IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 2062

# FINDING INTO DEATH WITH INQUEST

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

**Inquest into the Death of: RENEE TREEN**

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| Delivered On: | 29 January 2014 |
| Delivered At: | Coroners Court of Victoria,<br>222 Exhibition Street,<br>Melbourne |
| Hearing Dates: | 14, 15 and 16 October 2013 |
| Findings of: | HEATHER SPOONER, CORONER |
| Representation: | Mr McCloskey of Counsel for North Western Health |
| Police Coronial Support Unit | Senior Constable Tracey Ramsey |

I, HEATHER SPOONER, Coroner having investigated the death of RENEE TREEN

AND having held an inquest in relation to this death on 14, 15, 16, October 2013
at Coroners Court of Victoria, 222 Exhibition Street, Melbourne
find that the identity of the deceased was RENEE ANDREA TREEN
born on 31 July 1985
and the death occurred on 1 June 2010
at Tullamarine Freeway, Essendon North 3041
**from:**

1 (a) MULTIPLE INJURIES

**in the following circumstances:**

**1.** Ms Treen was aged 24 when she died. She lived at Unit 3, 75 Bulla Road, Essendon which was a youth residential supported accommodation unit run by the Doutta Galla Community Health Service. Ms Treen was a student and studying Multimedia at Kangan TAFE. She had a long history of psychiatric illness including admissions to Orygen Youth Mental Health Services. Ms Treen had been prescribed clozapine and an antidepressant but this medication was changed. At times, Ms Treen could be non compliant with her medication.

**2.** A police investigation was conducted into the circumstances surrounding the death.

**Brief Chronology of Events Leading to Death**

3. In May 2009 - Ms Treen's care transferred from Orygen to Inner West Area Mental Health Service (IWAMHS). Throughout this time, the Mobile Support and Treatment Service (MSTS) considered Ms Treen might have been suffering from underlying borderline personality traits. She was poorly compliant with Clozapine and difficult to engage in treatment. Her Community Treatment Order (CTO) was extended in September 2009.

14 April 2010 - Ms Treen was discharged from her CTO due to her being well, employed part-time, studying and increased insight into her illness and the need for treatment. She subsequently became non-compliant with medication and MSTS remained concerned about her ongoing alcohol and illicit substance abuse.

14 May 2010 - Ms Treen contacted her high school friend Jeremy Edwards on facebook.

15 May 2010 - Ms Treen went out with Jeremy Edwards for dinner and to see a movie.

18 May 2010 - John Cade Unit (RMH)

Admitted by principal registrar Dr Fraser as an involuntary patient following concerns of her case support worker Ms Gayle Oakley who witnessed Ms Treen on the nature strip aligned to the Tullamarine Freeway near her unit on Bulla Road, Essendon.

Ms Treen presented as perplexed, distracted, and unable to give an account on recent events. Self-reported recent alcohol binge drinking, cannabis use and non-compliance with antipsychotic medication for some months. Dishevelled appearance. Poor attention. Appeared to have a psychotic relapse.

19 May 2010 – Consultant psychiatrist Dr Veronique Browne, John Cade Unit (RMH) assessed Ms Treen in the high dependency unit (HDU). She presented as guarded, perplexed and thought disordered. She admitted to hearing '*voices*' in the past and described vague paranoid ideation. She denied any thoughts of harming herself or others. She was fully oriented at the time. She displayed poor insight into her illness and the need for treatment and saw no reason for her having been admitted the day earlier.

Following the doctor's assessment, it was considered that Ms Treen was experiencing an exacerbation of schizophrenia, secondary to non-compliance with antipsychotic medication and probable alcohol/cannabis use. The ITO was upheld and arrangements were made for Ms Treen to remain in the HDU due to her risk of absconding and sexual vulnerability. Recommenced on antipsychotic medication of risperidone and quetiapine.

20-21 May 2010 - Consultant psychiatrist Dr Siew, John Cade Unit (RMH) reviewed Ms Treen who appeared to be improving. She was less preoccupied and perplexed, and less thought disordered and was noted to no longer be responding to possible auditory hallucinations. On these reviews, it was considered that Ms Treen's psychotic relapse was already starting to resolve however she remained irritable and insistent on leaving the ward to have a cigarette and continued to display poor insight. It was decided she would remain in the HDU, but could be considered for low dependency unit (LDU) over the weekend if she continued to progress well.

22 May 2010 - The On-call Psychiatry Registrar, John Cade Unit (RMH) assessed Ms Treen who continued to improve in her mental state, with a reactive affect, no formal thought disorder, no paranoia or delusions and no thoughts of harming herself or others. She described ongoing auditory hallucinations but no command hallucinations. It was organised for Ms Treen to start sleeping in the LDU overnight and remain in the HDU throughout the day.

23-24 May 2010 - The on-call psychiatry registrar Dr Kochar, John Cade Unit (RMH) assessed Ms Treen. Over both reviews, she no longer presented as psychotic and she continued to deny thoughts of harming herself or others, but had been noted to be dressing inappropriately at times, and considered to remain sexually vulnerable, so remained in the HDU during the day and then slept in the LDU overnight.

25 May 2010 – Drs. Siew, Kochar, and Prash Puspamathan, John Cade Unit (RMH) reviewed Ms Treen and noted that she continued to deny having been unwell, taking substances, hearing voices or having thoughts of harming herself. It was considered she might have experienced a drug-induced psychotic episode with possible underlying Borderline personality traits but that she was still improving. Ms Treen was trialled in the LDU and her risperidone increased and depot Risperdal Consta commenced. Ms Treen appeared unwilling to engage in drug and alcohol services over the week.

26 May 2010 - Dr Veronique Browne, John Cade Unit (RMH) assessed Ms Treen as having managed her trial in LDU well and said she regretted ceasing medication prior to admission. She appeared to display some insight into the need to continue her medication and described having no concerns on the ward and feeling calm, without any thoughts of harming herself or others. She said she continued to experience auditory hallucinations. She was fully transferred to the LDU and remained there over the next two days.

