IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 0418

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: WARREN GUNERATNE

Hearing Dates:	4 February 2011 and 21 September 2011
Appearances:	Mr John Bushby of Counsel – Donaldson Trumble Lawyers on behalf of the North Western Mental Health Service
	Mr Paul Halley of Counsel –Adviceline Injury Lawyers on behalf of the Guneratne family.
Police Coronial Support Unit:	Senior Constable Greig McFarlane - Assisting the Coroner
Findings of:	AUDREY JAMIESON, CORONER
Distributed on:	7 October 2014

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

I, AUDREY JAMIESON, Coroner having investigated the death of **WARREN GUNERATNE**

AND having held an Inquest in relation to this death on 4 February 2011 and 21 September 2011

at the Coroner's Court of Victoria sitting at MELBOURNE

find that the identity of the deceased was **WARREN GUNERATNE**

born on 19 July 1982

and the death occurred on 28 January 2008

at the West Gate Bridge, Port Melbourne, Victoria 3207

from:

1(a) CONSISTENT WITH DROWNING IN A MAN WITH MULTIPLE INJURIES

in the following summary of circumstances:

1. On 4 February 2011, a mandatory Inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic) (the Act) began into the death of Mr Warren Guneratne;[2] because immediately before his death, Warren was "a person placed in....care" as it is defined in section 3 of the Act. Prior to his death, Warren was a patient in an approved mental health service within the meaning of the *Mental Health Act 1986.*

2. On 27 January 2008, Warren was admitted as an involuntary patient to the psychiatric unit of the Royal Melbourne Hospital (RMH). On 28 January 2008, Warren walked out of the unit prior to discharge, and attended his home where he collected his car and drove to the West Gate Bridge. Once on the bridge, he crashed his car into the left hand barrier on the westbound side of the bridge, and exited his car. He climbed up on the barrier and jumped from the bridge. Police attended and located Warren in the water on the eastern side

[2] Mr Guneratne's family requested that he be referred to as "Warren" during the course of the Inquest. For consistency, I have, in most part, avoided formality and also referred to him only as Warren throughout the Finding.

embankment. Resuscitation measures were implemented, however, Warren died from his injuries at the scene.

BACKGROUND CIRCUMSTANCES:

3. Warren was born on 19 July 1982. He was 25 years old at the time of his death. He lived with his mother and step-father in Glenroy. He was employed part time in the security industry.

4. In 1999, Warren was diagnosed with paranoid schizophrenia. His symptoms included suicidal ideation, homicidal urges towards his step-father, auditory hallucinations, and paranoid and delusional beliefs. His symptoms were complicated by illicit drug use, mainly cannabis. Between November and December 1999, he had two hospital admissions in quick succession, after which he received intensive outpatient treatment at the Early Psychosis Prevention and Intervention Centre (EPPIC).[3] His symptoms persisted for approximately one year. After trialling a number of medications, he was prescribed Clozapine[4] which treated his symptoms to good effect. Following 18 months of management by EPPIC, he was referred to the Broadmeadows Continuing Care Team where he was case managed for three years until December 2004 when his care was transferred to private Psychiatrist, Dr Chris Pantelis. During 2007, Warren suffered a relapse of his symptoms resulting in two contacts with the North West Crisis Assessment Treatment Team (CATT). His relapse developed in the context of ceasing Clozapine and commencing Amisulpride (Solian)[5] and his increasing use of cannabis, amphetamines and alcohol. He was prescribed antidepressants during the time, and was encouraged to comply with his medication regime which was erratic at times due to his substance abuse.

SURROUNDING CIRCUMSTANCES:

5. On 27 January 2008, Warren arrived at his home at approximately 4.00pm. Warren reported to his mother, Mrs Jennifer Guneratne, that he had been assaulted the previous day. He told her that he had received blows to the head and now had blurred vision. Mrs Guneratne observed a blood clot on the back of Warren's head. Warren was teary during this

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[3] EPPIC is an integrated mental health service aimed at addressing the needs of people aged 15-24 with emerging psychotic disorders in the western and north-western regions of Melbourne. It is a specialist clinical program of Orygen Youth Health, which is a component service of NorthWestern Mental Health and Melbourne Health.

[4] Clozapine is an atypical antipsychotic medication used in the treatment of schizophrenia.

[5] Amisulpride is an antipsychotic drug used in the treatment of schizophrenia.

conversation and told his mother that he had not taken his antidepressant medication for two or three days. Mrs Guneratne advised Warren to lie down and rest. Some time later, Mrs Guneratne gave Warren 10mg of Valium. This had good effect on Warren, and he seemed to relax. Warren asked his mother to contact Dr Pantelis. Mrs Guneratne was not able to contact Dr Pantelis, so Warren asked her to contact the CATT. Mrs Guneratne arranged for the North West CATT to attend. Soon after, Warren said he no longer needed the CATT, and just wanted sleeping tablets to help him sleep. Mrs Guneratne did not cancel the CATT as she felt they could help Warren. At approximately 8.00pm, two members of the North West CATT, Clinical Psychologist, Mr Damian Hardwick and Registered Psychiatric Nurse (RPN) Kok Lim, attended at Warren's house. They noted that Warren presented with paranoid and persecutory ideation, in that he believed that people were talking about him and he was being watched; suicidal ideation with plan and intent; and auditory and visual hallucinations. Further, he presented as euthymic[6] in mood, but labile[7] in affect, ranging from agitated and irritable to anxious and distressed, and depressed and teary. Warren reported that he had not slept for three days. During the assessment, Warren reported that he had been taking his antipsychotic medication, but not his antidepressant medication. He also reported that he had consumed methylamphetamines (ice) and cannabis over the previous two days. He also told them of the assault which occurred the previous day.[8]

