IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2015 6259**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**GM**
Date of birth:	**8 NOVEMBER 1963**
Date of death:	**BETWEEN 5 AND 12 DECEMBER 2015**
Cause of death:	**UNASCERTAINED**
Place of death:	**363 WARRNE ROAD, WANGOOM, VICTORIA, 3279**

HIS HONOUR:

BACKGROUND

1. GM was born on 8 November 1963. He was 52 years old at the time of his death. GM was diagnosed with Bipolar Affective Disorder in his 20s. GM was described by his mother BM as a very outdoor type of person who loved fishing and camping. She stated that up to his mid-40s GM was an active man who had normal relationships, many interests and good doctors. She stated that he was able to manage his illness with medication, however in the seven to eight years prior to his death, GM's mental health had worsened.

2. GM was treated and managed by Hamilton Mental Health Service periodically since 1991. Consultant Psychiatrist Dr Jayanta Deb stated that most of GM's inpatient admissions over the years were involuntary and that he preferred to be under the care of his General Practitioner rather than be involved with mental health services[1]. Dr Deb also noted that GM had prepared an Advance Statement[2] with his GP on 22 August 2014 which had a focus to receive further treatment as a voluntary client.

3. Prior to GM's mental health service contacts in December 2015, his last episode of care with Hamilton Community Mental Health Services was between 24 December 2010 and 3 September 2014. During this episode of care he was treated for a period as an involuntary inpatient and discharged on a Community Treatment Order which was ceased on 4 October 2013. This episode of care involved two inpatient admissions in the context of manic episodes. GM was discharged from the Service in September 2014 after a prolonged period of mental health stability, and it would appear that he remained relatively stable mentally until recent weeks prior to his admission to hospital on 2 December 2015.[3] According to his GP Dr Andrew McAllan, GM's "psychotic" episodes were usually precipitated by non-compliance with medication or cannabis usage[4].

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[1] Page 2, Reportable Death (Incident Report) prepared by Dr Jayanta Deb.

[2] An Advance Statement is a document prepared by a consumer to be read and used in case of a mental health crisis. Typically advanced statements contain special information outlining a person's unique circumstance, personal preferences regarding treatment choices and information about practical life management arrangements. An advance statement outlines the steps that must be taken to provide optimal support and care for a person with a mental illness during a time of crisis in order to limit or prevent the damage from that crisis. An authorised psychiatrist must have regard to a person's Advance Statement, but may make a treatment decision not in accordance with an Advance Statement if satisfied that the treatment request in the Advance Statement is not clinically appropriate or is not a treatment normally provided by the mental health service.

[3] Page 79 *Coronial Brief.*

[4] Page 19 Statement form Dr Andrew McAllan, *Coronial Brief*.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. GM's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as his death occurred in Victoria, and was both unexpected and unnatural.[5]

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial[6]. The purpose of a coronial investigation is independently to investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

6. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[7] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

10. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) 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

    (c) 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

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[5] Section 4, definition of 'Reportable death', *Coroners Act 2008*.
[6] Section 89(4) *Coroners Act 2008*.
[7] *Keown v Khan* (1999) 1 VR 69.

justice. These powers are the vehicles by which the prevention role may be advanced.

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[8] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

12. GM was identified by a DNA comparison with his mother BM and circumstantial evidence on 23 December 2015. Identity was not an issue and required no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

13. On 24 December 2015, Dr Victoria Francis, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an examination on GM's body and provided a written report dated 6 May 2016, concluding a reasonable cause of death to be "I(a) Unascertained". I accept her opinion in relation to the cause of death.

14. Toxicological analysis of post mortem specimens detected ethanol[9] (~0.01 g/100mL) in blood and (0.03g/100mL) in urine, pholcodine[10] (~0.1 mg/L) in blood and delta-9-tetrahydrocannabinol[11] was detected in blood. Whilst alcohol can be produced as part of the putrefactive process, given the presence of alcohol in his urine, the consumption of alcohol cannot be ruled out. Pholcodiene (an opioid medication) was also identified in the blood and evidence of prior cannabis consumption. Dr Francis noted that decompositional changes can alter the concentration of any drugs and poisons after death and may even prevent the detection of drugs and poisons by the presence of decomposition substances.

