IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 004772

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

Inquest into the Death of: Melissa Jane THORN

Delivered On:	19 December 2014
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	26, 27, 28, 29 and 30 March, 2 April and 26 July 2012
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr D. WALLIS of Counsel, instructed by Mr Sam Pearce from Maurice Blackburn, appeared on behalf of Mr Matthew THORN, the deceased's husband.
	Mr N. MURDOCH of Counsel, instructed by Ms Kate Birrell from Minter Ellison, appeared on behalf of Austin Health.
	Mr C. WINNEKE of Counsel, instructed by Ms Clare Cheeswright from DLA Piper, appeared on behalf of Healthscope (Northpark Private Hospital and its staff).
	Mr S. CASH of Counsel, instructed by Ms Kim Bowers from Avant Law, appeared on behalf of Dr Simon CROKE.
Police Coronial Support Unit	Sergeant Tracey WEIR, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of MELISSA JANE THORN

and having held an inquest in relation to this death at Melbourne

on 26, 27, 28, 29 and 30 March, 2 April and 26 July 2012:

find that the identity of the deceased was MELISSA JANE THORN

born on 27 October 1975, aged 33

and that the death occurred on 6 October 2009

at or near the Normanby Avenue pedestrian crossing over the Epping Railway line in Thornbury, Victoria 3071

from:

1 (a) MULTIPLE INJURIES IN A TRAIN INCIDENT

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES[1]

1. Melissa Jane Thorn was a 33 year old married woman who resided with her husband Matthew Thorn in Greensborough. Apart from her husband, Ms Thorn is also survived by loving and supportive parents, Ms Cheri Bruhn and Mr John Bruhn, and her siblings.

2. Ms Thorn had a long history of psychiatric illness commencing in about 1997 when she was in her early twenties. According to family reports, Ms Thorn's mental illness commenced after a relationship breakdown, followed by a sexual assault while she was interstate. In the years immediately preceding her death, when she was well, Ms Thorn functioned normally and held a part-time position in the Victorian public service. She was an intelligent and articulate woman with insight into her illness.

3. Ms Thorn's illness was mostly characterised by fluctuating mood with depression, anxiety and occasional periods of elation, by an inability to manage the emotional difficulty of life events and relationship breakdowns, and by psychotic features such as auditory hallucinations and persecutory delusions. Recurrent episodes of deliberate self-harm, suicidal thoughts and attempted suicide were significant features of her illness. According to her family, Ms Thorn

[1] This is a summary of uncontentious matters that give context to Ms Thorn's last admission and matters more proximate to her death.

had made about ten suicide attempts using a variety of means including overdosing on her prescription medication, inhaling motor vehicle exhaust fumes, on one occasion being found at the top of the Westgate Bridge intending to jump, and on another indicating that she would step in front of a train.

4. Ms Thorn's psychiatric illness had attracted various diagnoses over the years. An early diagnosis was Borderline Personality Disorder with multiple self-harms and family relationship conflicts. More recently, with a change of psychiatrist and clinical review during her last admission to the psychiatric unit at the Austin Hospital, her diagnosis was changed to Schizoaffective Disorder[2] with discrete illness episodes. Irrespective of the diagnosis, there is little doubt about the intensity and seriousness of the suicidal ideation and intent that Ms Thorn experienced, and reacted to from time to time.

5. Ms Thorn had more than 20 admissions to psychiatric hospitals in Victoria and interstate. These admissions were generally in the context of depressed mood, deliberate self-harm, suicidal thoughts plans or attempts. Treatment with Electroconvulsive Therapy (ECT),[3] and combination antipsychotics, including clozapine[4] and quetiapine,[5] mood stabilisers such as lamotrigine,[6] and lithium carbonate,[7] achieved periodic control of Ms Thorn's mental illness.

6. Between about 2006 and 2008, Mr Thorn had enjoyed relatively stable mental health when she was working, married and living in a supportive relationship with her husband. However, during 2008 and 2009, Ms Thorn's mental health became less stable, and she had several involuntary admissions to the psychiatric unit at the Austin Hospital where she had received ECT as part of her treatment regime. While clinicians felt she had a good response to this treatment modality, Ms Thorn did not like the confusion she experienced as a side-effect.

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[2] Schizoaffective disorder is a combination of two mental illnesses – schizophrenia and a mood disorder. The main types of associated mood disorder include bipolar (characterised by manic episodes or an alternation of manic and depressive episodes) and unipolar (characterised by depressive episodes). Diagnosis can be difficult because the symptoms of schizoaffective disorder are so similar to those of schizophrenia and bipolar disorder. A diagnosis of schizoaffective disorder is made by reference to the diagnostic criteria from the International Classification of Disease diagnostic codes - schizophrenia (ICD F20.0-20.3) and mood (affective) disorder codes (F30, F31 & FXX).

[3] Under general and steady, a carefully controlled electrical current is passed through the brain, affecting the brains the activity and producing an improvement in depressive and psychotic symptoms.

[4] A second generation antipsychotic generally used in treatment-resistant schizophrenia and monitored through the Highly Specialised Drug Program due to its potentially severe and life-threatening side effects.

[5] A second generation antipsychotic.

[6] An anticonvulsant and mood stabilizer.

[7] A chemical compound used to treat mood disorders.

FINAL PSYCHIATRIC ADMISSION FROM 27 SEPTEMBER 2009

7. In September 2009, Ms Thorn's mental health deteriorated once again. Over a two-week period culminating in her final admission to Northpark Private Hospital (Northpark) on 27 September 2009, she had developed lowered mood and motivation, as well as intermittent alcohol abuse and a worsening of long-standing derogatory auditory hallucinations. As with previous relapses, there was no obvious trigger for this deterioration. Ms Thorn sought admission, and arrangements were made for her to be admitted to Northpark on a voluntary basis.[8]

8. Ms Thorn was admitted on the evening of 27 September 2009, and was first reviewed by her treating psychiatrist Dr Simon Croke the following morning. Her treatment during this admission involved antidepressant and antipsychotic medication, counselling and observation. Despite compliance with her medication regime and with ward routines, Ms Thorn was generally difficult to engage and tended to isolate herself within the ward. Over the course of the admission, and despite medication, regular review by Dr Croke and attempts by nursing staff to engage her, Ms Thorn's mental state deteriorated.

9. The adequacy of the clinical management and care provided to Ms Thorn during this, her final admission to Northpark was the primary focus of the coronial investigation of her death and is examined in some detail below. Suffice to say, for present purposes, that having refused to take her medication on the evening of 5 October 2009 for the first time during this admission, and having indicated an intention to remain awake overnight, and doing so, Ms Thorn left from Northpark at about 7.30am on 6 October 2009.

10. Staff did not observe Ms Thorn actually leaving the ward. One of the night shift nurses was in the car park at the end of her shift, when she saw Ms Thorn leaving the hospital and raised the alarm.[9] Two other staff members followed Ms Thorn along Plenty Road towards the Bundoora shopping complex, got within about ten metres of her, but withdrew for fear that in running away from them, Ms Thorn might run into busy morning traffic.[10]

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[8] Exhibit U, statement of Dr Simon Croke, treating consultant psychiatrist, dated 10 August 2010.