28 May 2010 - Dr Siew, John Cade Unit (RMH) assessed Ms Treen who reported feeling better and keeping busy with activities on the ward. She engaged well in this interview and said that she was *"happy to stay in hospital for as long as doctors see fit"* and had no intention of absconding. She also reported, *"None of the medications have ever worked for the voices. They don't really bother me. They're never really*

*negative. It's usually like compliments and they're funny. I actually miss them when they're gone."* Ms Treen also reported that these voices were not affected by alcohol or drug intake. Given her positive progress, she was granted leave from the ward on hospital grounds and it was planned for her to be discharged the following Wednesday after a family meeting. A meeting was scheduled for 2nd June with Ms Treen and her family to discuss her progress and management following discharge, plus concerns about ongoing alcohol and marijuana use.

30 May 2010 - John Cade Unit (RMH) - Ms Treen was noted to display "*increasing frustration waiting for a male friend to arrive*" for a visit. Ms Treen then left the ward for leave on hospital grounds with Jeremy Edwards but did not return as she usually did, so was reported as absconded without leave to police.

31 May 2010 - John Cade Unit (RMH) - Ms Treen returned to the ward the following morning on her own accord. Dr Kochar and intern Dr Puspanathan reviewed her. She reported to them that she had a visitor the previous evening then "*went out for dinner and by the time I came back the doors were shut (overnight) and so I had to stay at a friend's place.*" She appeared remorseful for her actions. She denied any illicit drug use and spoke about how her studies were making her "*stressed*" prior to her admission. She accepted that her hospital leave was cancelled and she was observed on hourly ward observations. It is documented in the clinical file that Ms Treen was noted to be sleeping for much of the day, low in mood and tearful at times, but "*behaviourally settled*", "*no overt psychotic symptoms*" noted and "*polite*" to staff.

1 June 2010 - John Cade Unit (RMH) - Ms Treen was woken to get ready for ward round and appeared *"dishevelled and flat in affect"*. Ms Treen requested a nicotine patch from the nurse however when the nurse had returned, Ms Treen had left. Staff searched the hospital but she could not be located. She was then reported as absconded without leave according to ward policy. Victoria Police, Ms Treen's mother, Ms Karen Treen and the ROCKET program staff were contacted.

At approximately 11.05am, Ms Treen jumped off the Bulla Road Overpass and Tullamarine Freeway, falling 8 metres and hitting the ground before being hit by an oncoming mini bus that was transporting a passenger from the airport to a residential address. Ms Treen died as a result of the incident.

The manner of the police approach and attendance at the scene just prior to Ms Treen jumping was reviewed by me and found to be reasonable.

**Post Mortem Examination and Toxicology**

4. An Autopsy was performed by Dr Parsons Forensic Pathologist VIFM. Dr Parsons formulated the cause of death and in her report commented:

> *"RENEE ANDREA TREEN was a 24 year old female who according to the circumstances as detailed in the Victorian Police Report of Death Form 83 was reported as a missing person to the police by the Royal Melbourne on the 01/06/2010 and had not been seen since 0945 hours. The deceased was an involuntary patient at the Royal Melbourne Hospital. At about 11.00 am reporting person contacted 000 re concerns for deceased due to her peculiar behaviour and location (Bulla Road overpass). Police member attended in response to the initial 000 call. On their attendance they observed the deceased on the east side of the bridge, she had her hands wrapped around her waist and her head looking downwards. The police were in a marked sedan about 30 to 40 meters from the deceased. They had turned off their siren prior to entering Bulla Road. The deceased has then jumped over the bridge and landed on the inbound lane to the Tullamarine Freeway and was immediately struck by a 12 seater bus carrying a luggage trailer. Police were on scene immediately and an investigation was commenced. At the time the traffic was light to medium, the weather was fine and visibility was good. The deceased was conveyed to the Royal Melbourne Hospital and her identity was confirmed via fingerprints.*
>
> *The medical records from the Royal Melbourne Hospital were reviewed. These showed that the deceased was currently an involuntary patient at the psychiatric ward of the Royal Melbourne Hospital for schizoaffective disorder as she was currently experiencing thought disorder and hallucinations.*
>
> *On admission to the hospital she had had recent alcohol binges, cannabis and non compliance with her antipsychotic medication and appeared to be in a psychotic relapse. The police were contacted by the hospital after the deceased had absconded.*
>
> *The cause of death in this 24 year old female is multiple injuries.*
>
> *Toxicological analysis on post mortem specimens has detected a number of antipsychotic drugs and benzodiazepines consistent with therapeutic usage."*

**Community Care by Inner West Mental Health Service (IWMHS)**

5. I directed the Coroners Prevention Unit (CPU)[1] to review the mental heath treatment and information relating to Ms Treen's absconding whilst receiving services from the Inner West Mental Health Service (IWMHS) and specifically the Mobile Support and Treatment Service (MSTS) and John Cade Unit at Royal Melbourne Hospital (RMH) as part of the North Western Mental Health Service.

6. Ms Treen had been supported through case management by the IWMHS and specifically MSTS[2] and from her 18-month admission to the Rocket Program, a residential program specific to youth with psychosis.[3] Ms Treen was an involuntary patient under the *Mental Health Act 1986* (Vic) specifically a Community Treatment Order (CTO), for most of the time she was with MSTS.[4] The information available contained evidence that the psychiatric treatment was thorough and responsive to Ms Treen's experiences with side effects of medications and effectiveness of treatments. There were consistencies in assessment of risk and level of liaison with the staff at Rocket. Over the previous 18 months, Ms Treen had maintained her place at Rocket, had gained employment and was studying multi-media at Kangan TAFE.