15. Dr Francis noted the post mortem computed tomography (CT) scan showed moderate to severe decompositional changes. Rib fractures with callus formation were noted. She stated

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[8] (1938) 60 CLR 336.
[9] Alcohol is the common term for ethanol.
[10] Pholcodien is an opioid chemically related to morphine. Pholcodine is a cough suppressant and has a mild sedative effect.
[11] Delta-9-hydrocannabinol (THC) is the active form of cannabis (Marijuana).

there were healing anterolateral rib fractures and probable acute pneumonia was seen throughout all lung lobes. There was severe coronary artery atherosclerosis with mild perivascular and interstitial myocardial fibrosis. There was no evidence of significant acute injury.

16. Dr Francis commented that a possible mechanism of death was pneumonia that was potentially caused by GM's healing rib fractures in a setting of underlying coronary artery atherosclerosis. Dried mud was noted over GM's lower limbs and his body was found approximately 300 metres from the Hopkins River and he was naked when he was found. In the setting of a person found deceased in the summer months in such and environment, either hyperthermia or hypothermia may be mechanisms contributing to death.

17. Dr Francis stated that given the investigation findings, it is not possible to identify a clear unequivocal cause of death. However, taking into account GM's background, medical history, circumstances surrounding his disappearance, the environment in which his body was found and the limited autopsy findings due to decomposition, it is possible that his death was related to environmental exposure with bronchopneumonia in the setting of healing rib fractures, coronary artery atherosclerosis and recent pholcodine and possible alcohol consumption. There is no evidence identified during the post mortem examination that any other person was involved in GM's death.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

18. Between 17 November and 1 December 2015, a number of contacts to mental health triage were made by GM's mother BM, his sister JF and his former employer.

19. On 1 December 2015, GM was voluntarily brought to Hamilton Mental Health Service by police following family contact with concerns for his well-being. He was diagnosed as having a likely relapse/manic episode of bipolar disorder and deteriorating mental state. Upon clinical review he demonstrated some insight into his current mental state but declined the offer of a voluntary inpatient admission. He was however agreeable to be treated in the community by the Hamilton community team and was discharged from hospital. After his discharge, further calls were received by triage from BM and his sister who remained concerned about GM's behaviour and wellbeing. Overnight, GM was again brought to the Hamilton Hospital's Emergency Department, voluntarily, where a plan was made for his

voluntary admission to the psychiatry inpatient unit at Warrnambool hospital the next morning.

20. At approximately 10.00am on 2 December 2015, GM was transported by ambulance to the inpatient unit as planned. Goals of his admission were documented as re-start on medications (as it was thought that he was non-compliant), psychiatrist review and reduce his manic symptoms.

21. At approximately 11.24am, a medical examination was conducted by Dr Sleeth, HMO. GM reported a recent fall and pain in his right chest wall and it was noted that difficulty taking deep breaths due to pain was evident. Extensive bruising was also noted to the area and an x-ray was to be arranged. According to the medical record, GM was assessed as being at low risk of deliberate self-harm but at moderate risk of vulnerability due to "grand plans" associated with his manic state.

22. At approximately 2.20pm, GM told staff that he had secured a bank loan for $50000 and that he intended going to Mount Gambier to buy a car and drive to Cairns. He stated that he did not wish to stay to see Dr Deb, and some irritability was noted at the time by the clinician. Following a phone discussion with Dr Deb, Unit Manager Registered Nurse Neil O'Brien completed an Assessment Order as suggested by Dr Deb if GM met criteria for assessment under the *Mental Health Act, 2014* (Vic). Nurse O'Brien stated that GM left the ward as he was talking to Dr Deb and did not return. The MHA 101 Assessment Order form was completed by RN Neil O'Brien dated 2 December 2015 at 3.00pm.

23. It was unclear as to whether GM was aware of his compulsory patient status under the *Mental Health Act, 2014* (Vic) before absconding, as it was not documented to what extent any discussion about legal status with him had occurred and the exact timing of GM leaving the unit was unconfirmed.