6. Mr Hardwick and RPN Lim formed the view that Warren needed to be immediately admitted to hospital. They formed this view primarily because of his suicidal ideation, with plan and intent which he refused to divulge, his labile mood, and his ambivalence about ceasing illicit drug use. They were also of the opinion that he needed to be medically assessed regarding his head injury. Enhancing his risk level was the fact that Warren was a male in his mid-twenties, which is a known risk factor.[9] Mr Hardwick contacted the Metropolitan Ambulance Service to arrange transport to the closest Emergency Department (ED), which was the RMH. RPN Lim also contacted the RMH Enhanced Crisis Assessment and Treatment Team (ECATT) to discuss Warren's mental state and level of risk prior to his arrival at the ED. Warren was agreeable to the plan to admit him to the ED and he was transported to the RMH without incident.

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[6] Euthymic is a normal mood, in which the range of emotions is neither depressed nor highly elevated.

[7] Labile means a marked fluctuation of mood.

[8] Statement of Mr Damian Hardwick, dated 7 July 2010.

[9] Statement of Mr Damian Hardwick, dated 7 July 2010.

7. At approximately 10.26pm, Warren arrived at the ED of the RMH. Prior to Warren being assessed, the North West CATT members provided the ECATT member on duty, RPN Laura Harris, with a written and verbal handover of Warren's mental state. The written handover of their assessment of Warren included that he was diagnosed with paranoid schizophrenia, had suicidal thoughts, wanted to assault his mother's partner, and was hearing voices telling him to hurt himself, although he denied any intent to act on this. It stated that he had not taken his antidepressant medication for three days. It also stated that he had used 'ice' for the first time two days previously. Although, not in the written handover, RPN Harris recalls being made aware that Warren was labile in mood, was having paranoid ideation and sleep disturbance. She was also made aware that he had expressed suicidal ideation with a plan, however, he was not willing to discuss the plan but had alluded to cutting his throat; he had been using cannabis daily; and was the recent victim of an assault and was experiencing recurring headaches.[10]

8. On 28 January 2008 at 2.00am, Warren was assessed by RPN Harris. At this time, Warren presented as settled and cooperative, with no signs of distress, agitation or anxiety. He denied paranoid ideation, hallucinations or homicidal thoughts. He denied suicidal ideation, plans or intent. He reported that he had asked his mother to contact the CATT because he was coming off drugs and felt like he was becoming unwell. He displayed insight and recognised that illicit drug use contributed to the deterioration of his mental state. He stated that his daily cannabis use was not good for him and affected his thoughts. He reported that he felt calm and was unable to explain why he had presented differently to the CATT, but it may have been due to the dose of Valium that his mother gave him. Warren believed that he needed help and was agreeable to admission into hospital.[11]

9. As a result of the assessment, RPN Harris formed the view that Warren met the criteria for admission as an involuntary patient under s12AA *Mental Health Act 1986*.[12] She did this because of his previous presentation of labile mood and suicidal thoughts, and her concern that his current presentation may change. RPN Harris was of the opinion that he was settled

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[10] Exhibit 2 – Statement of RPN Laura Harris, dated 27 April 2008.

[11] Exhibit 2 – Statement of RPN Laura Harris, dated 27 April 2008.

[12] Exhibit 2 – Statement of RPN Laura Harris, dated 27 April 2008 and Clinical Progress Sheet of RPN Laura Harris, dated 28 January 2008

enough for admission into a Low Dependency Unit[13] (LDU), and made enquires of the Broadmeadows Adult Acute Inpatient Unit (BIPU), where Warren had previously been a patient. No beds were available at BIPU, so Warren was admitted into the LDU of the John Cade Unit of the RMH.[14]

10. RPN Harris consulted with the ED Medical Officer, Dr Aleya Begum, who signed the Recommendation order that Warren receive involuntary treatment, and wrote up the treatment chart. Dr Begum did not see Warren.

11. At approximately 3.40am, Warren was admitted into the John Cade Unit. RPN Harris gave staff on the ward a verbal handover, along with her notes. RPN Harris gave specific verbal advice that Warren could possibly change in presentation, and recommended that if this were to occur, he should be transferred to the High Dependency Unit[15] (HDU). At the time, there was one bed available in the HDU. Warren was observed hourly by nursing staff. It was expected that Warren would be reviewed by the Psychiatric Consultant later that morning.

12. When the morning shift commenced at 7.00am, a verbal handover took place from the night shift staff to the morning shift staff. Morning shift leader, RPN Wayne Mackey, was informed that Warren had been referred to North West CATT on 26 January 2008 with symptoms of anxiety, persecutory delusions and paranoia; he had suicidal ideation, and had used 'ice' on 25 January 2008. RPN Mackey was further informed that Warren's presentation had changed prior to his admission on the ward and he now denied suicidal and paranoid ideations, had shown insight into his illicit drug use, was agreeable to admission and was settled enough for LDU admission. His overall risk was assessed as low.[16] Warren was placed under 15 minute observations from 7.00am.

13. At approximately 7.30am, Warren approached RPN Melanie Wiltshire and asked her when he would be seen by a doctor. RPN Wilshire told Warren that the doctor had not yet arrived on the ward, but he would be seen as soon as possible. RPN Wiltshire then observed that

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[13] The LDU is an unsecured ward.