[9] Exhibit Q, statement of Ms Anna Colosimo, Division 2 Nurse, dated 3 August 2010, transcript p369 & following.

[10] Exhibit S, statement of Mr Geoff Lont, Associate Nurse Unit Manager, dated 4 February 2010, transcript p389 & following.

11. Police were notified and arrived at Northpark shortly after 8.00am. They obtained information about Ms Thorn from Northpark staff, including brief details of her psychiatric history and a description, and commenced enquiries to locate Ms Thorn.

12. Later that morning, at about 10.54am, some nine kilometres from Northpark, Ms Thorn was on the Normanby Avenue pedestrian crossing over the Epping railway line, between Thornbury and Croxton stations, when she stepped into the path of an approaching southbound train. The train driver applied the emergency brakes but was unable to stop the train in time to avoid impact.[11] Ms Thorn sustained fatal injuries and died at the scene.

13. Ms Thorn's actions were witnessed by the train driver and other eyewitnesses, one of whom identified a handbag found nearby as belonging to hers. In the handbag were items of personal property including documentation identifying Ms Thorn, and a handwritten note indicating an intention to take her own life.[12] In the meantime, another longer suicide note addressed to her husband and family, had been found by nursing staff in her room at Northpark, together with her mobile phone.[13]

INVESTIGATION – SOURCES OF EVIDENCE

14. This finding is based on the totality of the material the product of the coronial investigation of Ms Thorn's death. That is the brief of evidence compiled by Leading Senior Constable David Breer from the Epping Traffic Management Unit (TMU) of Victoria Police, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[14] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

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[11] Statement of Paul Downes, Senior Investigator, Connex Trains, dated 4 November 2009 at page 71 of the inquest brief and Connex report being Appendix 1 to the inquest brief.

[12] The note was found by Nurse Kashaeva (Exhibit G) and is an exhibit to the inquest brief, Exhibit HH. It is addressed to Ms Thorn's husband and family.

[13] The handbag was identified by a witness at the scene as belonging to Ms Thorn, it was taken into the possession of the police and its contents photographed, including the second shorter handwritten note. See pages 66 and following of the inquest brief, Exhibit HH.

[14] From the commencement of the *Coroners Act 2008* (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

PURPOSE OF A CORONIAL INVESTIGATION

15. The purpose of a coronial investigation of a *reportable death*[15] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[16] The *cause* of death refers to the *medical* cause of death, incorporating where possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[17]

16. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[18] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[19] These are effectively the vehicles by which the prevention role may be advanced.[20]

17. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited from including in a finding or comment any statement that a person is, or maybe, guilty of an

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[15] The *Coroners Act 2008,* like its predecessor the *Coroners Act 1985*, 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 in section 4 includes deaths that appear *to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury* and the *death of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986".*

[16] Section 67(1) of the *Coroners Act 2008.* All references which follow are to the provisions of this Act, unless otherwise stipulated.

[17] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[18] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[19] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[20] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

offence.[21] However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions *if the coroner believes an indictable offence may have been committed in connection with the death.*[22]

FINDINGS AS TO UNCONTENTIOUS MATTERS

18. In relation to Ms Thorn's death, many of the matters I am required to ascertain, if possible, were uncontentious from the outset. Her identity and the date and place of death were not at issue. I find, as a matter of formality, that Melissa Jane Thorn born on 27 October 1975, aged 33, late of Greensborough, Victoria 3088, died on 6 October 2009 on railway tracks forming part of the Epping line, at or near its intersection with Normanby Avenue, Thornbury, Victoria 3071.

THE MEDICAL CAUSE OF DEATH

19. Nor was the medical cause of death contentious. On 8 October 2009, Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (VIFM) performed an external examination of Ms Thorn's body in the mortuary, reviewed the circumstances of her death as reported by the police to the coroner and post-mortem CT scanning of the whole body (PMCT) undertaken at VIFM, and advised that it would be reasonable to attribute death to *multiple injuries sustained in a train incident,* without the need for a full post-mortem examination or autopsy.

20. In his written report, Dr Burke advised that external examination and PMCT showed severe injuries including a fractured skull and air embolism within the heart,[23] injuries almost certainly indicative of an instantaneous death.

21. Routine post-mortem toxicological analysis revealed ethanol/alcohol in blood at a concentration of ~0.03g/100mL and clozapine at a concentration of ~0.3mg/L, but no other commonly encountered drugs or poisons. Clozapine is an atypical antipsychotic primarily used in the treatment of schizophrenia, but also used in the treatment of other mental illness.

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[21] Section 69(1).

[22] Sections 69 (2) and 49(1).

[23] Dr Burke provided a five page report, that was available to the parties but not included in the inquest brief as no issues were taken with the cause of death. Attached to his report, was the toxicologist's report, also available to the parties.

Clozapine was one of Ms Thorn's regular medications during her admission to Northpark, and one of three regular medications she refused to take on the evening of 5 October 2009, the others being Lamotrigine and Lithium Carbonate.[24]

22. Based on the advice of Dr Burke, I find that the cause of Ms Thorn's death is *multiple injuries sustained in a train incident.*

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

23. In common with many other coronial investigations, the primary focus of the investigation and inquest into Ms Thorn's death was on the circumstances in which she died. Specifically, the adequacy of the clinical management and care provided to Ms Thorn during her last admission to Northpark, under the care of her treating psychiatrist Dr Simon Croke. Encompassed within this the broader issue are considerations of the physical environment and Ms Thorn's ability to leave an otherwise "secure" mental health unit, and her status in relation to the ***Mental Health Act 1986***. A subsidiary issue was the adequacy of the search effort made, first by Northpark staff, and then by Victoria Police.

24. Although addressed in detail in the inquest brief, there was no suggestion from any party that any deficiencies of railway infrastructure caused or contributed to Ms Thorn's death.[25] For many years now in Melbourne, the metropolitan rail network is organised in such a way that railway tracks are generally unfenced and easily accessible. Consequently, it is a given in this jurisdiction, that people intent on taking their own lives, can and do have access to railway tracks as a means of high lethality.[26] This is not an edifying state of affairs, but one I do not propose to re-visit in the course of this investigation.

ENTRY AND EXIT FROM NORTHPARK PSYCHIATRIC UNIT

25. Northpark is a 112-bed private hospital in Bundoora, serving Melbourne's northern suburbs, providing facilities for general surgery and a range of specialist surgical procedures, general

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[24] Lamotrigine is an anti-convulsant (prevents seizures) and a mood stabilizer. Lithium carbonate is a chemical compoud used to treat mood disorders.

[25] Transcript of Directions Hearing, 5 September 2011, at pages 1-2.