24. GM had not been reviewed by a psychiatrist between being admitted at 10.00am and leaving the unit at sometime around 3.00pm that afternoon. As he was initially a voluntary patient, not at high risk and had been on the ward for approximately five hours only, this was not unreasonable. The South West Healthcare Admission Guidelines[12] state that for voluntary patients admitted by means other than a psychiatrist clinical review, then a review of the clinical presentation should be completed by the treating psychiatrist within 48 hours of the admission.

[12] Refers to South West Healthcare Mental Services Admission Guidelines, Acute Inpatient Unit

25. Review of the medical record found no documentation of formal unescorted leave requests or approvals but it was noted that GM had been going out for short walks as an inpatient[13], which as a voluntary patient he was legally within his rights to do. However, South West Healthcare "Consumer Leave from the Acute Inpatient Unit" guideline cites as a key principle that the decision to grant consumer leave must be made within the context of the treatment objectives and strategies of the consumer's treatment plan and discusses requirements for the granting of leave regardless of whether consumers are voluntary or involuntary. The guideline states that "newly admitted consumers should generally not be granted leave until the treating psychiatrist has developed sufficient familiarity with the consumer to allow a judgement as to whether leave is appropriate." The fact that GM was allowed short periods of leave from the ward would have made it easier for him to leave the ward unchallenged at the time he absconded.

26. From the information reviewed there was no evidence of counselling or encouragement for GM to remain on the ward which may have been a more appropriate approach given GM's elevated state and the risk assessment that documented him as being at moderate risk of accidental harm.

27. South West Healthcare guideline "Absent without Leave or Permission" requires that the presence of all consumers on the ward must be monitored as per the allocated Nursing Observation Category (NOC)[14]. If further states that every consumer admitted to the AIU (Acute Inpatient Unit) must be allocated a NOC based on a comprehensive risk assessment, and sighted by the assigned nurse at the intervals specified on the NOC.

28. GM was allocated "NOC A" (visual sighting/observation intervals not more than hourly) according to the progress notes documented on 2 December 2015 following his admission to the ward. However, the form where visual sightings are documented by staff indicated a requirement for fifteen-minutely visual observations, which occurred. Visual observations were recorded on the pro-forma every fifteen minutes between 10.30 am and 12.15 pm then it was recorded that GM was "out".

29. The next recorded visual observation was recorded at 1.15 pm and every fifteen minutes thereafter until 2.30 pm. At 2.45 pm and thereafter until 5.15pm the pro-forma had "out"

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[13] Page 80 Historical/sequential events and contacts during the last episode of care, *Coronial Brief.*

[14] NOC A – to be observed at intervals of not more than 1 hour
NOC B – to be observed at intervals of not more than 15 minutes to 30 minutes as determined by the nursing staff
NOC C LDU – to be in sight of the nursing staff at all times
NOC C HDU – Nursing staff to be aware of consumer's location at all times and observe at intervals of not more than 15 minutes
NOC D – Nursing staff to be within arms-length of consumer at all times

written against GM's name. It can therefore be assumed that GM left the ward between 2.30 pm and 2.45 pm. The next entry on the progress notes recorded GM's NOC as "B 15" (visual sightings every fifteen minutes) and spoke of his reluctance to stay to see a psychiatrist.

30. When staff noted that GM was missing from the ward, form MHA 124 "Apprehension of patient absent without leave" was completed and faxed to Warrnambool police. It was unclear from the information reviewed what time this occurred, however police did receive a phone call from the ward at approximately 3.30pm.[15] Notification of GM's absence off the ward was made to his family at approximately 5.00pm.

31. It was unclear whether attempts were made by ward staff to contact GM by phone on 2 December 2015, after he left the ward but it was noted that attempted phone contact with GM via his mobile phone on the 3 December 2015 was unsuccessful.[16] On 3 December 2015, ward staff contacted Hamilton Police, Mount Gambier Police, the Mount Gambier Mental Health Service in relation to the Assessment Order. On 5 December 2015, the Assessment Order expired.

32. On 5 December 2015, a friend of GM's JD, spoke to GM at a supermarket in Hamilton and described GM as looking gaunt and unwell.

33. On 12 December 2015, Murray Adams was mowing the lawns on his property in Wangoom. There is an old run down bus on the property and Mr Adams noticed there was a drum stand in the door of the bus. As he reached in to get the drum stand, he discovered GM's body. Mr Adams stated that he had last checked the bus two to three weeks previously. Emergency Services were called and Police arrived shortly afterwards.

