IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2287/08

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of JOHN BERNARD TUFFY

Delivered On:	31 January 2012
Delivered At:	Melbourne
Hearing Dates:	10 September, 2010 at County Court, Melbourne
Findings of:	JANE HENDTLASS
Representation:	Leading Senior Constable McFarlane assisted the Coroner Mr Winneke appeared for Peninsula Health

I, JANE HENDTLASS, Coroner having investigated the death of JOHN TUFFY

AND having held an inquest in relation to this death on 10th September, 2010 at County Court, Lonsdale Street, Melbourne

find that the identity of the deceased was JOHN BERNARD TUFFY

Aged 48 years old

and the death occurred on or about 29 May 2008

at Foreshore Of Rosebud Beach, Rosebud, Victoria 3939

from:

1a. FINDINGS IN KEEPING WITH DROWNING

in the following circumstances:

1. John Bernard Tuffy was 48 years old when he died. He lived with his wife, Maree Tuffy, and their children at 1 Swans Way in Rosebud West. Mr Tuffy's medical history included previous unspecific chest pain and a panic attack in about 2005 as well as Willebrands disease which is a hereditary coagulation abnormality. He had no known previous history of mental illness. Mr Tuffy's general practitioner was Dr Matthew Evans at Mornington Medical Group. However, he had not seen Dr Evans since 26 September 2007.

2. On 8 May 2008, Mr Tuffy left Melbourne to visit his mother in Ireland after she had a stroke. However, she died unexpectedly two days after he arrived so he also attended her funeral. Mrs Tuffy explained that Mr Tuffy had a normal relationship with his mother: he went see her in Ireland about every five or six years and spoke to her about once a month on the telephone. His brothers told Mrs Tuffy that Mr Tuffy seemed well during this time in Ireland.

3. On 23 May 2008, Mr Tuffy commenced the return plane trip from Ireland to Australia. During the flight, he experienced severe chest pain and shortness of breath for three or four hours. He was given aspirin on the plane and transferred to Changi General Hospital when he arrived in Singapore.

4. At 12.26pm on 23 May 2008, Mr Tuffy was admitted to Changi General Hospital for cardiology investigations. On 24 May 2008, he was cleared for onward travel with no evidence of pulmonary embolism or cardiac disease.

5. At 6.30am on 25 May 2008, Mr Tuffy returned to Melbourne. Mrs Tuffy met him at the airport and noted that he seemed listless and tired. In evidence, she said he seemed vague and disoriented and did not know where things were. He told her that he must have had some sort of break down and that he needed help. Mr Tuffy also said he should have been arrested for his behaviour on the plane and believed he was wearing a label indicating he should be deported.

6. On 26 May 2008, Mr Tuffy stayed in bed while Mrs Tuffy took the children to school. Mrs Tuffy was concerned about Mr Tuffy's mental state and his inability to manage even the simple tasks

associated with day to day living. She made an appointment for Mr Tuffy to see Dr Cross at 5.00pm that afternoon at the Mornington Medical Group because Dr Evans was unavailable. At 9.31am, she also spoke to the Frankston Acute Mental Health Triage nurse who referred her to the Rosebud Crisis Assessment Team.

7. At 11.49am on 26 May 2008, Jackie McLean from the Rosebud Crisis Assessment Team rang Mrs Tuffy and spoke to Mr Tuffy. He told Ms McLean that he was crying much more than usual and having thoughts of wanting to be dead but had no active plans to self harm.

8. At 2.45pm on 26 May 2008, two other members of the Rosebud Crisis Assessment Team, Peter Middleton and Tony Flynn, assessed Mr Tuffy at home. Mr Middleton is a senior community clinician and social worker. Mr Flynn is an experienced psychiatric nurse.

9. Mr Middleton does not remember seeing Ms McLean's notes before this visit to Mr Tuffy's house or at all. He also says that Mr Tuffy did not tell him he had thoughts of wanting to be dead.

10. Rather, Mr Middleton and Mr Flynn described Mr Tuffy as vague, upset and perplexed. They were unable to complete the full assessment because of the level of agitation and perplexity but they decided to manage him at home as an acute patient.

11. At 4.00pm on 26 May 2008, Mr Middleton also contacted Dr Cross and told him Mr Tuffy had a panic attack on the flight from Ireland and was hospitalised in Singapore. Mr Middleton said that Mr Tuffy was having trouble sleeping and could be assisted by temazepam. He also had an infected foot injury.

12. At 5.00pm on 26 May 2008, Mr Tuffy consulted Dr Cross. Dr Cross ordered blood tests, prescribed temazepam and antibiotics and contacted Mr Middleton.