7. In April 2010, Ms Treen no longer met the criteria for a CTO and was discharged. IWMHS MSTS continued to case manage Ms Treen. She subsequently stopped taking her medications, giving the reasons that it was too expensive and because she was not on a CTO, she did not need the medications. Her deterioration could be considered rapid and was contributed to by her use of alcohol and cannabis. When contacted by Rocket staff IWMHS assessed Ms Treen and then involved her mother Mrs Karen Treen in the decision to admit Ms Treen to hospital, and arranged for her admission to John Cade Unit in a timely manner.

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1 The Coroners Prevention Unit is a specialist service for coroners created to strengthen their prevention role and provide them with professional assistance on issues pertaining to public heath and safety.

2 Mobile Support and Treatment Service provides long-term treatment, rehabilitation and support to people with severe mental illness who are living in community settings, including special residential services and boarding houses

3 Doutta Galla Rocket Program. Ms Treen was in the unit in 3/75 Bulla Rd, Essendon.

4 *Mental Health Act 1986* (Vic) Section 8 criteria: (a) the person appears to be mentally ill; and (b) the person's mental illness requires immediate treatment and that treatment can be obtained by the person being subject to an involuntary treatment order; and (c) because of the person's mental illness, involuntary treatment of the person is necessary for his or her health or safety (whether to prevent a deterioration in the person's physical or mental condition or otherwise) or for the protection of members of the public; and (d) the person has refused or is unable to consent to the necessary treatment for the mental illness; and (e) the person cannot receive adequate treatment for the mental illness in a manner less restrictive of his or her freedom of decision and action.

8. According to the CPU review the overall care and treatment of Ms Treen by IWMHS appeared to be appropriate and within clinical guidelines.[5] The recovery focused care provided at the Rocket Program was within guidelines.[6]

**Inpatient assessment and treatment at John Cade Unit until 30 May 2010**

9. Ms Treen was admitted to the John Cade Unit at Royal Melbourne Hospital on 18 May 2010. The assessments, both psychiatric and medical, were comprehensive and were directly linked to the treatment plan and risk assessments. The effectiveness of her medication was reviewed frequently and with regular consultant psychiatrist and psychiatric registrar reviews. Ms Treen was moved to the HDU as soon as was practicable and remained there because of ongoing concerns about her vulnerability due to sexual disinhibition and associated poor judgement. The health records contain evidence Ms Treen's behaviour was disinhibited, provocative and inappropriate in the initial eight days of her admission. This was related to her illness and increased her vulnerability. The assessment of risk and care taken by John Cade Unit was in line with the Department of Health guidelines for the safety of women in psychiatric units.[7] The staff were very careful about moving Ms Treen to the low dependency unit (LDU) and did so with a graduated approach, ensuring her initial time in LDU was completed only when the doors to the ward were locked. According to the CPU review the medical and pharmacological treatment of Ms Treen by John Cade Unit appeared to be appropriate and within clinical guidelines.[8]

**Leave for cigarettes**

10. On 28 May 2010 following a review by consultant psychiatrist Dr Leit-Chin Siew, Ms Treen was given leave to go outside for a cigarette. She had been fixated on having a cigarette and had been found with cigarette butts and lighters on at least two occasions in the unit. Ms Treen

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5 Therapeutic Guidelines, Psychotropic Medications - eTG Psychotropic Medications accessed at: <https://library.deakin.edu.au/record=b1943087~S9>

6 Department of Health, 2005.The PDRSS Young Persons Residential Rehabilitation Program. Revised Guidelines and Information accessed at: <http://www.health.vic.gov.au/mentalhealth/services/disability/index.htm>

7 Office of Chief Psychiatrist 2012. Promoting sexual safety, responding to sexual activity and managing allegations of sexual assault in adult acute inpatient units accessed at: <http://docs.health.vic.gov.au/docs/doc/Promoting-sexual-safety-responding-to-sexual-activity-and-managing-allegations-of-sexual-assault-in-adult-acute-inpatient-units--June-2012>
Department of Health 2008. The gender sensitivity and safety in adult acute inpatient units project accessed at: <http://www.health.vic.gov.au/mentalhealth/publications/index.htm>

8 Therapeutic Guidelines, Psychotropic Medications - eTG Psychotropic Medications accessed at: <https://library.deakin.edu.au/record=b1943087~S9>

had been using nicotine replacement therapy (NRT) during her ten-day stay, was not allowed leave to have a cigarette, and wanted a cigarette once she was formally moved to the LDU.

11. Specifically the *Mental Health Act 1986* (Vic) MHA21 Leave – Involuntary Patient form stated:

> *"Cigarette leave*
>
> - *10 mins at a time strictly*
> - *Return on time*
> - *Inform N/staff of leave times*
> - *At N/staff discretion".*[9]

12. According to the Office of the Chief Psychiatrist Guideline, *Inpatient leave of absence*, the MHA21 is required; *'A Leave of Absence form (MHA21) should be completed for all involuntary patients granted leave. This form is be used for whenever an involuntary patient is to be absent overnight or longer periods, and at other times at the discretion of the authorised psychiatrist or his or her delegate.'*[10]

13 Although ambiguous, a MHA21 was completed for Ms Treen but it was not consistent with the directions by Drs Siew, Kochar and Puspanathan, which are recorded on the Progress Note MR/45 dated 28 May 2010:

> *"4 x 15min cigarette leave today≥ 1 hour/day."*[11]

14. The smoke free environment and use of NRT is in line with the Office of Chief Psychiatrist guideline, *'Providing a smoke-free environment in public mental health inpatient and residential units.'*[12]

**Service response to incident of absconding on 30 May 2010**

15. The immediate response to Ms Treen not returning from leave on 30 May 2010 appeared appropriate and followed in the main, the IWMHS *Absence of Inpatients* policy.[13]

16. Ms Treen returned to the unit at 9.00am on 31 May 2010 after being absent overnight. She was reviewed by Drs Kochar and Puspanathan at 11.00am:

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9 IWAMHS Health record duplicate Legal Papers section.