Investigation into Mental Health Care

Contacts made to psychiatry triage

34. Telephone contacts were made to Hamilton Mental Health Service's (HMHS) Psychiatric Triage Service by GM's mother BM, his sister JF and previous employer during November and December 2015. A record of these were obtained from the service and reviewed. In the mental health care context, the main purpose of triage is to decide whether or not the person requires further assessment by the Mental Health Service (MHS) or other services, and the

[15] Page 22 Statement of Paul McGovern, Warrnambool Uniform, *Coronial Brief.*
[16] Page 81, Historical/sequential events and contacts during the last episode of care, *Coronial Brief.*

degree of urgency for the response from mental health or other services.[17] As part of the MHS clinical pathway people are linked to the right care and supports where an acute MHS response is not required.

35. I reviewed the contacts made to the HMHS Psychiatry Triage service in November and December 2015, and note there were frequent contacts to the psychiatric triage service by GM's mother BM. The information documented indicated that appropriate advice was conveyed to her and clinicians worked within the parameters that she would initially allow, within directives contained within GM's advance care plan (preference for voluntary treatment) on considering his risk factors at the given points in time and within requirements legislated in the *Mental Health Act (VIC),* 2014.

36. Contact with GM's mother was also discussed with the HMHS service's Multidisciplinary Team with documented entries dated 23/11/2015, 24/11/2015 and 1/12/2015 that was indicative of additional clinical over-sight and clinician consensus on proposed further actions or responses which included correspondence with GM's General Practitioner.

37. Psychiatry Triage acted appropriately in their communications with BM, JF and GM's former employer. Advice that Psychiatry Triage provided was based on the clinical information that they could obtain from BM at those points in time and their assessment of risk based on this information. The psychiatry triage service was somewhat hampered in initial stages by the fact that BM did not want GM to know that she was talking to them and meant that in the absence of high risk, the triage service were unable to initiate assessment without BM being willing to act as referrer.

Care provided at South West Health

38. The issues that have been identified through this investigation include the Advance Statement, nursing observations and that GM was able to leave a locked unit unsighted. Additional issues identified include the incongruence of the leave polices at the time of GM's death and the lack of accommodation for the rollout of the non-smoking policy at that time. In addition, the failure to immediately communicate to all on-duty staff the escalation of risk as and when noted by Nurse O'Brien, who responded to GM's disclosure he wanted to leave to drive to Cairns, with the clinically correct decision to make him a compulsory patient.

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[17] Victorian Government Department of Health "Statewide Mental Health Triage Guidelines", 2010 accessed at https://www2.health.vic.gov.au/about/publications/policiesandguidelines/triage-scale-mental-health-services 23 January 2017.

Advanced Directive

39. The application of GM's Advance Statement was appropriate and there is nothing to suggest he should have been made a compulsory patient at any stage prior to the point at which Nurse O'Brien assessed his risk to have changed which triggered an immediate contact with Consultant Psychiatrist Dr Deb and an assessment order put in place. The medical records note a low tolerance for changing GM from a voluntary to a compulsory patient.

40. The internal review conducted by South West Healthcare identified the lack of staff knowledge in relation to the Advance Statement. The service has undertaken a set of actions in response to a recommendation to improve the staff knowledge and skills regarding these documents which are regulated under the *Mental Health Act 2014* (Vic). However, based on the available information, GM was willing to receive treatment and be admitted and thus the *Mental Health Act 2014* (Vic), could not have applied, prior to the point at which Nurse O'Brien contacted Dr Deb.

Leave policies at South West Healthcare

41. The *Consumer Leave from the Acute Inpatient Unit Clinical Guidelines* provided by South West Healthcare (dated 27 February 2014) includes the following:

> Newly admitted consumers should generally not be granted leave until the treating psychiatrist has developed sufficient familiarity with the consumer to allow a judgement as to whether leave is appropriate.[18]

42. According to information provided by South West Healthcare Director, Mental Health Services Karyn Cook, GM had been allowed leave to go into the central business district and to have cigarettes. The decision to allow this seems to be based on the assessment of GM as low risk.