13. At 10.30am on 27 May 2008, Mrs Tuffy rang Mr Middleton to say that Mr Tuffy had slept only intermittently overnight with the assistance of two doses of temazepam because he still thought he was in trouble for the incident on the plane and wanted to check no one was looking for him.

14. At 1.00pm on 27 May 2008, Mr Middleton assessed Mr Tuffy again at home. It became apparent that his condition was continuing to deteriorate and he was having a psychotic episode. In his view the triggers were his mother's death, the long flight, the sleeplessness and the incident that had happened on the plane. On the other hand, Mr Middleton noted that Mr Tuffy had no prior history of mental illness or substance abuse and there did not seem to be any acute risks to justify involuntary treatment or hospitalisation.

15. Therefore, in Mr Middleton's professional opinion, the risk of self harm or harm to others was insufficient to justify imposing involuntary treatment and neither Mr or Mrs Tuffy considered it was required. Mr Middleton arranged for the psychiatric registrar, Dr Suzanne Redston, to prescribe diazepam in addition to his temazepam.

16. At about 7.00pm on 27 May 2008, Mr Flynn visited Mr Tuffy again at home. Mr Flynn suggested Mr Tuffy should be admitted to the acute mental health unit at Frankston Hospital but both Mr and Mrs Tuffy felt he could be treated at home and there were no current risk factors to impose treatment. He made an appointment for Mr Tuffy to consult Dr Redston at 10am next morning and gave him two tablets of diazepam. Mr Tuffy then went to bed as directed by Mr Flynn.

17. At 8.25pm on 27 May 2008, Mr Tuffy went missing from home and Mrs Tuffy contacted Mr Flynn. When he returned at 8.45pm, Mr Tuffy said he had tried to walk to the police station to turn himself in because he was going to be arrested and deported. However, he had become disoriented and lost so he came home again. He took another two tablets of diazepam before going back to bed but he did not sleep.

18. At 8.30am on 28 May 2008, Mr Tuffy told Mrs Tuffy he was still feeling depressed and wanting help. At 9.30am, they presented as arranged at the Outpatient Psychiatric Clinic at Bayview House Clinic which is part of Rosebud Hospital. Mr Tuffy was dishevelled and disorganised with no shoes.

19. Mr Flynn and Dr Redston assessed Mr Tuffy as perplexed and confused with guilty delusions and hallucinations associated with an acute psychiatric disorder that had been precipitated by the sudden death of his mother, returning to Ireland for the funeral and having to be removed from the plane at Singapore for assessment for acute chest pain. Mr Tuffy was unable to manage daily tasks and at risk of self neglect or accidental harm but no acute suicidal ideation or intent.

20. Dr Redston formally identified the differential diagnoses of Major Depression with psychosis or schizophreniform psychosis or psychotic disorder secondary to general medical condition. She arranged for Mr Tuffy's voluntary admission to Frankston Hospital acute adult psychiatric ward for containment, diagnosis and treatment. Her plan was for Mr Tuffy to be admitted for a CT head scan, a full organic screen and appropriate medication.

21. A bed was available at Frankston Hospital Psychiatry Unit later in the afternoon so, in the meantime, Dr Redston ordered the blood tests and a CT scan to be performed at Rosebud Hospital before Mr Tuffy was transferred to Frankston.

22. Mr Tuffy seemed calm and told Dr Redston that he would not hurt himself because he would not do that to his daughters. Therefore, there was no suggestion that he would leave without notifying staff or commit suicide.

23. Mr Flynn also observed that Mr Tuffy seemed more anxious but less disoriented than before. In his opinion:

"He wasn't in the least disorientated."

24. At about 10.30am, Mrs Tuffy went home to pack some clothes for Mr Tuffy to take to hospital. She says that she reminded Dr Redston to ensure he waited somewhere where he was under observation to make sure he did not wander off because of his disorientation. Dr Redston does not remember this

conversation but she specifically noted that Mr Tuffy should be kept at the clinic until he could be transported because of his:

"Acute Risk of serious self neglect and vulnerable to accidental harm."

25. At 11.10am on 28 May 2008, Mr Flynn went with Mr Tuffy to Dorevitch Pathology which is a few doors up the road for the blood tests. These did not indicate any metabolic abnormalities or evidence of myocardial infarction. At about 11.30pm, Mr Tuffy and Mr Flynn returned to the hospital.

26. The CT scan was booked for 2.00pm on 28 May 2008 so Mr Tuffy sat in the waiting room at Bayview House Clinic where the receptionist could see him. The waiting room was busy because one of the medical staff was away and a patient was acting in a disturbed manner. Further, the receptionist was not told the reason for Mr Tuffy being in the waiting room and observation of patients is outside the work for which administrative staff are trained or take responsibility.