10 Office of Chief Psychiatrist 2009. Inpatient leave of absence accessed at: <http://www.health.vic.gov.au/mentalhealth/cpg/index.htm>

11 IWAMHS Health record.

12 Office of Chief Psychiatrist 2012. Providing a smoke-free environment in public mental health inpatient and residential units accessed at: <http://www.health.vic.gov.au/mentalhealth/cpg/index.htm>

13 Victoria Police Brief of Evidence page 175.

*"Went AWOL last night: 'I had a visitor last night. I went out for dinner and by the time I came back the door was shut and so I had to stay at a friend's place (I know I shouldn't have).' Denies any drug use. Admits to unprotected sex at friend's place. 'I've been on the {? mend} for awhile. When I came in people were worried for me. I was having trouble concentrating on my studies and things and I was getting quite stressed out. It was getting me down.'*

*'I do hear the voices. Not right now but from time to time." (Never tell her to harm self/others).*

*Hasn't had any problems being in hospital.*

*Claims some of her meds never do anything for the voices.*

*They make her less anxious but the voices remain."* [14]

17. All leave was cancelled and Ms Treen was for review on 1 June 2010 by consultant psychiatrist Dr Veronique Browne. There is a recorded *Revised Risk Assessment* by Dr Puspanathan with Ms Treen's risk of absconding assessed as moderate, substance abuse, and inappropriate sexual behaviour as moderate with suicidality and all other criteria as low.

18. The evidence in the health record suggested Ms Treen did settle upon return to the unit but the health records suggest her mood did not. Mary Ferguson psychiatric state enrolled nurse (PSEN) stated in the Progress Note MR/45 dated 31 May 2010 at 1.30pm:

> *"..Renee presents as labile in mood, responding to internal stimuli, gesturing, laughing..... Nursed on 15min obs."* [15]

19. The 15-minute observations, seemingly commenced by nursing staff, were not recorded on the Functional Observations form. It is possible the nursing staff increased the frequency of observations between 9.00am and 11.00am until Ms Treen was reviewed by medical staff but this was not recorded formally.

20. On the following shift, Nurse Howarth described Ms Treen as *"..mood flat, appears low in mood, tearful at times."*[16]

Nurse Howarth wrote that following description of Ms Treen's telephone contact with her mother:

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14 IWMHS Health record Progress Note MR/45 dated 31 May 2010 by Dr Puspanathan.
15 IWMHS Health record Progress Note MR/45, 1.30pm dated 31 May 2010.
16 IWMHS Health record Progress Note MR/45, 7.50pm dated 31 May 2010.

*"Made contact with mother, tearful when reporting same. Would not elaborate further."*[17]

However, Nurse Howarth found no evidence of formal thought disorder or behavioural issues.

**Issues**

21. There were several mental health service issues identified around the assessment of risk after Ms Treen returned from leave, the timeline to establish her probable time of absconding and the timeliness of the response by the unit once it was recognised that Ms Treen had left, including the following:

Assessment of risk after Ms Treen's return from absconding on 31 May 2010

22. The assessment of risk of Ms Treen from her admission on 18 May 2010, did not rate Ms Treen's risk of suicide above *low*. There appeared to have been no weight given to her previous history of suicide attempts (although known to and available to clinicians) and especially the proximate and preadmission suicidal ideation and behaviours, including standing beside a freeway, which had contributed to her admission on 18 May 2010.

23. The risk assessment completed by Dr Puspanathan on 31 May 2010 following the review by Drs Kochar and Puspanathan, changed the risk of absconding from low to moderate while all other criteria remained the same. The health records contained evidence Ms Treen was making decisions suggestive of poor judgement and disinhibition, such as absconding, staying out all night, and having had unprotected sex with a friend during that time. The decision to leave Ms Treen in the LDU is in line with the least restrictive approach to care promoted under the *Mental Health Act 1986* (Vic). However, citing the least restrictive approach as the rationale did not alleviate the responsibility of JCU to keep a patient safe regardless of status, but especially so, if the patient was on involuntary status.

24. The LDU doors were unlocked during the daytime, and the nursing staff appear to have increased the frequency of sight observations for Ms Treen immediately upon her return to the unit from one hourly to every 15 minutes. It was not clear why the assessment of risk completed by Dr Puspanathan did not include a more frequent sight observation (more than once every hour) until Ms Treen could be reviewed by a consultant psychiatrist which was arranged for 24 hours later.

Policy/guidelines for staff

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17 IWMHS Health record Progress Note MR/45, 7.50pm dated 31 May 2010.

25. The 2007 NWMHS document provided in the Brief of Evidence, entitled *Functional Observations* did not specify the required response for a patient who returned from an episode of absconding, other than the treating team being responsible for conducting a risk assessment.[18]

26. The *Absence of Inpatients* policy includes the following responsibilities once a patient returns from an absconding episode:

> *"Inform family*
>
> *Inform CATT*
>
> *Complete a Riskman to reflect when the patient returned*
>
> *Complete a Risk Assessment."*[19]

27. The Brief of Evidence contained information and copies of risk assessment forms but it was unclear if they were part of the *Absence of Inpatients* policy or the NWMHS risk assessment policy or if either were in place at the time of Ms Treen's death. The policy stated:

> *"High risk factors indicating the need for increased containment or observation are: suicidality, harm to others, absconding and deliberate self-harm."*[20]

Clarification of the timeline when Ms Treen left John Cade Unit on 1 June 2010

28. Nurse Walker recorded on the Nursing Level Category Observation form that she last sighted Ms Treen at 8.00am and in her statement said:

> *"At 0915 [9.15am] as I was in the process of locating another patient to attend ward round, Renee approached me to request a nicotine patch.*
>
> *In the presence of Renee I approached RPN Mary Ferguson, who was the allocated nurse to dispense medications, to inform her of Renee's requirement of a nicotine patch. RPN Ferguson told Renee she would provide her with a nicotine patch as soon as she had finished her current medication administration. Renee returned to sit in the lounge in front of the television. I continued with ward round.*

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18 Victoria Police Brief of Evidence page 168.
19 Victoria Police Brief of Evidence page 175.
20 Victoria Police Brief of Evidence page 177 - 180.