43. The clinical guideline and the decisions made by nursing staff appear to be in conflict, especially as there appears to have been no attempts made to restrict GM from having leave as suggested in the clinical guideline should be the case. For example, there is nothing to suggest GM was offered or prescribed nicotine replacement therapy or that escorted leave was considered.

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18 Consumer Leave from the Acute Inpatient Unit Clinical Guidelines, page 2.

44. In acknowledging GM was in the unit for some hours only, it should be stated that the reliability of any risk assessment for newly admitted patients who staff are yet to establish a relationship with or that have not been assessed by a psychiatrist is low. It is for that reason and patient safety that mental health units restrict leave of newly admitted patients until they are assessed.

45. The safety of a patient who is a smoker is no less important than one who is not. At that time, South West Healthcare did not appear to have in place adequate guidance for staff in how to implement the Acute Inpatient Unit Clinical Guideline principle of newly admitted patients generally not being allowed leave until they are reviewed by a psychiatrist. Including balancing the rights of a patient who is voluntary, the low reliability of risk assessments for newly admitted patients and the rights of patients who smoke, to leave the unit to have a cigarette in that period.

46. South West Healthcare has reviewed their guidelines and now leave can only be granted following review by a psychiatrist and is based on an assessment of risk. In addition each patient has, as part of their treatment plan, a leave plan which is approved and discussed with the patient.

47. South West Healthcare's Acute Inpatient Unit and Acute Inpatient Unit Risk Management Guidelines now include guidance for staff regards inpatients wanting to leave the acute unit for the purpose of having a cigarette. The guidelines are referenced to the May 2012 Chief Psychiatrist Guideline Providing a Smoke-free Environment in Public Mental Health Inpatient and Residential Units, and are appropriate.

Communication within the unit

48. A focus of the advice to date has been on the nursing observation categories which there is a lack of clarity about however the Acute Inpatient Unit was locked at the time of GM having left it sometime after 2.15pm on 2 December 2015.

49. Nurse O'Brien recognised GM was at greater risk and acted immediately to change his status to compulsory. This was clinically appropriate and a timely response. Nevertheless, while Nurse O'Brien was arranging for the assessment order under *Mental Health Act 2014* (Vic) GM was released by a staff member from the locked unit.

50. South West Healthcare Director, Mental Health Services Karyn Cook states this probably occurred because GM left when the door was opened for another patient, that there is a blind spot in the line of sight from the Nurses Station and the doors are some distance from the Nurses Station. Ms Cook also states CCTV was not in place at the time.

51. The action undertaken by South West Healthcare in the Acute Inpatient Unit have increased the safeguards when a patient attempts to leave the unit unsighted. It also addresses all-of-staff access to real-time information about who has or has not been allocated approved leave and any conditions. In addition, the use of CCTV has reduced the structural line of sight issues. Its installation was to be completed by end of October 2017.

52. There is nothing to suggest that the nursing staff on shift at the time Nurse O'Brien rang Dr Deb regarding changing GM's status knew of GM's increased risk and where alerted to his intent to leave the unit.

53. South West Healthcare has made changes to the nursing observation records for each patient, which adds to the accessibility, accuracy, and usefulness of the form. The use of a Patient Status at a Glance board, use of an Inpatient Admission Plan and improve rigor about clinical handover are all aimed at improving the quality, reliability and currency of the information communicated between staff about patient's risks on and between shifts.

54. The actions undertaken by South West Healthcare are contemporary and should contribute to a safer environment in the Acute Inpatient Unit, the identification of and a timely and safe response to individual patient risks and changes in risks.

FINDINGS

55. Having investigated the death of GM and having considered all of the available evidence, I am satisfied that no further investigation is required.

56. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

(a) that the identity of the deceased was GM, born 8 November 1963;

(b) that GM died between 5 and 12 December 2015, at 363 Warrne Road, Wangoom, Victoria from unascertained causes; and

(a) that the death occurred in the circumstances described in the paragraphs above.

57. I convey my sincerest sympathy to GM's family and friends.

58. Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

(a) GM's family, senior next of kin;

(b) Investigating Member, Victoria Police; and

(c) Interested Parties.

Signature:

MR JOHN OLLE
CORONER
Date: 1 February 2018