27. Mr Flynn spoke to Mr Tuffy twice in the waiting room after 11.30am on 28 May 2008 and gave him a cup of tea. At 1.30pm, Mr Tuffy also spoke to Dr Redston when she checked on him. He was drinking a cup of tea and reading the newspaper.

28. Some time after 1.30pm on 28 May 2008, Mr Tuffy then told the receptionist he would wait outside for 'some air' until his wife arrived. At 1.50pm, Mr Flynn and Dr Redston returned to the waiting room at Bayview House Clinic. Mr Tuffy was missing.

29. Mr Flynn and Dr Redston undertook a thorough search but were unable to find him. At 2.00pm on 28 May 2008, Mr Flynn contacted police and reported Mr Tuffy as a missing person. However, Mr Tuffy was not seen again alive.

30. At 2.30pm on 29 May 2008, a passerby found Mr Tuffy unresponsive floating in the sea on the Rosebud foreshore about 500 metres from Bayview House. He could not swim. Police reported that there was some post mortem decomposition.

31. John Tuffy was identified by DNA matching with his child, Shannon Tuffy.

32. The forensic pathologist who performed the autopsy formed the opinion that the cause of death was in keeping with drowning. He also commented that the state of the tissue was consistent with a relatively short post mortem period but this could have been minimise by the cold water. No alcohol or other drugs were detected.

33. Accordingly, I find that John Tuffy died from drowning in circumstances which make suicide unlikely.

COMMENTS:

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

1. John Tuffy was 48 years old when he died. He lived with his wife and their two children. He had recently returned to Melbourne from visiting and attending the funeral of his mother in Ireland. There is no evidence that Mr Tuffy was unwell in Ireland.

2. On the way home from Ireland, Mr Tuffy was involved in an incident on the plane which was variously described as severe chest pain and/or a mental break down. He was admitted to Changi General Hospital for 24 hours for assessment before being cleared for onward travel from Singapore.

3. On 25 May 2008, Mr Tuffy arrived home in Melbourne. He expressed paranoid concerns about his behaviour on the plane and believed he should be arrested or was under surveillance from immigration authorities. Mr Tuffy was also disorganised and vague so that he was unable to manage the simple tasks associated with daily living. However, he denied any intention to commit suicide because of the effect it would have on his family.

4. By the morning of 26 May 2008, Mrs Tuffy was very concerned about Mr Tuffy's mental state and arranged for assessment by his general practitioner and the Frankston Crisis Assessment Team. He was assessed by Peter Middleton and Tony Flynn from the Rosebud Crisis Assessment Team. In their opinion, Mr Tuffy's mental state deteriorated further over the next three days and he was prescribed temazepam to help him sleep and diazepam to reduce his anxiety.

5. On 28 May 2008, Dr Suzanne Redston assessed Mr Tuffy at Bayview House which is the mental health facility attached to the Rosebud Hospital. She confirmed that he was experiencing a mental illness with differential diagnoses of Major Depression with psychosis or schizophreniform psychosis or psychotic disorder secondary to general medical condition and arranged for his voluntary mental health admission to Frankston Hospital.

6. At about 11.30am on 28 May 2008, Mr Tuffy was left in the waiting room at Bayview House to wait for transfer to Frankston when a bed became available later in the day. There had been no suggestion or reason to believe that Mr Tuffy might deliberately abscond. However, Mrs Tuffy and Dr Redston were both concerned that he might wander off because of his disorientation.

7. Mr Tuffy had no direct supervision in the waiting room but Dr Redston and Mr Flynn checked on him from time to time and he agreed to talk to the receptionist if he needed assistance. The receptionist was not aware of the reason Mr Tuffy was in the waiting room and supervision of patients is not a task usually performed by administrative staff. However, there were no extra staff available at Bayview House to supervise Mr Tuffy if that had been considered necessary and there was no other place at Bayview House where Mr Tuffy could wait.

8. By about 1.00pm on 28 May 2008, the waiting room at Bayview House had become quite busy and very noisy. Despite these conditions, Dr Redston was not concerned that Mr Tuffy's risk level had increased when she spoke to him at 1.30pm. He was drinking a cup of tea and reading the newspaper. Other than the increased activity in the waiting room, there was no reason for Dr Redston to change the arrangements she had made for Mr Tuffy to wait for his CT scan and transfer to Frankston Hospital.

9. Sometime between 1.30pm and 1.45pm on 28 May 2008, Mr Tuffy told the receptionist he would wait outside for 'some air' until his wife arrived and he left the waiting room. Mr Tuffy was not seen alive again.

10. There is no evidence that Mr Tuffy left the waiting room at Bayview House with any intention of absconding or harming himself. Further, he had repeatedly stated that he would not commit suicide because of his family. Therefore, I do not accept that he left Bayview House because he was disoriented or suicidal.