[26] Statistics provided by the Coroners Prevention Unit indicate that of 99 "potential" train suicides between 2009 and 2011 inclusive, four deaths were determined not be suicides and the intent of 11 was unable to be determined. The remaining 84 were determined to be suicides – and in terms of frequency, of these there were 24 in 2009 (including Ms Thorn), 28 in 2010 and 32 in 2011.

medical care, maternity and paediatrics, specialised mother and baby unit and psychiatric care.[27] For the purposes of the inquest, and as at September-October 2009, there were four wards or units, a maternity ward, a mother and baby unit, a surgical and medical ward and East Ward a 33-bed inpatient psychiatric ward, actually in the south-east corner of the hospital building.[28]

26. Northpark is not gazetted for the purposes of the ***Mental Health Act 1986,*** and thus can only admit psychiatric patients on a voluntary basis. While patients cannot be detained against their will at Northpark, unless the provisions pertaining to involuntary treatment under the MHA are invoked, East Ward was a secure or locked psychiatric ward at the relevant time.[29]

27. The rationale for this advanced on behalf of Healthscope/Northpark was that it was desirable for staff to have some control over patients and visitors and knowledge of the whereabouts of patients in particular, falling short of detention against their will.[30] Neither of the consultant psychiatrists who testified as experts at the inquest took issue with this state of affairs. Indeed they sanctioned the practice of "locked wards" in the setting of a private psychiatric facility.[31]

28. That said, precisely how "secure" a ward it was, was the subject of extensive evidence at the inquest. In reviewing the inquest transcript, I was struck again by how much time was spent in seeking to establish that which should have been obvious, or readily ascertainable.[32]

29. I do not propose to summarise the evidence of all those witnesses who gave evidence about the points of ingress and egress to East Ward, and how access was controlled at the material

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[27] According to Northpark's website at http://www.healthscopehospitals.com.au/infor/general/Hospital/get/1562/itemId/

[28] As at the date of the inquest, Ms Gaylyn Cairns, General Manager of Northpark, gave evidence that *"The hospital has undergone a redevelopment over the past eighteen months. The mental health unit has had additional beds built and the unit now has 44 beds and has been split into two wards. All fittings and fixtures are detention style to minimise hanging points."* Exhibit D was her statement dated 25 January 2012.

[29] However, this was a relatively recent change and there was some confusion even among staff as to how access was controlled. See paragraphs XX below.

[30] As its General Manger as at the date of the inquest, Ms Gaylyn Cairns put this position on behalf of Healthscope/Northpark. Exhibit D and transcript p

[31] See paragraphs 70 and following below. Transcript p 593-594 for Assoc Prof Damodaran's views and transcript p 683-684 for Dr Read's views..

[32] The apparent ease with which Ms Thorn was able to leave East Ward was identified as an issue, early in the investigation and certainly highlighted at the Directions Hearing on 5 September 2011 – see transcript pages 12-17. Unfortunately, having asked Healthscope for a witness who is able to speak to this issue, they proffered Ms Gaylyn Cairns who was General Manager at Northpark from March 2011 and therefore not well placed to speak first hand about security arrangements as at 6 October 2009, discussions with the linen delivery service and the nature of any remedial "education" offered to delivery drivers/sub-contractors.

time. I accept that each witness was doing their best to recollect the situation, as it pertained to Ms Thorn's admission, in circumstances where they believed the ward was locked or secured, where this was a relatively recent change from the open ward it had been, and where Ms Thorn's admission (and flight) was not necessarily a point of reference for them in relation to this issue.

30. For inquest purposes, Healthscope provided a coloured diagram of Northpark as it was configured in 2009.[33] Apart from Exit 3 which was an internal door leading from East Ward into the Radiology/Pathology unit controlled by a key pad and security code, the evidence supports a finding that there were three exit doors leading either directly outside from East Ward, or outside from East Ward through other parts of the hospital.

31. Exit 1 as designated on the diagram, was the main entry into East Ward from the main hospital entry on the east side of the hospital. It was the door adjacent to rooms 38 and 39, room 39 being the room occupied by Ms Thorn during the later part of her admission, including overnight on 5-6 October 2009. The door was controlled by a buzzer and CCTV camera that displayed in the main East Ward nurses' station. Patients or visitors seeking to enter or to leave, would need to press the buzzer and be identified by someone in the nurses' station who could then release the locking mechanism remotely and open the door.[34] Staff had swipe card access.

32. Exit 2 as designated on the diagram, allowed exit via the medical and surgical ward to the west. There were two sets of doors at this approximate location, one outside room 20 and the other outside room 24, the functionality of the doors changing according to whether rooms 20-24 were occupied by psychiatric or medical/surgical patients. The evidence supports a finding that, at the material time, the set of doors nearest room 24 was serving as Exit 2 and required swipe card access.[35]

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[33] Clean copies of this diagram were marked by a number of witnesses and tendered – Exhibit E/Ms Gaylyn Cairns, Exhibit H/Ms Elena Kashaeva, Exhibit J/Mr Robert Dudley, Exhibit N/Ms Wilma Lanyon, Exhibit FF/Mr Amir Asif.

[34] Exhibit D and transcript p71, 184, 397.

[35] Transcript p68-70, 377-378.

33. Exit 4 as designated on the diagram, also referred to as the ambulance entrance during the inquest, was on the eastern side of the building, nearest Greenhills Road.[36] Anyone seeking entry through this door, which was a glass exterior door, would press a buzzer to alert the nurses's station situated a short distance down the corridor to the west. Nursing staff had the option of either looking to see who it was and/or unlocking the door remotely. The evidence supports a finding that this door was generally locked. Staff had swipe card access.[37]

34. At the material time, linen for the whole of Northpark, was delivered through Exit 4 each weekday morning between about 6.00am and 7.30am. According to Mr Dudley, a principal of Dudley Tranpsort Pty Ltd, sub-contractor to Ensign, depending on the requirements on the particular day, the delivery comprised between eight and 12 trolley loads.[38] The delivery driver would bring all trolleys in to the corridor immediately inside Exit 4. He would then take designated trolleys to each part of the hospital, unload the fresh linen and remove the empty trolleys, again through Exit 4.[39]

35. As a result of this process, all the hospital's linen passed through East Ward whereas only one trolley load of linen was required in East Ward each day, compared with the substantially greater linen requirements of the medical/surgical ward and the maternity ward, for instance.[40] Mr Dudley's evidence was that he appreciated the need to close doors as quickly as possible once through them, and was conscious of the nature of East Ward and the need to exercise care. Not only did he understand that he had no power to prevent anyone else going through a door, as a courtesy, he would give priority to nursing staff and patients as they moved about

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[36] Ms Gaylyn Cairns, General Manager of Northpark Private Hospital, as at the date of inquest, testified that among changes made at Northpark since Ms Thorn's death (though not necessarily arising from her death) Exit 4 no longer leads to the car park but to an enclosed courtyard. The exit from the courtyard is connected to the fire panel and only opens when the fire alarm is activated. Exhibit D and transcript p62-64.

