or at Oznam House, should have preceded any such discussion with the Consultant, and that discussion concerning Marks presentation, his clinical history, Dr Browne's treatment plan to have him reviewed directly by a Consultant Psychiatrist, and the possible application of Section 8 of the Act, should then have occurred.

[45] Section 8 of the Mental Health Act stipulates that a patient should be admitted as an involuntary patient only if,

a) the person appears to be mentally ill, and

b) the persons mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order, and

c) because of mental illness, involuntary treatment of the person is necessary for his or her health or safety(whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public, and

d) the person has refused or is unable to consent to the necessary treatment for the mental illness, and

e) the person cannot receive adequate treatment for mental illness in a manner less restrictive of his or her freedom or action.....

I am satisfied that by 18 March 2008 and thereafter, there was a prima facie case that all requirements for 'sectioning' were satisfied, in that an implied condition of accepting treatment, is the requirement that he take medication in the manner prescribed, which in this instance included the requirement that he take medication under supervision (while remaining in the John Cade Unit), a condition that Mark had shown himself to be either unwilling, or unable to comply with.

12. I further find that given the circumstances of his intervening history, the decision to effectively disregard Dr Browne's plan without her knowledge was sub optimal. As above, I also consider that this conduct may have breached the Mental Health Act (1985) and was not in the public interest.

13. I find that following Mark's return to Oznam House on the evening of 20 March 2008, he continued to use Valproic Acid and other such medication as he had access to in a reckless way, as he continued *'to push the boundaries and overdose'* in the manner he had described to Ms Alexander[46]. I am also satisfied that he followed this course either intending to take his own life or while being reckless to that possibility. In conclusion, I find that the approach to decision making by ICATT staff who advised Dr Nicholls on 20 March 2008 at RMH, and earlier the IWCATT triage officer who spoke with Fiona Alexander on 18 March 2008, were both inappropriately superficial and dismissive of Mark's condition. As such, these omissions effectively took away important opportunities to protect Mark from self harm and in this way contributed to his death.

Recommendations

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

The evidence establishes that there was a plan put in place by Dandenong Hospital Emergency Department CATT on the advice of Dr Eric Thomas, to transfer Mark to Oznam House on the

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It was also relevant that his self-harming and impulsive (and abusive) use of prescription medication sometimes in combination with alcohol, were themselves symptoms of his mental illness. His need for care, pending planned Consultant review (see evidence of Dr Browne), necessitated that he remain in a safe and stable environment, where his oral intake could be monitored.

The evidence that both Dr Loon and Dr Ziffer separately contemplated this possibility in the circumstances of future abscondence is referred to at footnotes 26 and 17 above.

More specifically applying Section 8(1), the requirements of each part were arguably satisfied by,

(a) Marks known history and symptomatic conduct;

(b) that Mark required both a psychiatric illness and medication review to ensure on going support for a complex mental illness previously identified and treated in Wollongong NSW;

(c) his preservation of health and safety necessitated that Mark be kept away from opportunities to engage in what were his consistently impulsive behaviour(s), causing harm. [See also Sections 8(2)(k) and 8(3)];

(d) informed consent to 'necessary treatment' required a commitment to the exclusion of his own (unauthorised) oral intake of levels of medication and alcohol, which were threatening to his well being. Marks earlier diagnosis and conduct to that time reflected that his behaviour was symptomatic of his previously diagnosed mental illness and that he was not capable of giving any meaningful consent to an (unsupervised) medication intake, which excluded harmful consequence; and e) see c) above:

[46] See exhibit 14(a) page 3 of 9.

evening of 17 March 2008, this to allow for his re-appearance at RMH the following morning. The evidence establishes to my satisfaction that the plan was communicated to the John Cade Unit, but significantly does not establish how this matter was viewed by ECATT staff at RMH.

It also does not establish how it was intended that ECATT should implement this plan in respect of Mark, who remained a recently discharged voluntary patient. (I have found that the mode of discharge, was inappropriate in this instance).

1. I recommend that the Department of Health investigates how best to facilitate arrangements for inter hospital transfer of voluntary (and involuntary) patients. This, in my view, might reasonably involve discussion between such units at Consultant level.

...

Mark had access to medications earlier prescribed by his GP.

There was no documented risk history by either the John Cade Unit staff or Dandenong Hospital Emergency Department CATT as to Mark's ongoing access to medication in light of the knowledge that he was at risk of impulsive overdose. There is no indication that either CATT team obtained relevant information from his GP concerning this matter.

The history of recent serious overdose and Marks' conversations with his OZNAM House caseworker referred to above establishes to my satisfaction that he was not capable of making safe judgement calls concerning medication intake.

2. I recommend that the ongoing training of CATT clinicians generally should further emphasize the need for risk assessments undertaken in respect of suspected Borderline Personality Disorder diagnosed patients, to particularly address safety around the patient's potential for the (ongoing) self-administration of prescribed medication[47].

3. I recommend that where it is known by CATT clinicians that such patients are returning to community facilities (like Oznam House), that relevant information and advice determined as a result of compliance with Recommendation 2 above, is passed on to the manager of such a facility. This may allow facility staffers to collect medication supplies in appropriate cases and hold them centrally. It will also permit the further delivery of that medication in a

[47] I acknowledge that management of this issue is an extremely challenging task. Training which highlights the difficulty and brings focus to appropriate strategies for addressing the problems involved, can only lead to improvement in clinical management in this area.

diagnosed patients, having particular regard to the issue of prescription medication management[48].

3. I recommend that Oznam House introduces a prescription medication management programme in respect of resident clients, where admission or subsequent risk analysis establishes an occupational health and safety need to do so.

...

I direct that this finding be distributed to the following interested parties:

The family of Mark Bethell
The Secretary of the Department of Health in the State of Victoria
The CEO Royal Melbourne Hospital
The CEO Acute Inpatient Unit John Cade Building
The CEO Dandenong Hospital
The CEO ECATT
The CEO DCATT
The CEO IWCATT
The CEO Oznam House
Dr E Thomas
Dr V Browne
Dr F Nicholson
Ms M Lizarazo
Peter Francis Kelly
Fiona Alexander, St Vincent de Paul Society

Signature:

PETER WHITE
CORONER
Date: 24 April 2014.

Coroners Court of Victoria

[48] I acknowledge that management of this issue is an extremely challenging task. Training which highlights the difficulty and brings focus to appropriate strategies for addressing the problems involved, can only lead to improvement in clinical management in any particular case.