*"This was at 0940 [9.40am]. At this time I was approached by RPN Mary Ferguson enquiring as to Renee's location. Nurse Mary Ferguson had a nicotine patch for her but could not sight Renee."*[21]

29. However, it was Ms Walker and not Ms Ferguson who signed for a nicotine patch at 9.45am on 1 June 2010. It was unclear why Ms Walker would sign for a nicotine patch she claims was to be administered by Nurse Ferguson and why if she knew Ms Treen had been last sighted on the unit at 9.15am, she would sign to administer a nicotine patch after that time.

30. Given Ms Walker stated she was not responsible for the sight observations, but was the nurse allocated for Dr Browne's ward round, there was no record of the nurse allocated to complete the sight observations as having done so. The Nursing Level Category Observation form's last three entries were recorded as completed by Ms Walker and an untimed entry of *'AWOL'*. There was no record of sighting at 9.00am, which was required given Ms Treen was on hourly sight observations.

Response to incident of absconding on 1 June 2010

31. The enacting of the IWMHS *Absence of Inpatients* policy and time of notification to Victoria Police of Ms Treen's having absconded again had implications in this case, because at 10.55am, Victoria Police were notified of Ms Treen behaving oddly at the Bulla Road overpass and at the DFO by a passerby. It was also at that time Ms Walker notified Carlton Police that Ms Treen had absconded from the John Cade Unit.

32. Ms Walker informed consultant psychiatrist Dr Browne at 9.50am that Ms Treen was last sighted at 9.20am and after searching the building and grounds, Victoria Police were notified at 10.55am. Although it is not uncommon to wait for a period of time before enacting the IWMHS *Absence of Inpatients* policy, especially as the staff and Dr Browne appear to have thought Ms Treen had left for a cigarette, nonetheless based on the timeline, it was 1.35 hours between Ms Treen disappearing and enacting the IWMHS *Absence of Inpatients* policy. Even if the staff believed Ms Treen had initially left the unit for a cigarette, it was unlikely to have taken that long. Ms Walker stated she was directed by Dr Browne to commence the IWMHS *Absence of Inpatients* process at the completion of the ward round. This appeared to have occurred at 10.40am. In her statement, Dr Browne states:

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21 Victoria Police Brief of Evidence page 87.

*"On being informed that she had absconded a second time within 2 days, I decided that she should be placed in HDU when she returned and to be reviewed by myself."*[22]

33. There was no record of Dr Browne's orders in the health record and according to Ms Walker, Dr Browne directed she delay enacting the IWMHS *Absence of Inpatients* policy for nearly an hour after she was informed of Ms Treen's disappearance and approximately 1.35hrs after Ms Treen had been last sighted on the unit. The implications of an increased risk to Ms Treen from a second absconding episode in 2 days were recognised by Dr Browne, but it did not translate to a congruent response.

34. The *Absence of Inpatients* in the Policy and Procedure Manual was undated and it was unclear if the escalation plan referred to in the Policy and Procedure Manual was recorded in the health record.[23]

Patient access to the inpatient unit after hours

35. Ms Treen told Drs Kochar and Puspanathan, her mother Mrs Karen Treen and nursing staff that she had returned to the unit on the evening of 31 May 2010 but the doors were locked. Mr Jeremy Edwards, with whom Ms Treen had met that evening stated he returned Ms Treen to the lifts in the Royal Melbourne Hospital at 8.30pm. Dr Browne stated the doors are locked at 11.00pm, which indicated that it took Ms Treen 2.5 hours to return to the John Cade Unit or the doors were locked much earlier than 11.00pm. In addition, the North Western Mental Health Director of Operations Peter Kelly's statement dated 11 August 2011stated the LDU was locked between 8.00pm and 8.00am.[24]

Monitoring of leave

36. Ms Treen was not on approved leave at the time of her death and information suggested the leave policy that contributed to the unit's approach to monitoring of patients who are on the LDU, was not implemented appropriately in the inpatient unit. A review of the health records did not contain any specific record of the leave taken by Ms Treen, whether it complied with the MHA21 form's directions or that nursing staff were aware of the amount of leave Ms Treen was taking for cigarettes. For example, the Progress note by Nurse Cate Groudsky on 30 May 2010 states:

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22 Victoria Police Brief of Evidence page 92.
23 Victoria Police Brief of Evidence page 175.
24 Additional statement sought by Coroner Hendlass and in the Brief of Evidence folder.

*"spending ++ time off ward smoking, does return."*[25]

37. In addition, Mr Jeremy Edwards stated Ms Treen had spoken to the nursing staff on the night of 31 May 2010 and approval was given for her to have dinner with him. This was not the leave outlined on the MHA21 or in the health record as approved leave outlined in section 1.3 of the review. It was unclear to what degree the nursing staff had discretion of approving leave as an authorised psychiatrist's delegate using the MHA21as the authoring documents and North Western Mental Health have not provided documentation suggestive of a leave register found on many inpatient units. It was apparent that proximate to her death, Ms Treen was utilizing and having approved leave she did not have formal approval for under the *Mental Health Act 1986* (Vic) if the MHA21 were considered current.

**Inquest**

38. There were a number of witnesses who gave evidence at inquest and ultimately I focussed on the following areas:

- Discharge of the Community Treatment Order (CTO) by consultant psychiatrist Dr Louise Dawson in the community without personally reviewing Ms Treen
- The implementation, monitoring and recording of nursing visual observations
- The implementation, monitoring and recording of approved leave from JCU
- Cancellation of approved leave and assessment of risk on 31 May 2010
- Nicotine withdrawal assessment and management
- Access to RMH and JCU after 9.00pm

<u>Discharge of the Community Treatment Order (CTO) by consultant psychiatrist Dr Louise Dawson in the community without personally reviewing Ms Treen</u>

39. The Office of Chief Psychiatrist document, *Community Treatment Orders, Chief Psychiatrist Guidelines, November 2005*[26] states:

> *The monitoring psychiatrist must therefore remain mindful of their responsibility to continue to review the need for the community treatment order. They need not personally examine the person prior to discharging the community treatment order,*

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25 IWMHS Health record Progress Note MR/45, dated 30 May 2010.