[37] Mr Dudley testified that there was once occasion when he found Exit 4 unlocked (Exhibit I, transcript p) and Ms Bruhn testified that she had once entered through Exit 4 when she found it unlocked and (Exhibit , transcript p).

[38] There was a slight discrepancy in Mr Dudley's evidence about the number of trolleys. According to his statement it was between nine and 12 (Exhibit I) whereas in evidence he said between eight and 12 (transcript p193).

[39] At the material time, Ensign linen services held the contract to supply linen to Northpark. See his statement dated 23 February 2012, Exhibit I and transcript p191 and following. Soiled linen was collected separately. As at the date of the inquest, the contract to provide linen to Northpark had been assigned to another supplier.

[40] Current practice is that linen for Northpark as a whole is delivered to another part of the hospital and only the linen required by East Ward is delivered to East Ward. See evidence of Mr Dudley transcript p196-197 and Ms Cairns transcript p72 and following.

the hospital. He could not always distinguish psychiatric patients from other people who might be in East Ward.[41]

36. Nurse Kashaeva testified that Northpark staff had made a few requests to the delivery people about not "jacking" the door open, and on one occasion shortly before 6 October 2009, that she personally had remonstrated with the delivery person about jacking the door nearest Ms Thorn's room open, as it was meant to be locked.[42]

37. The regular delivery driver at the time of Ms Thorn's final admission to Northpark was Mr Imran Asif, who had taken over from Mr Dudley and testified that he was shown how to make the deliveries at Northpark, by either Mr Dudley or his son. It is possible however, that he did not actually make the delivery on the morning of 6 October 2009.[43] Mr Asif's statement and evidence at inquest were broadly consistent with Mr Dudley's evidence about how deliveries were made.[44] He could not recall actually doing the delivery to Northpark on 6 October 2009, and strenuously denied that he ever left any door open or ever propped any door open to facilitate his comings and goings.[45]

MS THORN LEAVES NORTHPARK

38. Nurse Anna Colosimo worked in East Ward overnight on 5-6 October 2009. She was familiar with Ms Thorn from previous admissions, and made numerous observations of her during her shift pursuant to nurse-initiated plan to place Ms Thorn on 15-minutely observations overnight.[46] At the end of her shift at about 7.30am, Nurse Colosimo was in the car park,

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[41] Transcript p211.

[42] Transcript p144-145.

[43] Mr Dudley testified that he could not locate Dudley Transport Pty Ltd records to verify who actually made the deliver on 6 October 2009. Nurse Kashaeva testified that it was not the same delivery person each day and there were a few faces that were familiar but she couldn't say how often they rotated – transcript page 155.

[44] Mr Asif's statement dated 12 March 2012 was Exhibit EE and his evidence transcript p710 and following.

[45] Except as to whether or not they required a key (Mr Dudley) or a swipe card (Mr Asif) to gain access to the rest of Northpark from East Ward. It was conceded by Mr Wallis on behalf of the family that the doors were controlled by swipe card access at the material time. Transcript page 215.

[46] Nurse Colosimo's last documented observation is at 7.00am ("Watching TV"), while the last observation overall was documented by Nurse Kashaeva at 7.15am ("awake, watching TV").But see transcript p368-9 and p

sitting in her car, waiting for it to warm up, when she saw Ms Thorn walking away from the hospital through the car park.[47]

39. Although she did not actually see which exit Ms Thorn used, Nurse Colosimo assumed that she had left through the Main Hospital Entrance on the east side of the building - accessible most directly from East Ward via Exit 1 – and nearest Ms Thorn's room.[48] Nurse Colosimo immediately ran back to East Ward, entering through Exit 4. She went to the second nurses' station, the one nearest room 39 occupied by Ms Thorn and alerted staff, including Nurse Elena Kashaeva, Acting Assistant Nurse Unit Manager, and Nurse Geoff Lont, Intake Coordinator.

SEARCH BY NORTHPARK STAFF

40. In response to this information from Nurse Colosimo, Nurse Kashaeva immediately ran to the front door of East Ward/Exit 1 and noticed that it had been propped open with a delivery crate, with the delivery person nowhere to be seen. She ran through the car park to the Shell petrol station nearby and saw Nurse Geoff Lont and Nurse Michael Kanniah in pursuit of Ms Thorn. Nurse Kashaeva returned to East Ward and notified the Duty Co-ordinator before calling 000 and reporting the matter to police.[49]

41. At inquest, Nurse Kashaeva explained that she assumed that Ms Thorn had left through Exit 1, in part because she found the door propped open so soon after the alarm was raised, and in part because she expected that Ms Thorn would have been seen going past the second nurses' station if she had used either of the other exits from East Ward, that is Exits 2 and 4. There was no challenge to this aspect of her evidence.

42. Nurse Geoff Lont left immediately via Exit 4, before Ms Colosimo had even finished speaking.[50] As he understood it, Ms Thorn was heading south along Plenty Road and he headed in the same direction, running through the Shell service station. By the time Ms Thorn

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[47] Exhibit Q, Nurse Colosimo's statement dated 4 August 2010.

[48] Transcript p380-382.

[49] Statement of Nurse Elena Olegovna Kashaeva dated 22 October 2010, Exhibit G and transcript p129-130. Nurse Kashaeva identified the nurse accompanying Nurse Lont as "Michael". It is apparent from other evidence that she was referring to Michael Kanniah, an agency nurse. See Nurse Lont's statement dated 4 February 2010, Exhibit S and transcript p379, 392.

[50] Thus he could neither contradict nor confirm that the door to Exit 1 was propped open, as described by Nurse Kashaeva. Transcript p389.

was near the intersection of Plenty Road and Mc Lean's Road, he had gained ground on her. He called her name and she looked around at him, before taking off and running through the intersection.[51] Nurse Lont stopped at this point, some metres short of McLean's Road.

43. Nurse Lont testified that he was unaware that Nurse Kanniah was also in pursuit until he stopped. They briefly discussed whether they should continue following Ms Thorn, but decided against it out of concern for her safety.[52] Nurse Lont understood that Ms Thorn was a voluntary patient and he had no power to detain her, but he felt he had some rapport with her and thought he might be able to persuade her to return to East Ward, as he had done once before.[53]

44. Nurse Lont returned to East Ward. After a discussion with Nurse Kashaeva, he and Nurse Diana Stevens set off in his vehicle to continue searching for Ms Thorn. They searched around the Bundoora shopping complex, including the pub and bottle shop, the tram stops along Plenty Road for about one kilometre beyond the Bundoora shopping complex and around another shopping strip at the intersection of Plenty Road and Grimshaw Street further south.[54] They made no further sightings of Ms Thorn.

SEARCH BY VICTORIA POLICE

45. Senior Constables Daniel Basile and Alison Bardsley were working divisional van duties in the Epping area on 6 October 2009 when, at about 7.50am, they were dispatched to Northpark in relation to a missing person report. They arrived at Northpark at about 8.07am and spoke first to Nurse Kashaeva alone and later in the presence of Dr Croke.