[14] Exhibit 2 – Statement of RPN Laura Harris, dated 27 April 2008 and Clinical Progress Sheet of RPN Laura Harris, dated 28 January 2008

[15] The HDU is a secure ward.

[16] Exhibit 4 – Statement of RPN Wayne John Mackey, dated 12 February 2009.

Warren was in possession of a mobile phone with a camera, which was against ward policy. He was asked to hand over the phone, but he declined.[17] At approximately 7.50am, Warren approached RPN Mackey and asked him if he could use the ward telephone to call his mother. RPN Mackey was busy and asked Warren to wait a moment. Warren became agitated at having to wait, and asked when he would see seen by a doctor as he wanted his medication. RPN Mackey told Warren that the doctor would be on the ward within half an hour, and he would get his medications after that. This seemed to settle Warren. RPN Mackey was approached soon after by RPN Wiltshire and advised that Warren was in possession of a mobile phone with a camera. RPN Mackey explained to Warren that due to privacy issues, he was not permitted to have a phone on the ward. Warren accepted this and handed his phone over. Warren then requested the phone back so that he could note down some numbers stored on the phone. This request was granted and he was given a pen and paper and shown to the phone room at approximately 8.00am so that he could phone his mother. At this time, Warren showed no signs of distress.[18]

14. At approximately 7.45am, Psychiatric Consultant, Associate Professor (A/Prof) John Fielding, arrived on the ward to review new admissions and conduct statutory reviews. A/Prof Fielding was informed by RPN Mackey that Warren was a new admission, and wanted to see him in regards to going home. A/Prof Fielding was available to see Warren at approximately 8.00am, but at that time Warren was on the telephone to his mother. A/Prof Fielding did not want to interrupt Warren's telephone call, so he continued to see other patients with the view to seeing Warren in approximately one hour's time.[19]

15. At approximately 8.00am, Warren called his mother and asked her when she was coming to pick him up. During this call he was agitated and wanted to come home immediately. Mrs Guneratne tried to calm Warren down and told him that she would be there in 20 minutes. Warren asked her not to hang up, and while she was talking to him she realised that Warren had left the hospital and was getting into a taxi. Mrs Guneratne continued to speak to Warren on the telephone while he was in the taxi trying to calm him down.

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[17] Statement of RPN Melanie Wiltshire, dated 14 December 2009.

[18] Exhibit 4 – Statement of RPN Wayne John Mackey, dated 12 February 2009.

[19] Exhibit 6 – Statement of Associate Professor John Fielding, dated 20 May 2010.

16. Whilst on the ward, Warren had been observed every 15 minutes between 7.00am and 8.00am.[20] At the observation round at 8.15am, RPN Wiltshire noticed Warren missing and notified RPN Mackey.[21] A search of the vicinity was conducted by staff, but Warren could not be located.

17. At approximately 8.45am, Warren arrived at his home. Mrs Guneratne assumed that Warren had been discharged, so she was not alarmed by Warren returning home. Warren told her that the hospital had not given him his medication, so she gave him 400mg of Solian and 15mg of Valium. She told Warren to rest, and she lay with him and tried to keep him calm. Warren appeared calm, but he kept telling her that he wanted to go for a drive. Mrs Guneratne offered to go with him however, Warren hugged her and told her that he loved her, and got into his vehicle. At approximately 9.30am, Warren drove off in his vehicle. Mrs Guneratne rang him on his mobile phone, and he told her that he was going for a drive. Mrs Guneratne reports that Warren was calm during this call. Approximately 5 minutes later, she rang again, but Warren did not answer. Approximately 10 minutes later, she rang again and a young boy answered. He told her that he had found the mobile phone on Northumberland Road, Pascoe Vale.[22]

18. At approximately 10.00am, RPN Margaret DeBono called Mrs Guneratne and informed her that Warren had left the ward at around 8.15am. Mrs Guneratne advised her that Warren had arrived home and had left again. At approximately 10.15am, RPN DeBono contacted the Carlton Police and advised them that Warren had absconded.[23]

19. At approximately 10.20am, Warren was observed driving his vehicle in an erratic manner and at high speed in a westerly direction over the West Gate Bridge. Warren's vehicle then collided heavily with the railing on the left hand side of the bridge, causing the airbags to be deployed. Warren alighted his vehicle and walked to the middle of the bridge, before returning to the left hand side of the bridge. Witnesses at the scene tried to talk to Warren, but he did not speak to them. Warren climbed the left hand side railing, and jumped off the

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[20] John Cade Level 1 – nursing observations – contained in RMH medical records.

[21] Statement of RPN Melanie Wiltshire, dated 14 December 2009.

[22] Exhibit 1 – Statement of Jennifer Guneratne, dated 5 February 2008.

[23] Statement of RPN Margaret DeBono, dated 10 May 2009 – contained in RMH medical records.

bridge.[24] Police located Warren's body underneath the bridge floating in the river. Police entered the water and brought Warren to shore where they commenced cardiopulmonary resuscitation. Ambulance paramedics attended and continued cardiopulmonary resuscitation, however, Warren could not be resuscitated, and he was declared deceased at 10.36am.[25]

INQUEST

Jurisdiction

20. At the time of Warren's death, the *Coroners Act* 1985 (the Old Act) applied. From 1 November 2009, the *Coroners Act 2008* (Vic) (the Act) has applied to the finalisation of investigations into deaths that occurred prior to the new Act commencement.[26]

21. The Act commenced operation on 1 November 2009. Schedule 1, section 7 of the Act states "*Subject to clause 10, if the hearing of an Inquest has begun under the old Act and the Inquest is not completed before the commencement day, the old Act continues to apply on and from the commencement day to the Inquest*". Clause 10 does not apply to these circumstances.