26 Victorian Government, Department of Human Services, Office of Chief Psychiatrist 2005. *Community Treatment Orders, Chief Psychiatrist Guidelines, November 2005*, also available at: <www.health.vic.gov.au/mentalhealth>

*and in practice would often rely on information conveyed by the case manager and the supervisor medical practitioner.*[27]

40. In addition, it documents the requirement for the monitoring psychiatrist to personally review the patient as:

> *[the monitoring psychiatrist] aim to personally examine the person on the community treatment order at least three months, or as otherwise indicated,*
>
> *[the monitoring psychiatrist] regularly consider whether or not the criteria in S.8 still apply to the person and immediately discharge the person if these criteria are no longer fulfilled.*[28]

41. A review of the medical records confirmed that the case manager/psychologist Ms Ebony Collins and Dr Bailey, psychiatry Honorary Medical Officer (HMO) and psychiatric registrars did review Ms Treen frequently and comprehensively documented her mental state, risk assessment, the outcomes and plans for treatment.

42. The record of the clinical discussion that was noted by Dr Bailey in the medical record on 14 April 2010 reveals that Ms Treen was found passed out in the driveway at Rocket, and she had not collected her medication pack *for a while* suggesting she was already non compliant with treatment when the decision was made to discharge the CTO. It appears Dr Dawson was part of the clinical review meeting and the team made the decision to discharge the CTO, however Ms Treen had improved overall during her admission to Rocket and it remained reasonable to remove the CTO and continue monitoring her mental state, which is what the service did. Ms Treen did no longer came within the *Mental Health Act 1986* (Vic) because she had improved overall and was engaged in therapy. It could not have been predicted Ms Treen would have deteriorated so rapidly without the CTO and in line with least restrictive care, so it was appropriate for her to have the opportunity to engage in treatment as a voluntary patient. Dr Dawson appeared to have complied with the requirements of the *Mental Health Act 1986* (Vic) and the guidelines provided by the Office of Chief Psychiatrist.

<u>The implementation, monitoring and recording of nursing visual observations</u>

43. It remained unclear which nurse was responsible for the hourly visual sightings of Ms Treen after 8.00am on 1 June 2010, because Ms Walker was coordinating the ward round and there

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27 Ibid page 36.
28 Ibid, page 18.

was no record of the 9.00am sighting.[29] The only record was by Ms Walker when Ms Treen requested NRT at 9.15am. This suggested that the system for negotiating a change of nurse responsibility for completing sightings on allocated patients while the nurse coordinates a ward round was either ineffective or not implemented appropriately.

The Implementation, Monitoring and Recording of Approved Leave from JCU

Conditions of Approved Leave

44. The *Mental Health Act 1986* (Vic) and guidelines by the Office of Chief Psychiatrist[30], identify the responsibilities of staff in approving and monitoring leave. The statements of staff suggested the allocation, monitoring, and recording of leave concerning Ms Treen was inadequate. There were clear differences between the written orders on the *MHA 21 Leave – Involuntary patient* form[31], dated as effective between 28 May 2010 – 28 June 2010, completed by consultant psychiatrist Dr Leit-Chin Seiw, and the progress note entry made by Dr Puspanathan on the same day, however both were clearly for the sole purpose of Ms Treen having a cigarette.[32] The *Mental Health Act* 1986 (Vic) requires that a copy of the completed form with the conditions of leave is provided to the patient. Neither document identified or specified any geographical boundaries or locations regarding where Ms Treen could go to have a cigarette, but both recorded the requirements for Ms Treen to inform staff and adhere to the conditions of number and duration of leave occasions.

Monitoring of Leave

45. JCU relied on staff members being in the reception area and/or staff base to monitor who came and went from the unit when the doors were open between the hours of 8am and 9pm.[33] Dr Browne stated the unit was very busy and there are times when there is no one in these areas.[34] Ms Treen was able to leave the unit on 1 June 2010 without being noticed or if she was noticed, it was not recorded by anyone. This suggested the current system of relying on staff being present in the staff base and/or reception area to notice and intervene with patients without approved leave who are attempting to leave the LDU was inadequate.

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29 Inquest transcript pages 110 – 111; 194 – 196.
30 Office of Chief Psychiatrist 2009. Inpatient Leave of Absence, accessed at: <http://www.health.vic.gov.au/mentalhealth/cpg/index.htm>
31 IWAMHS Health record original Legal Papers section.
32 IWAMHS Health record.
33 Inquest transcript pages 246 - 252.
34 Inquest transcript pages 75 – 76.

Leave Conditions and Approval

46. There was no doubt the allocation of leave under the *Mental Health Act* (Vic) was the responsibility of the authorized psychiatrist, or delegate:

> *The authorized psychiatrist may allow an involuntary patient to be absent from the approved mental health service in which the involuntary patient is detained –*
>
> *(a) for such period; and*
>
> *(b) subject to any conditions - that the authorized psychiatrist considers appropriate.*[35,36]

47. It was also clear that nursing staff were responsible for implementing and monitoring patient compliance with the conditions of approved leave at JCU.[37] It was also clear the nursing staff did not have the capacity to change the conditions of the approved leave under the *Mental Health Act 1986* (Vic) without the consultant psychiatrist's approval.[38]

48. Witnesses at inquest referred to approved leave for Ms Treen as *hospital ground leave*[39] so she could have a cigarette, however, the Royal Melbourne Hospital[40] is smoke free in line with the Victorian Government smoke free policy for public hospitals, and supported by the Office of Chief Psychiatrist[41]. Mr Peter Kelly stated that the site is smoke free and patients have to go to the street at the front of RMH to have a cigarette.[42]