46. It appears from the statement of S/C Basile,[55] the relevant daybook entries,[56] and his evidence at inquest, that the source of most of the information obtained by the police was Nurse

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[51] Transcript p392 *"Was there any consideration given to someone maybe passively following Melissa and one person returning to the hospital? - - - So we did, but we were concerned that if we persisted – we discussed it briefly and I said to Michael, "Even if we follow, there's a risk that if" - you know, "if we persist that she's going to do something impulsively".*

[52] Transcript p391-392, 398.

[53] Transcript p390, 398.

[54] Exhibit S and transcript p392-393.

[55] Exhibit X.

[56] Exhibit Z.

Kashaeva.[57] There is one curious inconsistency however between the information S/C Basile said he was given and Nurse Kashaeva's evidence. That is, his reference to information he received to the effect that Ms Thorn had said the day before that she "wanted to get hit by a bus", as opposed to a train, which was Nurse Kashaeva's evidence. Short of miscommunication or mistaken recall, their evidence on this point is irreconcilable.[58]

47. While there was no criticism made by the family or any other party of the search efforts made by the police, it is appropriate to provide some detail in this finding for completeness. After speaking to Nurse Kashaeva and Dr Croke, S/C Basile and S/C Bardsley obtained a detailed description of Ms Thorn and the clothing she was wearing and left Northpark at about 8.45am to conduct a thorough patrol of the Bundoora shopping complex.

48. At 9.16am they received information via police communications that a woman had jumped from an overpass onto the Hume Highway, Wollert, and drove to that scene arriving at 9.24am. After ascertaining that the woman was not Ms Thorn, they left Wollert returning to Epping Police Station at 9.50am. There they continued to conduct enquiries and received information from Mr Thorn that his wife had withdrawn $90 from an ATM in Bundoora. S/C Basile contacted police communications and requested that a "Keep a Look Out For" alert be broadcast in relation to Ms Thorn. He also contacted the District Patrol Sergeant and informed him/her of Ms Thorn's disappearance.[59]

49. At 11.00am S/C Basile received information via police communications that a female had committed suicide at a train station in Northcote, and at 11.15am he was further informed that the deceased female had been identified by police as Ms Thorn.[60]

ADEQUACY OF CLINICAL MANAGEMENT AND CARE

50. There was confusion from the outset about Ms Thorn's legal status in the last 24 hours or so of her admission to Northpark. Whether she was a voluntary psychiatric patient, or an involuntary psychiatric patient, pursuant to sections 8 and following of the ***Mental Health ct 1986.***

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[57] Such as information that Ms Thorn had been made an involuntary patient on 5 October 2009, that the door was unlocked because the laundry was getting done, that staff members gave chase heading south down Plenty Road

[58] Exhibits G, X and transcript p156, 519-520

[59] Exhibit X, statement of Senior Constable Daniel Basile dated 8 February 2010.

[60] Exhibit X and transcript

51. That confusion was evident from the statements of several of the Northpark nursing staff and Dr Croke, and was compounded by the apparent alteration of the date on the actual Recommendation document itself.[61] However, irrespective of what may have gone before, it is clear that shortly after Ms Thorn fled Northpark, the process for recommendation for involuntary treatment was initiated, by Dr Croke completing the relevant documentation and Nurse Kashaeva signing the necessary request. On its face, the document cites Ms Thorn's refusal of medication on 5 October 2009 and "absconding from the ward" on 6 October 2009, as facts communicated to Dr Croke by another person in support of the recommendation.

52. The family's criticisms of the clinical management and care provided to Ms Thorn pertain to the period between her discussion with Nurse Elzbieta Hodgins on the afternoon of 4 October 2009, and her flight from Northpark at about 7.30am on 6 October 2009.

53. Poor documentation and communication of clinical relevant information aside, the family's criticisms are, in essence, that Dr Croke should have recommended Ms Thorn for involuntary treatment earlier, some time on the afternoon/evening of 5 October 2009, and should have had her transferred to the Austin Hospital or any other Emergency Department, where she would have been safer. Alternatively, the family submit that Ms Thorn's clinical state and evident risk was such that she should have been provided with one on one supervision or "specialling" overnight on 5-6 October 2009, to ensure her safety.[62]

54. In the private hospital setting, the medical practitioner is responsible for the clinical management of the patient and the nursing staff provided the day to day care. In terms of Ms Thorn, apart from when Dr Croke was at Northpark reviewing her in person, he relied on nursing staff, not only as his eyes and ears, but also for their professional assessment of her clinical presentation. Good communication, between Dr Croke and the nursing staff was imperative, whether it was verbal communication, or documented in the medical record.

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[61] The full title of the document that appears in Ms Thorn's medical records at Northpark is "Recommendation for Person to Receive Involuntary Treatment from an Approved Mental Health Service" and it was completed by Dr Croke as a registered medical practitioner and dated 5/6 October 2009, and accompanied by a "Request for Person to Receive Involuntary Treatment from an Approved Mental Health Service" completed by Nurse Kashaeva on 6 October 2009.

[62]

THE EVIDENCE OF NURSE ELZBIETA HODGINS

55. Nurse Hodgins had a significant conversation with Ms Thorn on 4 October 2009. In her entry in the progress notes made towards the end of her afternoon shift, Ms Hodgins summarised Ms Thorn's presentation in the following terms – "*Melissa visited by husband this evening. Still preoccupied with voices and thoughts of self-harm. Encouraged to stay in L/R [lounge room] for her safety and thoughts distraction. Frighten [sic] about going to public hospital. States that does not want engage with nurses as she does not want to be moved out of here. Hot meal in her room. Doing very hard.*"

56. At inquest, Nurse Hodgins expanded on this conversation, saying that she knew that Ms Thorn had not been engaging with staff when she went to her room and more or less persevered until she would speak to her. During the conversation that lasted about 45 minutes, Ms Thorn opened up, saying that she had had enough, that she was ruining the lives of everybody and felt like cutting her throat with a knife or just throwing herself under a train. There were lighter moments during which they spoke about Nurse Hodgins' dogs and Ms Thorn laughed appropriately.[63]

57. Overall, while she felt that Ms Thorn was "doing it hard", Nurse Hodgins was reassured that this had been a good therapeutic exchange. She was also reassured later when, as he was leaving, Mr Thorn thanked her for talking to his wife, saying that she felt very much at ease and that he appreciated it. Nurse Hodgins testified that she was further reassured the following day, 5 October 2009, when she saw Ms Thorn laughing during a visit from her mother.[64]

58. According to Nurse Hodgin's evidence, she attempted to call Dr Croke to let him know about this conversation, understanding that he would want to know about any fluctuations of mood, but she was unable to contact him.[65] Following a discussion with Nurse Kashaeva on 5 October 2009, in the course of handover, and pursuant to her direction, Nurse Hodgins called

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[63] Transcript p 232-233, 247-252.

[64] Ibid.