22. In the preamble to the Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety are referred to in other sections of the Act.[27]

23. Section 67 of the Act describes the ambit of the Coroner's findings in relation to a death investigation. A Coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.[28] The

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[24] Statement of Graeme Kemp, dated 12 March 2008.

[25] Statement of Constable Corinne Lowry, dated 28 January 2008.

26 Section 119 and Schedule 1 - Coroners Act 2008.

27 See for example, sections 67(3) & 72 (1) & (2).

[28] Section 67(1).

'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

24. A Coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.[29] A Coroner may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death, which the Coroner has investigated including recommendations relating to public health and safety or the administration of justice.[30] A Coroner's role is also to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice.[31]

INVESTIGATION

Identity

25. The identity of Warren Guneratne was without dispute and required no additional investigation.

The medical investigation

26. On 30 January 2008, Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Warren, reviewed a post mortem CT Scan, and the Form 83 Victorian Police Report of Death. Anatomical findings included multiple rib fractures, a ruptured liver and bilateral small pleural effusions.[32] The post-mortem examination showed no evidence of any injuries that would have been immediately fatal in the motor vehicle accident. There was no evidence of any significant underlying natural diseases. Toxicological analysis of blood retrieved post mortem showed the presence of Citalopram,[33] Diazepam,[34] Amisulpride and cannabinoids.[35] Dr Bourke ascribed the cause of Warren's death as consistent with drowning in a man with multiple injuries.

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29 Section 67(3).

30 Section 72(1) & (2).

31 Coroners Act 2008 (Vic), Preamble and s 1.

32 Pleural effusion is excess fluid that accumulates in the pleural cavity, the fluid-filled space that surrounds the lungs. Excessive amounts of such fluid can impair breathing.

33 Citalopram is used in the treatment of depression.

34 Diazepam (Valium) is a sedative/hypnotic drug of the benzodiazepines class.

Inquest

Viva Voce evidence at Inquest

27. *Viva voce* evidence was obtained from the following witnesses at the Inquest:

- Jennifer Guneratne;
- Associate Professor John Fielding, Clinical Director of the Inner West Area Mental Health Service and authorised psychiatrist of the RMH;
- RPN Laura Harris, Registered Psychiatric Nurse;
- RPN Wayne John Mackey, Registered Psychiatric Nurse; and
- Dr Aleya Begum, Medical Officer at the Royal Melbourne Hospital.

Submissions

28. At the conclusion of the Inquest, Counsels appearing on behalf of Interested Parties and the Coroner's Assistant provided final submissions, which I have considered for the purposes of this Finding.

Issues investigated at Inquest

29. A number of issues were examined in the course of the Inquest regarding Warren's contact with mental health services including but not limited to:

a. Warren's classification as a low dependency patient;

b. security arrangements at the low dependency unit;

c. the rationale for housing involuntary patients in an unlocked or open ward;

d. the frequency and effectiveness of observations/risk assessments;

e. communication and documentation;

f. the timeliness of psychiatric assessment;

g. the timeliness of reporting absconding patients to Police; and

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[35] Cannabis (marijuana) contains the main active psycho-active ingredients Delta 9-tetrahydrocannabinol and 11-OH-Delta 9-tetrahydrocannabinol. These are collectively known as cannabinoids.

h. safety barriers on the West Gate Bridge.

Warren's admission into the Royal Melbourne Hospital

(a) Warren's assessment by ECATT

30. On his admission to the RMH ED, RPN Harris engaged in a verbal handover with North West CATT, and was in possession of their notes. She was aware of his previous suicidal ideations.[36] RPN Harris gave evidence that when she assessed Warren several hours later, she undertook a risk assessment of Warren.[37] He denied his previous suicidal and homicidal ideation, he was planning for the future, was feeling settled and was agreeable about being admitted into hospital. RPN Harris was of the view that Warren required treatment, but due to his change in presentation at her assessment, he needed containment in the event that he reverted back to his previous mental state as assessed by the CATT. She formed the opinion that Warren should be made an involuntary patient,[38] and that in his present state, his risk level was low and therefore was suitable for admission into the LDU. [39] RPN Harris was aware that Warren had been given Diazepam by his mother, and that may have been responsible for his change in presentation, so she advised nursing staff at the John Cade Unit that there was a potential that Warren's presentation could change rapidly, and he should be placed in the HDU if this were to occur.[40] RPN Harris stated that nursing staff on the ward would have been able to assess any behavioural changes, and make the decision to admit him to HDU.[41] Although legislation requires that a patient be reviewed within 24 hours after admission as an involuntary patient,[42] RPN Harris anticipated that Warren would have been reviewed much sooner by the Psychiatric Consultant on the morning shift.[43]

31. RPN Harris' assessment of the labile nature of Warren's risk was correct and realised with adverse outcome. Her concern that Warren may need to be treated in HDU if his condition changed fell short of placing the LDU staff on high alert/flagging her actual concerns. I do

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[36] Transcript of evidence, p21.

[37] *Acute-Inpatient Clinical Risk Screening Assessment and Management* – contained in RMH Medical Records.

[38] Transcript of evidence, p21.