11. Accordingly, I accept Mr Tuffy's expressed purpose for leaving the waiting room. However, I am unable to explain why he left the waiting room at this time other than to speculate that he was affected by the noise and people around him.

12. At about 3.30pm on 29 May 2006, bystanders found Mr Tuffy unresponsive floating in the sea about 450 metres from the Rosebud foreshore about 500 metres from Bayview House. Mr Tuffy died from drowning. He could not swim.

13. We know from the geography of the area that Mr Tuffy had to cross the two divided lanes of Point Nepean Road outside the Rosebud Hospital and negotiate his way through a ti-tree plantation to reach the beach. The water is difficult to access at low tide but he could have reached deeper water from the Rosebud Jetty at high tide.

14. The Rosebud Jetty is north of the area he was found. High tide at Rosebud Jetty was at 8.21pm on the night of 28 May and 8.16am on 29 May 2008. Therefore, it is likely that Mr Tuffy entered the water at either 8.30pm on 28 May or about 8.00am on 29 May 2008.

15. There is no evidence of Mr Tuffy's state of mind in the period between 1.30pm on 28 May 2008 and when he entered the water. Therefore I am unable to say whether his state of mind had changed between when he was last seen and when he entered the water, that is whether his drowning was an accident associated with his disorientation or whether he was responding to psychotic stimuli in entering the water or whether he had become suicidal.

16. Mr Middleton has also considered this question:

> *"My initial belief was that he had committed suicide, that he'd left the clinic in a panic feeling that he was going to be arrested or suddenly scared about the possibility of hospital even and he'd wandered off and felt that that was a better option. My other thought on it is that he was*

disorientated and could've wandered off and, you know, walked on the pier, fallen into the sea and drowned as a matter of an accident. But I really don't know. I'm somewhere in between those two things. It's very hard to know what was in a person's mind."

17. Mr Flynn has a different opinion:

"I'm not sure whether there's some organic issues going on, but I certainly don't believe it was a deliberate suicide attempt. He made it very clear that he wasn't suicidal and that wasn't an option because of the children."

18. Dr Redston has also considered an explanation of Mr Tuffy leaving the waiting room and his subsequent death:

"I don't think it's a suicide. I've often wondered, well, how does a man end up in the bay? It was a very cold night and he was - he did have guilt and I wonder if he decided not to return home because he knew that his wife was dealing with the children and that he in some way thought I'd wait here and then got it into his head that he should swim back to Ireland -sort of motivated in a way that clearly is from mental illness so not logical. But it would be consistent with the delusional system that he was evolving, which was linked in with immigration and sort of being in some way in trouble but not knowing why."

19. It is not unusual for mental health patients to leave hospital without medical authorisation. From July 2008 to June 2010, over 450 patients left the Emergency Departments in Peninsula Health at own risk after treatment had commenced and a further 651 left without treatment.[1] Two of these patients committed suicide within six days of presentation.

20. However, no one else has ever absconded from Bayview House while they were waiting for transport to Frankston Hospital. Therefore, there was no reason for concern about their waiting room arrangements at that time.

21. Peninsula Health have acknowledged that Mr Tuffy would not have been able to leave the waiting room if he had been more closely supervised while waiting for transport to Frankston Hospital. Accordingly, within weeks of Mr Tuffy's death, they organised immediate transfer of Rosebud mental health patients who are waiting for admission to Frankston Hospital so that they can be more closely supervised.

22. If there is no mental health bed available, the patient waits in the Emergency Department at Rosebud Hospital and the Rosebud community mental health staff use an emergency ambulance or their own work vehicle to transport them to the Emergency Department at Frankston Hospital. In the 18 months after Mr Tuffy died, eight patients were transferred to the Emergency Department at Frankston Hospital to wait for admission to the Psychiatry Unit.

[1] These data include patients who return to the Emergency Department after follow up.

23. Further, Peninsula Health have acknowledged that the shared waiting room at Bayview House with easy egress may have contributed to Mr Tuffy becoming further disoriented on 28 May 2008. They have now modified another room behind the reception area so that they can separate patients who are transferring to Frankston Hospital from community patients and others in the outpatient waiting room. These arrangements must be documented in the Clinical Notes.

24. However, use of this new facility as a waiting room is limited by the policy of transferring patients awaiting admission to Frankston. Further, in a community mental health facility, acute staff are frequently out of the building so it is difficult to ensure proper supervision on the extra room. Therefore, this room is more effectively used as an extra interview room.

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

In view of the changes already implemented by Peninsula Health, I make no recommendations.

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

Minister for Health
Head of Psychiatry, Peninsula Health
Royal Australian and New Zealand College of Psychiatrists

Signature:

DR JANE HENDTLASS
CORONER
31 January 2012

Coroners Court of Victoria