49. An authorised psychiatrist or delegate does have complete discretion under the *Mental Health Act 1986* (Vic) to approve and revoke leave but this brings with it the responsibility of ensuring the leave is appropriately implemented and monitored. Neither the *MHA 21 Leave – Involuntary patient* form or the progress entry by Dr Puspanathan, contain any reference to Ms Treen being required to remain on hospital ground to have a cigarette. It appeared the additional conditions (going onto the street, remaining on hospital grounds) were not recorded on the *MHA 21 Leave – Involuntary patient* form but were implemented by nursing staff with the knowledge of the approving psychiatrist and psychiatry registrar.[43] In addition, the period

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35 Mental Health Act 1986 (Vic) Section 40, page 90.
36 Inquest transcript page 267.
37 Inquest transcript pages 194 – 197.
38 Inquest transcript page 232.
39 Inquest transcript page 85, 86, 194, 231.
40 <http://www.rmh.mh.org.au/>
41 Office of Chief Psychiatrist 2012. Providing a smoke-free environment in public mental health inpatient and residential units accessed at: <http://www.health.vic.gov.au/mentalhealth/cpg/index.htm>
42 Inquest transcript page 255.
43 Inquest transcript pages 89, 90 - 91, 93, 108-109, 194 – 197.

of approved leave was for one month, and it was not clear if this long-range approval of leave and conditions was in line with the of Chief Psychiatrist's *Inpatient Leave of Absence guidelines.*[44]

50. According to witnesses,[45] Ms Treen did not have permission on 30 May 2010 to leave hospital grounds to have dinner with Mr Edwards, although it remains unclear if nursing staff were aware of this in advance.[46] Witnesses also agreed that it was a frequent event for patients to change their leave[47], providing reasons why patients cannot comply with the time conditions of the approved leave (distance, complexity of route, going to the cafeteria).[48] There was also evidence of vague recording and monitoring of leave, and communication between disciplines of individual patient compliance.[49]

51. Drs Browne, Kochar and Puspanathan, and nursing staff provided their thoughts on why they believed patients breached the conditions of their leave at JCU, suggesting a culture of tolerance to breaches of the conditions of approved leave. The *MHA 21 Leave – Involuntary patient* form was used to document and communicate the conditions of approved leave to a patient and the staff who would be implementing and monitoring it. It was reasonable to expect the conditions of approved leave were practical, current, implementable, consistently communicated and in a form and language, that makes sense to the patient and staff.

52. The implications of increased risk for Ms Treen having absconded a second time in two days was recognised by staff, yet did not translate to a congruent response.[50] It was approximately 1.35 hours between Ms Treen disappearing and Ms Walker contacting Victoria Police. There remained some conflict in the witness statements regarding how the delay occurred[51] on 1 June 2010, of JCU reporting Ms Treen as having absconded to Victoria Police. It was apparent that the timeliness of notification to Victoria Police increased the possibility of intervention prior to the incident involving Ms Treen at 11.05am.

53. The lack of responsiveness appeared to be influenced by inadequate monitoring, conflicting, incomplete or poorly communicated approved leave conditions, and a culture of

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44 Office of Chief Psychiatrist 2009. Inpatient Leave of Absence, accessed at: <http://www.health.vic.gov.au/mentalhealth/cpg/index.htm>

45 Inquest transcript pages 87, 220.

46 Inquest transcript pages 87, 146.

47 Inquest transcript pages 106,195, 196.

48 Inquest transcript pages 106, 206, 194, 231 - 232.

49 Inquest transcript pages 32, 76 – 77, 88, 109 – 110, 207 – 208, 227 - 228.

50 Victoria Police Brief of Evidence page 92.

51 Inquest transcript pages 18, 19, 20, and 26, 105 – 107, 211 – 212.

interdisciplinary rationalising of breaches of approved leave. The *Absence of Inpatients* Policy was appropriate but its implementation was inadequate.

Cancellation of approved leave and assessment of risk

54. Dr Kochar cancelled Ms Treen's leave on 31 May 2010, believing it a *sufficient measure to address an apparent impulsive absconding in a patient who had been improving overall and showed no acute signs of deterioration.*[52] Drs Kochar and Puspanathan did not change any other treatment orders, including Ms Treen remaining in the LDU, acknowledging the legitimate concerns regarding confining Ms Treen to the HDU. This suggested they believed she was unlikely to act on impulse again and Ms Treen remained in the unlocked unit for 24 hours on hourly visual sightings and the notes suggest, did settle.

55. The assessment of risk was complex and subjective and the cancellation of leave and assessment of risk was discussed with Dr Browne, however, it is not clear why the frequency of visual observations was not increased until, when practicable, Ms Treen was reviewed by the consultant psychiatrist.[53] Ms Treen's return to JCU following implementation of IWMHS *Absence of Inpatients* policy and her expression of remorse appears to have held greater weight than her impulsivity and poor judgement in the 24 hours prior to her return.[54] There is nothing to suggest the cancellation of leave for the purpose of smoking cigarettes was in any way punitive.