[39] Transcript of evidence, p21.

[40] Transcript of evidence, p23

[41] Transcript of evidence, p31.

[42] See s12AC *Mental Health Act 1986* (repealed).

[43] Transcript of evidence, p39.

not accept the submission made on behalf of the family that RPN Harris *made a mistake in not formulating that the admission should be HDU* but instead I find that she was entitled to formulate that the admission should be to the LDU with the articulated caveats based on her thorough assessment of Warren. She was also entitled to believe that Warren would be observed in a manner that reflected her assessment and was entitled to believe that Warren would receive a thorough psychiatric assessment in a timely manner. Her verbal handover *albeit* appropriate at the time failed however to stand the test of effective communication to the subsequent shift, staff members and medical staff.

32. Dr Begum gave evidence that although she did not assess or see Warren at all, she was confident in RPN Harris' assessment of Warren, so she signed the 'Recommendation for Person to Receive Involuntary Treatment from an Approved Mental Health Service' form ('involuntary treatment form').[44] She gave evidence that she signed the involuntary treatment order based on information provided to her by RPN Harris both verbally, and by the perusal of RPN Harris' notes of her assessment of Warren.[45] She did not sight the North West CATT assessment notes.[46] Dr Begum noted the facts communicated to her by RPN Harris on the involuntary treatment form. These were that Warren was: *'labile in mood, paranoid and persecutory ideation, auditory and visual hallucinations, suicidal ideation and plan, thoughts to harm his step father'*.[47] Dr Begum agreed in evidence that a patient with such a presentation probably should have been assessed as suitable to HDU,[48] however it was not her decision to make as to whether Warren was sent to the HDU or LDU, but rather she was guided by RPN Harris' recommendation.[49] She stated that, upon reflection, if she had seen Warren, her opinion would have changed, and she would have recommended him to be admitted to the HDU.[50]

33. A/Prof Fielding gave evidence that there was an expectation that Dr Begum would have consulted with Warren before signing the Involuntary Treatment Order, however, medical

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[44] Transcript of evidence, p44-45.

[45] Transcript of evidence, p47.

[46] Transcript of evidence, p44.

[47] 'Recommendation for Person to Receive Involuntary Treatment from an Approved Mental Health Service' form, dated 28 January 2008 – contained in RMH medical records.

[48] Transcript of evidence, p49.

[49] Transcript of evidence, p51.

[50] Transcript of evidence, p50.

officers on duty often do not have a great deal of experience in Psychiatry, and are guided by the advice of the ECATT Nurses who have significantly more experience.[51] A/Prof Fielding stated that although Dr Begum signed the order recommending Warren for involuntary treatment, it is not until it is actually affirmed by him, in his role as the Consultant Psychiatrist, that a person is truly recommended for involuntary treatment.[52]

(b) Warren's admission into the John Cade Unit

34. Upon Warren's admission into the John Cade Unit, notes were made at the verbal handover from RPN Harris to nursing staff. A member of the nursing staff completed the *'Summary of Presentation'* form ('the form'). RPN Mackey gave evidence that the form was written at handover and its purpose was for medical staff that came in "a couple of days later" to read in order for them to get an idea of the patient's presentation when they arrive in the unit.[53] The form described Warren's psychiatric history, his history of his medication and his current risks. Under the entry 'History of presenting complaint', it states: *"Referred to NWCATT by c/m after having concerns about pt's mental state. Anxious, labile, persecutory delusions, paranoid about people talking and watching him. AH + VH – friends talking about him. Suicidal ideation & plan. Used ice and tequila on Friday'.* [54] Further, under 'Risks', it states: *'current suicidal ideation with current plan but refused to state what it is'.*[55] It is not clear from the evidence whether RPN Mackey read these notes, but he stated that the incoming shift would not generally read them, but would have gone straight to the full written assessment made by RPN Harris.[56]

35. Once settled in the LDU, Warren was placed under 15 minute observations which is mandatory for patients who arrived via the ED, regardless of their risk assessment. However, when the unit is locked at night, observations are performed hourly.[57] Nursing notes made by night shift nursing staff in the John Cade Unit indicate that Warren was settled for the first few hours in the unit. An entry at 6.05am states, *'Warren has been awake*

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[51] Transcript of evidence, p93.

[52] Transcript of evidence, p93.

[53] Transcript of evidence, p78-79.

[54] *'Summary of Presentation'* – contained in RMH medical records.

[55] *'Summary of Presentation'* – contained in RMH medical records.

[56] Transcript of evidence, p79.

[57] Transcript of evidence, p59-60.

@ 0400 hours and on subsequent rounds. Pleasant. Polite. Counselled smoking in his room. Settled'.[58]

36. RPN Mackey gave evidence that the handover from the night shift to the morning shift took place between 7.00 and 7.30am. At the handover, he was given a verbal handover of every patient. During this handover, he was not made aware of the ECATT assessment,[59] RPN Harris' verbal handover[60] or Dr Begum's notation on the involuntary treatment form.[61] RPN Mackey admitted that he does not read a patient's full file when he starts his shift,[62] and he only knew that Warren had had suicidal thoughts, but did not know his suicide risk.[63] RPN Mackey stated that if Warren had been presenting as currently suicidal, he would have been assessed by RPN Harris for admission into HDU. He was content that RPN Harris' assessment of Warren was correct.[64] He was not made aware that RPN Harris advised that Warren was labile in mood and that he may need to be considered for admission to the HDU. RPN Mackey stated that if he was made aware of those risk factors, he would have spoken to Warren and assessed his mental state, and if he felt Warren was at any risk whatsoever, he would have put him in the HDU.[65]

(c) Warren's absconsion from the LDU on 28 January 2008

37. A/Prof Fielding gave evidence that he arrived on the ward at 7.45am. Once on the ward, he was given an overview by medical staff as to which patients he needed to see. A/Prof Fielding stated that he was not told that Warren was a high risk of suicide,[66] but he made the decision to see Warren as a matter of priority because he knew that Warren was anxious to see him, and was wanting to leave the ward.[67] When he was told that Warren was on the

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[58] *Total Care Progress Notes* – contained in RMH medical records.