[65] Transcript p233, 240-241. This is likely to refer to Dr Croke's entry in the progress note dated 2 October 2009 to the effect that *any escalation of behaviour, expressed intent, inability to ensure safety – certify and transfer to Austin.* See transcript p495.

Dr Croke some time between 2.00pm and 3.00pm advised him about her interaction with Ms Thorn the previous day.[66]

59. Nurse Hodgins' entry made in the progress notes at the conclusion of her shift and dated 5 October 2009, is in the following terms – *"Melissa kept low profile this evening, not engaging, decline 1:1, Dr Croke was notified about her suicidal thoughts and plan as per last 1:1 with staff (04.10.09). She appears anxious, low. Was observed to distract herself with iPod. Was encouraged to be with other co-clients in L/room. Had dinner in her room and want it [sic] to be left alone."*

60. Although Nurse Hodgins was cross-examined at some length about this entry, in particular, her use of the word "plan",[67] she maintained that she did not interpret what Ms Thorn had told her as a suicidal plan with intent, but rather as a manifestation of her suicidal thought or ideations, consistent with her clinical presentation throughout her current admission. Furthermore, in communicating with Dr Croke about her one on one conversation with Ms Thorn the previous day, she would not only have conveyed what was said, but how it was said, that is her overall clinical impression of the interaction.[68]

THE EVIDENCE OF DR CROKE

61. While at inquest Dr Croke could not recall a conversation with Nurse Hodgins on 5 October 2009, about Ms Thorn's disclosures on 4 October 2009, he did not deny that it took place. He explained that he would not necessarily recall such a conversation as he was constantly communicating with nursing staff about patients. He would however expect to remember a conversation of clinical significance, such as a conversation that would lead him to change his clinical management or plan for a patient.[69]

62. In any event, Dr Croke had reviewed Ms Thorn himself at about 10.45am on 5 October 2009, to some extent superseding Nurse Hodgins' clinical impression from the day before. Dr Croke failed to make an entry in the progress about this review, and testified that this was an

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[66] Transcript p241-242.

[67] I note that Nurse Kashaeva likely encouraged Nurse Hodgins to advise Dr Croke about this conversation as she understood it to be a "plan" and therefore potentially an escalation or clinical deterioration that Dr Croke may have found useful in relation to recommendingMs Thorn.

[68] Transcript p248 and following, p268.

[69] Transcript p490-495.

oversight and not in accordance with his usual practice. In his statement, Dr Croke described Ms Thorn at this review as – *"more depressed in mood and admitting to suicidal ideation but not describing any specific plans or intention to carry out self harm although being vague and reluctant to elaborate. She was continuing to accept medication and cooperate with staff and ward routines without any dangerous or inappropriate behaviour. Of concern was that she declined adamantly to consider electroconvulsive therapy which had previously been beneficial when she was in a similarly worsened state."*[70]

63. Dr Croke's précis of this review as documented on the Recommendation was consistent with but not in identical terms with his statement – *"Currently admitted to private hospital psychiatric ward. Subdued, withdrawn behaviour. Very limited eye contact. Admits to suicidal ideation declines to elaborate" "You'll think worse of me." Refusing ECT despite previous response. Past history of significant self harm."*[71] Significantly, Dr Croke "case" for recommendation was being put on the basis of general deterioration and suicidal ideation, as opposed to a suicide plan or plan with intent, and on the desirability of ECT as a treatment modality for Ms Thorn given her past response.

64. According to his statement, Dr Croke initiated contact with North East Triage/Austin Health, shortly after 3.00pm on 5 October 2009.[72] In so doing, he was anticipating that if Ms Thorn continued to deteriorate and to refuse ECT, she would likely require involuntary hospitalisation and treatment, as had occurred in the past.

65. At inquest, he was cross-examined about the reference in the Austin Health "Screening Register" to Ms Thorn being withdrawn, with suicidal ideation and speaking of death as a realistic option. He noted that these were not his words but those of the writer and, in any event, maintained that he did not believe that Ms Thorn had a specific suicidal plan with intent, and would have clearly articulated this if he did. He also maintained that, at that time, of his contact with North East Triage/Austin Health, he had insufficient evidence to satisfy the criteria for involuntary treatment set out in section 8 of the ***Mental Health Act 1986***.[73]

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[70] Dr Croke's statement dated 10 August 2010 is Exhibit U.

[71] Part of the medical records.

[72] Transcript p411, 439. It appears this contact was with clinician Nick Cleave who passed a message on to the Triage Nurse David Henry.

[73] Transcript p759-760 and following.

66. At 3.30pm, Mr David Henry, North East Triage Nurse, Austin Health responded to Dr Croke's call. In his statement and at inquest, he gave an account that was consistent with Dr Croke's in terms of what he was told about Ms Thorn's presentation, her likely need to be treated involuntarily in the near future and the absence of any indication of a suicide plan with intent or imminent risk.[74]

67. Mr Henry testified that if Ms Thorn had expressed a specific plan to suicide in front of a train, he would have wanted to know. He had no memory of being told anything along those lines, and if he had, was sure that he would have documented it.[75] While he did not agree that he would have "requested" that Ms Thorn remain at Northpark pending a bed becoming available at the Austin, he agreed that the option of her remaining there would have been discussed with Dr Croke.[76]

68. Following the discussion between Dr Croke and Mr Henry, effectively treated as a "referral", Mr Henry consulted Dr Lanny Boschler, Consultant Psychiatrist for the North East Crisis Assessment Treatment Service (NECATS). Dr Boschler provided a statement and testified at inquest.[77] While he was not involved in any discussion about Ms Thorn being made an involuntary patient, Dr Boschler confirmed that Ms Thorn was accepted for treatment and placed on the waiting list for a bed in the Acute Psychiatry Unit at the Austin, with a view to transferring her on 6 October 2009.

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[74] He documented the presenting problem as follows on the relevant Screening Register, Exhibit W – *"Melissa is a well known client to NE CATT, having spent a 3 month admission to APU (Adult Psychiatric Unit) commencing late last year after her suicidal thoughts and depressed mood were no longer manageable by NorthPark Private. She was treated with 2 courses of ECT with good mood lifting effect. She currently sees PP (Private Psychiatrist) Dr Simon Croke, who has admitted her to North Park for the last week with the intention to commence ECT. However she is deteriorating and is refusing ECT. She has low engagement with staff, poor eye contact, socially withdrawn, getting worse over the weekend. Dr Croke feels she requires ECT and as she won't consent he doubts North Park's ability to adequately treat her. PHx (past history) of serious suicidal and self harm action. Is currently on Clozapine."*

[75] Transcript p450-451.