Nicotine withdrawal management

56. Ms Treen had been prescribed and administered NRT during her initial stay when she was not allowed leave to have a cigarette. The last recorded administration of NRT was 11.10am on 27 May 2010, after which time she had approved leave. There was no evidence Ms Treen had been offered NRT until she requested it at 9.15am on 1 June 2010. The medical records and witness statements supported the proposition that having a cigarette for patients addicted to nicotine had a calming effect and Ms Treen became distressed when she could not have a cigarette.[55]

57. Tobacco (nicotine) withdrawal is a clinically recognised and coded disorder. The World Health Organisation International Classification of Disease[56] (ICD-10) code is for a tobacco

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52 Inquest transcript page 189.
53 Inquest transcript page 233, 235.
54 IWAMHS Health record.
55 Inquest transcript pages 17 – 18, 93, 102, 193, 206.
56 World Health Organization 2004. International Statistical Classification of Diseases and Health Related Problems.

withdrawal state [F17.3] and the Diagnostic and Statistical Manual of Mental Health Disorders (DSM) states the withdrawal symptoms *cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.*[57] Nicotine withdrawal consists of the presence of cravings to smoke plus four or more additional symptoms such as anxiety restlessness, difficulty concentrating, frustration or anger, increased appetite, insomnia, irritability, dysphoric mood, and decreased heart rate. In addition, other symptoms experienced can include mouth ulceration, increased cough, malaise or weakness and constipation.[58,59,60]

58. There was nothing to suggest that staff of any discipline assessed the impact of the withdrawal from nicotine since the cancellation of the cigarette leave was made on 30 May 2010. The impact of not being able to have a cigarette and the management of any withdrawal on Ms Treen's mental state did not appear to have been considered, assessed or managed.

Access to JCH and RMH after 9.00pm

59. Mr Kelly provided evidence of the boards placed around the RMH campus directing people through the emergency department once the doors close each evening. There was however, no evidence that the effectiveness of this approach had been evaluated.

60. The photos of the front entrance of JCU entry doors which are locked at 9.00pm revealed a staff swipe card point and a small intercom, however there was nothing identifying it as an intercom to staff, when it can be used, and by whom.

**Finding**

I find that Ms Treen unfortunately died from multiple injuries sustained from jumping off the Bulla Road overpass onto the Tullamarine Freeway and in the circumstances set out in this finding.

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57 American Psychiatric Association. Diagnostic and statistical manual of mental health disorders. 5th ed. Washington DC: American Psychiatric Association; 2013.

58 Department of Health, Western Australia. Clinical guidelines and procedures for the management of nicotine dependent inpatients. Perth: Smoke Free WA Health Working Party, Health Networks Branch, Department of Health, Western Australia; 2011.

59 NSW Health, 2009. Smoke-Free Mental Health Facilities in NSW - Guidance for Implementing. NSW Department of Health.

60 Zwar N, Richmond R, Borland R, Peters M, Litt J, Bell J, Caldwell B, Ferretter I, 2012. Supporting smoking cessation: a guide for health professionals. Melbourne: The Royal Australian College of General Practitioners.

## Comments

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

The least restrictive approach to the delivery of mental health care in Victoria is a real and admirable focus for public mental health services and is in line with world wide moves to a recovery and self determining model of care. However, for very practicable and rational reasons the JCU is locked at 9.00pm each day and the leave of an individual patient, regardless of status, is restricted. This demonstrates JCU recognises its responsibilities regarding the safety and security of patients and staff.

Mr Kelly provided information of improvements to the JCU since the death of Ms Treen and this work is commendable, particularly the gender sensitivity project which will improve the safety of women in the unit. A major part of this is the installation of lockable doors in a corridor in the unit and women patients will reportedly have a wristband that will allow them to enter and leave this area at will. This is an excellent example of the use of technology to enable patients to enter a safe and secure place with restriction but according to allocated access. This example highlights the opportunities for services to have alternatives to locked doors in low dependency units, whilst maintaining unrestricted access when appropriate in the spirit of the *Mental Health Act 1986 (Vic).*

## Recommendations

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

1. To increase the safety of patients, the John Cade Unit should undertake an evaluation of the current system for the allocation and implementation of visual sightings in the low dependency unit. The evaluation should include an assessment of risk associated with a contact nurse with responsibility for coordinating the ward round having to negotiate and re-allocate responsibility for the visual sighting of their allocated patients to staff members.

2. To increase the safety of patients in the low dependency unit, the John Cade Unit should undertake an evaluation of all aspects of approved leave under *Mental Health Act 1986* (Vic), including approval, monitoring and recording. The scope of the evaluation is to include the effectiveness of the reliance of staff being available in the reception area and/or staff base to monitor compliance.

3. The John Cade Unit should review the appropriateness of maintaining minimal frequency of nursing visual observations of a patient who is an involuntary patient under the *Mental Health Act* 1986 (Vic) and who has absconded from and returned to the unit in any previous

24 hours and remains in the low dependency unit until when practicable, is reviewed by a consultant psychiatrist.

4. To improve the safety of patients who are involuntary under the *Mental Health Act 1986* (Vic) and who are tobacco dependent and who do have approved leave, the John Cade Unit should:

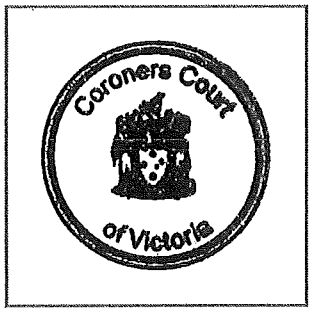
    - Review the available body of evidence-based guidelines regarding withdrawal from tobacco, including best practice in the assessment, prevention, and management of withdrawal symptoms.
    - Undertake a programme of education with the medical and nursing staff that addresses not only the administration of the rules of a smoke free environment, including staff and patient safety, but best practice in the assessment, prevention, and management of withdrawal symptoms from nicotine as a substance of addiction and prevent or manage the symptoms.

5. To improve out of hours access for patients, the John Cade Unit should install and ensure adequate signage proximate to the intercom at the front doors to the unit with sufficient information to guide patients who return after 9.00pm on both how to use it and how to contact staff.

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

The Family of Renee Treen
Senior Constable Robert Goodman, Investigating Member, Victoria Police
Dr Louise Dawson, North Western Mental Health
Dr Veronique Brown, Royal Melbourne Hospital
Caz Healy, CEO Doutta Galla Community Health, PO box 39, Moonee Ponds
Peter Kelly, North Western Mental Health
Fiona Landgren, VNSHS, Suite 8, 150 Chestnut Street, Cremome

Signature:




HEATHER SPOONER
CORONER
Date: 29 January 2014