[59] Transcript of evidence, p56.

[60] Transcript of evidence, p55.

[61] Transcript of evidence, p60.

[62] Transcript of evidence, p61.

[63] Transcript of evidence, p60.

[64] Transcript of evidence, p62.

[65] Transcript of evidence, p70.

[66] Transcript of evidence, p111.

[67] Transcript of evidence, p112.

phone, he made the decision not to disturb Warren, and to come and see him later, because he is of the opinion that it is beneficial to patients to be able to contact friends and family.[68]

38. RPN Mackey gave evidence that there was a ratio of 7 nurses to 26 patients on the ward on 28 January 2008. He stated it was quite a busy day, but at the time Warren was there, it was not busy.[69] The 15 minute observations continued, and he was last sighted at 8.00am in Room 14.[70] When Warren was noticed missing at the 8.15am round, staff followed the policy in place at the time for patients who have absconded. In his statement read into evidence, A/Prof Fielding gave an overview of the policy. He stated that in an overwhelming number of these cases, patients return of their own accord after leaving for a cigarette, going to the shop or returning home and it is for these reasons that a two hour window is given before staff contact the police. Immediate police notification about all patients who have left the ward for brief periods is generally not appreciated by patients or the police. The decision to inform police is based on clinical common sense, while considering the least restrictive management of patients, and the wish to engage patients in ongoing treatment. Where a patient is considered to be at considerable risk, then police are notified earlier.[71] A/Prof Fielding elaborated on this policy in his oral evidence to the court. He stated that it helps a patient if they come back on their own accord because it encourages their engagement with the service because they are not being treated like they are in jail.[72] RPN Mackey explained that because the majority of absconding patients go home, the policy at the time was to give the patient enough time to get home, and then call them to encourage them to come back to the ward, thereby avoiding police involvement.[73] At the time, RPN Mackey believed that Warren was a low risk patient, so he was given time to return of his own volition.[74] RPN Mackey stated that if he knew that Warren was at a high risk of suicide, he would have notified police immediately.[75]

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[68] Transcript of evidence, p115.

[69] Transcript of evidence, p62.

[70] John Cade Level 1 – nursing observations – contained in RMH medical records.

[71] Exhibit 6 – Statement of Associate Professor Fielding, dated 20 May 2010.

[72] Transcript of evidence, p120.

[73] Transcript of evidence, pp62-63.

[74] Transcript of evidence, p63.

[75] Transcript of evidence, p60.

Housing involuntary patients in LDU

39. The *Mental Health Act 1986* (repealed) required that people with mental disorders be given the best possible care and treatment in the *least restrictive environment.*[76] As a result, in hospital Psychiatric wards, it is standard practice to avoid admitting patients to locked wards where circumstances allow.[77] RPN Mackey gave evidence that the majority of the patients in the John Cade Unit are involuntary patients, with most housed in the LDU. He estimated on average that they would only have three to four voluntary patients, and the remainder would be involuntary patients.[78]

40. RPN Mackey is of the view that if a patient has been assessed properly, then there is no reason why involuntary patients cannot be admitted to the LDU.[79] He stated that he was authorised to transfer a patient from the LDU into the HDU, but not *vise versa*. If a patient's presentation changed, he would take charge of the patient and make a decision as to whether to transfer the patient into the HDU.[80] However, he stated that just because someone had suicidal ideation the previous day, it is not an indication that they should be placed in the HDU.[81]

41. A/Prof Fielding gave evidence that when patients are admitted into locked wards, they feel they are being punished rather than helped.[82] Medical staff must strike a balance between a patient's known risk factors, and the obligations under the *Mental Health Act 1986.*[83] The ultimate goal is to engage the patient and minimise risk through their ongoing treatment rather than locking people up.[84] A/Prof Fielding disagreed with the assertion that suicidal patients should be placed in a secure environment. He stated that with some patients, just the very fact that they are admitted to hospital and out of the stressful situation that caused their distress, is enough to settle a patient down.[85]

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[76] Section 4(2)(a) *Mental Health Act 1986* (repealed)

[77] Transcript of evidence, p94.

[78] Transcript of evidence, p57.

[79] Transcript of evidence, p57.

[80] Transcript of evidence, pp61-62.

[81] Transcript of evidence, p61.

[82] Transcript of evidence, p96.

[83] Transcript of evidence, p109.

[84] Transcript of evidence, p95.

[85] Transcript of evidence, pp96-97.