[76] Transcript p452-455. Of note, he testified that *"...the normal scenario for a person ending up in the emergency department is that they're not in a hospital somewhere else being cared for. That they're – they're at home, they're on the streets, they're unwell. And it's for that they come into the emergency department...the alternative...of having her...in a private psychiatric hospital in a...locked ward in her own room, would be a much better scenario..."* and also, in answer to a question from Mr Wallis about whether patients were secure in the emergency department *"...I guess they you would say yes...nothing's a hundred per cent secure by the very nature of – that people can run away, they can overpower other staff; things happen. But generally ah, there would be people ah, appointed to keep a very close eye on a person whos is recommended in the emergency department." at transcript p446-447.*

[77] Exhibit T is Dr Boschler's statement dated 6 September 2010 and his evidence is at transcript p408-429.

THE EVIDENCE OF NURSE JOANNE STAFFORD

69. Much later on 5 October 2009, Dr Croke was appraised of some more information about Ms Thorn's clinical state. Nurse Joanne Stafford was the night shift Associate Nurse Unit Manager. After taking handover from Nurse Hodgins between 9.30pm-10.00pm, she commenced medication rounds. She recalled being told at handover of a possibility that Ms Thorn would be transferred to the Austin, that she had had some suicidal ideation and that Dr Croke could be contacted at any time.[78] When Ms Thorn refused to take her evening medications, at about 11.30pm, Nurse Stafford called Dr Croke to advise him and met with a rather curt response.[79]

70. Nurse Stafford also became aware early in the shift that Ms Thorn intended to stay up all night, as did Nurse Colosimo.[80] When asked early in the shift, Ms Thorn guaranteed her safety, but would not elaborate as to why she intended to stay up all night. After consultation with other nursing staff, it was decided to initiate and maintain 15 minutely observations of Ms Thorn overnight.

71. Dr Croke's evidence at inquest was that he was not notified about this change in Ms Thorn's behaviour during the night shift.[81] Nurse Stafford was unsure about the sequence of events, and conceded that even if she was aware of this development at the time of their phone conversation, she may not have advised Dr Croke.[82] The progress notes and other documentation sit more comfortably with Dr Croke not being advised about this.

EXPERT EVIDENCE

72. Associate Professor Saji Damodaran is a Consultant Psychiatrist with 18 years combined experience in public and private sector psychiatry who was asked to review the clinical management and care provided to Ms Thorn during her last admission to Northpark. He was provided with all relevant material available at the time. And, as is commonly the case,

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[78] Transcript p313-314, 321, 346 .

[79] Transcript p315 – *"What are you telling me for?"*

[80]

[81]

[82] Exhibit O, the progress note entry made by Nurse Stafford, dated/timed at 2310 5/10/09 – *"Melissa refused to take regular medications. Dr Croke informed of same. Nil further instructions."*, followed by Nurse Colosimo's notation 6/10/09 0600 *"Melissa staetd at commencement of shift that she ws going to stay up all night, staff asked why Melissa stated she couldn't say. Staff put her on 15 min obs throughout night. Melissa awake on all rounds..."*

provided his expert assessment without prescience as to the evidence at inquest.[83] Assoc Prof Damodaran's expert opinion was modified somewhat by his evidence at inquest.

73. He maintained that the medical records indicate a lack of clarity about the clinical plan for Ms Thorn on 5 October 2009, and evidenced confusion among nursing staff about her voluntary/involuntary patient status.[84] He expressed the opinion that Dr Croke did not have a sound basis for recommending Ms Thorn for involuntary treatment on the afternoon of 5 October 2009. However, he considered that the clinical picture changed for the worse later that night when she refused her evening medication, indicated an intention to stay up all night, and did so.

74. In his expert report, Assoc Prof Damodaran interpreted the events on 5 October 2009 as an instance where a patient was placed on a waiting list for involuntary treatment, and inappropriately kept at Northpark pending a bed becoming available. He was rightly critical of such a practice.[85]

75. At inquest, he conceded that even late on 5 October 2009, by which I understood him to mean after Nurse Stafford advised Dr Croke about Ms Thorn's refusal of evening medications, she would not have fulfilled the criteria for involuntary treatment. It was only later when she absconded, and thereby indicated a refusal of all treatment, considered in the context of her overall clinical presentation, that Ms Thorn fulfilled the criteria.[86] Moreover, apart from the absence of threshold criteria for recommendation, Assoc Prof Damodaran accepted that Dr Croke's rationale for keeping Ms Thorn at Northpark, in her own room in a locked ward, rather than have her waiting in an public hospital emergency department, was an appropriate patient-focused plan.[87]

76. At a later point, in cross-examination by Mr Cash, Assoc Prof Damodaran expressed matters somewhat differently. His evidence was that Ms Thorn fulfilled the criteria for involuntary treatment when she refused her evening medication at about 11.30pm, that Dr Croke could recommend her at that time and if he had, Ms Thorn would spent the night in the emergency

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[83] Assoc Prof Damodaran's expert report dated 17 November 2011 is Exhibit AA. His evidence is at transcript p

[84] Trancript p555.

[85] Exhibit O page 8.

[86] Transcript p554 and following.

[87]

department pending admission to the Austin the next day. He agreed that this might be deleterious to her and that Dr Croke was entitled not to rush to recommendation but to maintain the status quo until a bed was available, as a better option.[88]

77. Dr Peter Read also had experience in the public and private sector as a Consultant Psychiatrist and provided a medico-legal opinion for Mr Matthew Thorn. In his report, he made a number of criticism of the clinical management and care provided to Ms Thorn during her admission.[89] He was critical of Dr Croke's lack of response to the disclosures made by Ms Thorn to Nurse Hodgins on 4 October 2009 communicated to him on 5 October 2009, on the basis that they amounted to a clear suicide plan

78. Dr Read was also critical of the level of supervision of Ms Thorn overnight on 5-6 October 2009 and expressed the view that "specialling" or constant line of sight supervision was warranted given a combination of factors that were known (or should have been known) at that time – including Ms Thorn's elusive responses to Dr Croke in relation to her suicidal ideation, the impending transfer to the Austin, her refusal of medication[90] and her reported suicidal thinking and expressed plan.[91]

79. At inquest, Dr Read conceded that, absent knowledge of a suicide plan, it was not inappropriate for Dr Croke to wait until 6 October 2009, to recommend Ms Thorn for involuntary treatment, if his decision was that Ms Thorn required ECT treatment for general deterioration in her mental state, consistent with her past longitudinal history, and she continued to be intractable in refusing ECT.[92]

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[88] Transcript p602-606.

[89] Dr Peter Read's expert report dated 27 February 2012 is Exhibit DD. The transcript of his evidence is at p 651-709.

[90] Exhibit DD p12 – *"There are many potential reasons for a patient refusing medication; these might range from side effects to psychotically derived thinking. It seems likely that Melissa did not take her medications so as to be able to stay up all night as she had indicated was her plan. It is possible that she did not wish to be asleep in the morning if it was her plan to leave the ward. However, without the issue being more fully explored, it is difficult to be definitive rather than speculative. That Melissa had communicated a suicide plan to nursing staff, the refusal to take medication was however of increased significance..."*

[91] Exhibit DD

[92] Transcript p698.