42. RPN Mackey gave evidence regarding the security arrangements of the John Cade Unit. The John Cade unit is staffed by approximately seven nurses. The HDU has 8 beds, with two entry doors into the ward, both of which are locked at all times. The LDU has 21 beds, and is an unlocked ward during the day. The two doors into the ward are locked automatically between the hours of 11.00pm and 6.00am, but remain unlocked at all other times. One door was adjacent to the Nurse's station, but due to it being a public holiday on 28 January 2008, there was no clerical staff on the desk that could have seen Warren leaving. At the time, there was a courtyard which had an unlocked gate and a fence approximately 1.5m high, so it was possible for patients to leave the unit via the courtyard.[86]

Improvements to the delivery of health services

43. I am satisfied that the Inner West Area Mental Health Service/RMH undertook a systems review after Warren's death, and in response to identified shortcomings have instituted a new policy regarding the absence of inpatients.[87] This policy addresses the procedure that must be followed by staff when a patient leaves the ward without permission. The procedure includes:

    a) A risk review be undertaken for all absent patients. This must be undertaken when it is noticed that a patient is missing, and must include a complete risk assessment to identify significant risks to the patient's wellbeing or the wellbeing of others.

    b) Following the determined level of risk, the Psychiatric Consultant is notified and an action plan must be instituted. The action plan must specify the level of response – low, medium or high.

    c) The Consultant Psychiatrist, in consultation with the shift leader, must decide on one of the following options:

        i. report the absence to police for the purposes of apprehending the patient, and returning the patient to the hospital;

        ii. retrospective certification of the patient, if required;

        iii. place the patient on leave; or

[86] Transcript of evidence, pp56-57.

[87] Exhibit 5 – *Continuum of Care – Planning, Implementation & Evaluation – Absence of Inpatients*

iv. discharge the patient.

d) Next of kin must be notified. An attempt must be made to locate the patient by contacting his/her residence, family members and significant others.

e) All absent involuntary patients must be reported to the police. The absence of all medium to high risk patients must be reported to police, regardless of their legal status.

f) Where a patient has been assessed as low risk, such as a patient who is known to leave the unit without permission, but always returns within the hour, the plan would be to reassess the risk if the patient has not returned within the hour. This may include contacting the patient's family or relevant community team, or reclassifying the patient to medium or high risk, and instituting the actions required for that level of risk.

44. RPN Mackey confirmed in evidence that the requirements in this policy are undertaken as soon as a patient is noticed missing. He also elaborated that changes have been made to the procedure on the ward regarding 15 minute observations. He stated that rather than just sight a patient, nurses must now engage them so that an assessment of a patient's mental state is ongoing.[88]

45. RPN Mackey gave evidence that security in the ward had been upgraded with the heightening of the courtyard fence and a lock on the gate to prevent patients absconding through the courtyard.[89]

46. Following the close of the Inquest, I received correspondence[90] from the lawyers acting on behalf of the NorthWestern Mental Health Service enclosing *the conclusions of the Root Cause Analysis undertaken.* I requested this document during the course of the Inquest but it was not forthcoming nevertheless I now replicate the most relevant parts of the correspondence. The conclusions of the Review were:

1. The level of risk of the patient for suicide was underestimated. This arose from the interaction of multiple factors including:

[88] Transcript of evidence, pp74-75.

[89] Transcript of evidence, p75.

[90] Correspondence from Ms Jan Moffatt, Donaldson Trumble Lawyers dated 1 December 2011.

a. *Perceived level of insight and judgement during admission. The patient was keen to meet with the oncall psychiatrist and was cooperative with the treatment plan in place;*

b. *The consumer was unknown to the inpatient unit;*

c. *Unavailability of a collateral history and information indicating the significant change in the consumers presentation occurring out of hours;*

d. *Confounding effect of recent drug use; and*

e. *High threshold for escalation of treatment plan with in the inpatient unit.*

2. *The design of the unit meant that the patient while deemed appropriate for care within a low dependency area had easy access to leave the unit. The two points of exit from the unit are not formally monitored. The front exit ensures that consumers must leave past the clinicians' workstation and may be observed. Exit through the garden area at the back of the unit is possible over the existing fence or gate that was unlocked at the time of the event.*

3. *Recent relapse of psychosis in the setting of increased alcohol and illicit drug use led the consumer to have a labile mental state, which resulted in an apparent impulsive suicide. No indication of intent was communicated or identified.*

47. The recommendations arising from the Review were stated to be:

1. *Review and develop clinical guidelines on the assessment of risk with particular reference to :*

   i. *the significance of the unknown patient;*

   ii. *effect of recent drug use on a consumer's mental health state; and*

   iii. *development of clinical prompts that indicate the need to escalate a consumer's treatment plan with relevance to these areas.*

2. *Consider the inclusion of clinical, collateral documentation to be part of the admission notes, particularly in the instances of consumers who are from areas outside of the services catchment area.*

3. *Review the points of entry and egress within the ward and develop a policy that outlines when the rear exit is accessible by consumers.*

4. *Review current training on dual diagnosis issues and ensure that all staff are trained in the assessment of the impact drug and alcohol use has on mental state and risk assessment.*

48. The other significant issue identified in the Review and already referred to was that there was a significant delay in staff alerting the police of Warren's absence from the ward This led to a recommendation for a review of the policy which has been attended to and referred to above.

The West Gate Bridge

49. On 9 May 2012, the installation of permanent safety barriers on the West Gate Bridge were completed and operating as intended - that is, to reduce/prevent the use of the West Gate bridge as a jump from height suicide location. Additional measures were introduced by VicRoads including a night-time security patrol of the bridge and increased monitoring of the bridge with CCTV. In a previous matter, I addressed the sharp decline in jump from height suicides at the West Gate Bridge since the completion of the barriers.[91] Analysis of suspected suicides by the Coroners Prevention Unit (CPU)[92] since the installation of safety barriers on the West Gate Bridge indicates that jump from height suicides have not increased at other locations nor has the frequency of rail suicides increased. These deaths continue to be monitored by the Coroners Court of Victoria and we engage in ongoing consultation with responsible government departments and public health and safety agencies to keep Coroners appraised of the nature and frequency of these deaths and the presence and efficacy of potential suicide prevention strategies.

50. In the circumstances it is not necessary for me to make any additional comment of recommendation in respect of the West Gate Bridge.

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[91] See Attachment A of Finding into Death with Inquest in the matter of Allem Halkic – COR 2009 0655 – delivered on 27 June 2012.

[92] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the Coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations.

FINDINGS

1. I find the identity of the deceased is Warren Guneratne.

2. I am unable to find that Warren's death could have been prevented if he had been admitted to the HDU in the first instance. I cannot therefore accept the submission that the decision not to admit him to the HDU is causative to his death because there are other possible scenarios.

   I find that it was reasonable and appropriate to admit Warren to the LDU with the verbal caveats as conveyed by RPN Harris following her risk assessment. However, RPN Harris' documentation fell short of effective communication. Ultimately only RPN Harris had the full clinical picture about Warren because her verbal communications were not relayed to other treating staff. Documentation is the foundation for effective communication in the medical/mental health setting but even appropriately completed documentation is only effective as a means of communication if there is in fact a culture of referring to it and not just relying on the verbal "handover".

3. I find that a number of opportunities were lost to the North Western Mental Health Service to provide Warren with a medical mental health assessment so that his treatment could be titrated accordingly. The family is justified to be aggrieved that Warren never saw a doctor during his involuntary admission to a major mental health facility. Through the breakdown in communication about fundamental aspects of Warren's mental state, the mental health service let him down. RPN Mackey was unaware of RPN Harris' articulated concerns about Warren's lability[93] and unaware of the ECATT assessment the previous evening.[94] A/Prof Fielding's decision to defer Warren's full psychiatric assessment on the morning of 28 January 2008, because Warren on the telephone was in itself innocuous but when making that decision to indulge Warren's time on the telephone, A/Prof Fielding was not fully cognisant of RPN Harris' concerns about the labile nature of Warren's mental state, that Warren had been assessed as high risk of suicide hours earlier or that Warren had been in the facility for approximately six hours without a mental health assessment being performed by a Doctor. A/Prof Fielding did not know the full clinical picture and I accept his evidence that if he had known this, he would have assessed Warren as a matter of urgency.[95] The

[93] Transcript @ p55

[94] Transcript @ p56

[95] Transcript @ p112

decision to defer the medical mental health assessment of Warren provided him the opportunity and possibly the reason to abscond from the unit. I find that this systemic breakdown in the exchange of critical information about Warren was not acceptable and enabled the passive deference of his mental state assessment. In letting Warren down, the mental health facility have let the family down which I acknowledge has contributed to their grieving. I do however also acknowledge that the North West Mental Health Service has accepted there were shortfalls in the delivery of care and have implemented measures aimed at prevention of like circumstances occurring again.

4. AND I further find that the delay in notifying Warren's mother that he had absconded from the unit was an opportunity lost for intervention and/or detainment by Police. Whilst I acknowledge that the window of opportunity was at best 1 hour and 15 minutes from the time he was noted to be absent from the unit and his departure from his mother's home, and the possibilities for intervention by Police and/or Jenny Guneratne herself are speculative, it was a significant enough delay in instigating notification of Warren's absconding so as to postulate that the outcome may have been different. But again I acknowledge that at the time staff were acting in accordance with existing practice and procedure and that the North West Mental Health Service has accepted that the implementation of acting upon the belief that a patient has absconded from the facility could be time critical and have reviewed and instigated change with the aim of preventing like circumstances occurring in the future.

5. Given the conclusions and recommendations in the Root Cause Analysis regarding the design of the unit and in particular with reference to the entry and egress points and the intention to review the same I make no comment, finding or recommendations regarding how Warren came to leave the LDU without being observed or without apparent difficulty.

6. I accept and adopt the medical cause of death as identified by Dr Michael Burke and find that the death of Warren Guneratne is consistent with drowning with multiple injuries consequent of jumping from the West Gate Bridge and that death occurred on 28 January 2008.

7. AND I further find that immediately before Warren jumped from the West Gate Bridge his actions and conversations with his mother reflect that he was capable of forming a plan and as such I find that Warren's actions in driving to and at the West Gate Bridge were with the intention of taking his own life.

8. AND I am unable to find that Warren would not have taken his own life on this day if safety barriers had been in place. It would be speculative to conclude that he would not have adopted some other means and as such I cannot make a finding that his death was preventable.

9. AND having regard to the restorative and preventative measures undertaken by the NorthWestern Mental Health Service since Warren's death, I have determined that no additional recommendations to the Services' own are required.

I direct that the Finding be published on the Coroners Court website in accordance with section 73(1) of the Act.

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

- Ms Jennifer Guneratne
- Ms Stella Gold, Adviceline Injury Lawyers on behalf of the Guneratne family.
- Ms Jan Moffatt, Donaldson Trumble Lawyers on behalf of the North Western Mental Health Service.
- Dr Mark Oakley Browne, Chief Psychiatrist
- Senior Constable Rebecca Lawther

Signature:

AUDREY JAMIESON
CORONER
Date: **7 October 2014**

Coroners Court of Victoria