CONCLUSIONS

80. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[93] Moreover, the effect of the authorities is that Coroners should not make adverse findings against or comments about individuals or institutions, in their professional capacity, unless the evidence provides a comfortable level of satisfaction that they departed materially from the standards of their respective profession/s and in so doing, caused or contributed to the death.

81. It is axiomatic that the assessment of clinical management and care must be undertaken strictly without the benefit of hindsight. The trajectory of a patient's clinical deterioration may well be obvious after the event. Patterns or causal connections that can be traced from the privileged position of knowing the tragic outcome, may not have been obvious or even appreciable before that outcome. In respect of Ms Thorn, Dr Croke's clinical management, and the nursing care provided by the nursing staff of Northpark, both need to be assessed against what they actually knew, or should reasonably have known about her at the time of her admission, and without the benefit of hindsight.

82. Having applied the applicable standard to the available evidence, I find that –

- Ms Thorn was familiar with East Ward routines, dreaded ECT and anticipated that she may soon be recommended for involuntary treatment, not necessarily because she had been told of or overheard this possibility, but because she had experienced similar outcomes to voluntary admissions in the past, and Dr Croke had already broached the subject of ECT with her during this admission.

- By 7.30am on 6 October 2009, having formed the intent to take her own life, Ms Thorn had written at least one and possibly two of the suicide notes found later, and was looking or waiting for an opportunity to leave.

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[93] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

- At about 7.30am on 6 October 2009, in the course of delivering the linen for the rest of Northpark, the delivery driver who may or may not have been Mr Imran Asif, left or propped the door at Exit 1 open.

- Ms Thorn, did not (need to) assert her right not to be detained against her will, but rather left Northpark opportunistically, via the door at Exit 1 which had been left or propped open.

- In taking the decision to move to a locked or secure psychiatric ward, Northpark Management and/or Healthscope should have identified the risk posed by the linen delivery process as it then was, and should have addressed that risk before Ms Thorn's flight.

- The efforts of Nurse Colosimo who alerted the other nursing staff to Ms Thorn's departure, and Nurses Lont and Kanniah who gave chase, where entirely appropriate and commendable.

- The search efforts of S/C Basile and Bardsley were reasonable and appropriate given the information they elicited from Northpark staff, and the time and resources available to them.

- There was no want of clinical management on the part of Dr Croke that caused or contributed to Ms Thorn's death.

- Specifically, Dr Croke's decision not to recommend Ms Thorn on the afternoon of 5 October 2009, and plan to review her on the morning of 6 October 2009, was a reasonable and appropriate clinical response, even given that Nurse Hodgins had conveyed to him her clinical impression of the disclosures made by Ms Thorn on 4 October 2009.

- Information from Nurse Stafford that Ms Thorn had refused her evening medications on 5 October 2009, was a change that warranted review by Dr Croke, but not necessarily earlier than the following morning, as planned.

- There was nothing untoward about the discussions between Austin Health staff and Dr Croke, about the possibility of admitting Ms Thorn for involuntary treatment, and the lack of an immediately available bed at Austin Health was not causally related to Ms Thorn's death.

- There was no want of clinical care on the part of the nursing staff of Northpark that caused or contributed to Ms Thorn's death.

- Specifically, in the context of her current admission, and given the tenor of the whole conversation between them, Nurse Hodgins was entitled to interpret Ms Thorn's disclosures of 4 October 2009 as consistent with the suicidal thoughts/ideation that had been a feature of her admission, rather than an acute deterioration or suicidal plan with intent.

- Nurse Joanne Stafford appropriately advised Dr Croke about Ms Thorn's refusal of her evening medications, and absent further orders from him, and in consultation with other night shift nursing staff appropriately initiated and maintained 15 minutely observations of Ms Thorn overnight.

- It is unlikely that Nurse Stafford also conveyed to Dr Croke Ms Thorn's intention to stay up all night. I imply no criticism of her in this regard, as it is likely that Nurse Stafford perceived that Dr Croke would not welcome another interruption, and in any event, the regime of frequent overnight observations was an appropriate clinical response that enhanced Ms Thorn's safety.

83. I am somewhat loathe to focus on the physical environment, where concerns are raised about the adequacy of clinical management and care. However, I am persuaded that Dr Croke's decision not to recommend Ms Thorn on 5 October 2009 was influenced by his belief that she would be comfortable and, more importantly, safe in the meantime, in her own room in a secure ward.[94] I am also persuaded that events would have been significantly different had Ms Thorn simply been in the ward for review by Dr Croke on the morning of 6 October 2009. Armed with information that she had not only refused her evening medications, but also announced her intention to stay up all night and done so, Dr Croke would have been able to canvass those matters with her, and absent compelling evidence of clinical improvement, would likely have recommended her for involuntary treatment/ECT.[95]

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[94] Transcript p499.

[95] Exhibit U and transcript pXX

84. However, my findings above should not be read as a complete endorsement of the clinical management and care provided to Ms Thorn or an indication that there is no scope for improvement.

85. I am mindful of the verbal culture in Northpark and other hospitals, such that important current clinical information passed on at handover, is not necessarily documented or readily ascertainable from the medical records/progress notes. An obvious example is the lack of reference in the progress notes to Ms Thorn saying on 4 October 2009 that she felt like jumping in front of a train, and yet a number of nurses having this information, presumably because it was communicated verbally, whether at handover or otherwise.

86. Coronial investigations that tend to rely on witness recollection some time after the event and, directly or indirectly, on documentation, can be impoverished because of this verbal culture. Moreover, a number of nurses indicated that they did not know salient aspects of Ms Thorn's past history and that there were matters put to them at inquest that they would have wanted to know that might have influenced their clinical assessment of Ms Thorn.

87. In that context, and without finding any causal connection with Ms Thorn's death, I find that there were aspects of documentation in the medical record, that were sub-optimal. Undated risk assessments; scant detail of past history, particularly significant information about the nature and extent of Ms Thorn's suicidality and history of absconding; lack of detail or verbatim accounts of significant disclosures, so that other clinical staff could pursue themes with some continuity; and poor documentation of the patient's most current clinical plan, all indicate that there is room for improvement.

88. Similarly, while it is likely that Dr Croke contributed to the confusion about Ms Thorn's status, there was a baffling and concerning lack of appreciation on the part of some nursing staff of the provisions of the ***Mental Health Act 1986*** governing the recommendation of a patient for involuntary treatment, and the need for a request and timely transfer to a gazetted psychiatric facility, that warrants remedy.

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

Mr Matthew Thorn

Ms Thorn's family

Dr Simon Croke, Consultant Psychiatrist

Northpark Private Hospital c/o Healthscope

Austin Hospital c/o Austin Health

Leading Senior Constable David Breer c/o O.I.C. Epping Traffic Management Unit

Mr Michael Averkiou, Department of Infrastructure

Ms Eva Deligiannis, Transport Accident Commission

The Chief Psychiatrist

Signature:

PARESA ANTONIADIS SPANOS
Coroner
Date: 19 December 2014