IN THE CORONERS COURT

. OF VICTORIA

AT MELBOURNE

Court Reference: COR 2011 000293

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

Inquest into the Death of: TMY

Delivered On:	10th July 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne, Victoria
Hearing .Dates:	21st May 2014
Findings of:	Coroner Rosemary Carlin
Representation:	Mr Sean Cash, on behalf of Monash Health Mr Ron Gipp for Victoria Police Dr SL Keely for Dr Mei Ling Doery
Counsel Assisting:	Ms Jodie Burns

I, ROSEMARY CARLIN, Coroner having investigated the death of TMY

AND having held an inquest in relation to this death on 21st May 2014
at MELBOURNE
find that the identity of the deceased was TMY born on 10th September 1958
and the death occurred on 23rd January 2011
at Cranbourne.

from:

l(a) HANGING

In the following circumstances:

BACKGROUND

1. TMY[1] was born on 10th September 1958 and was 53 years old at the time of his death. He resided in Narre Warren with his wife BC and their two sons CR and DX. TMY was a panel beater by trade and at the time of his death, he owned a car sale business.

2. TMY had a long history of mood swings and anger management issues. When angry he would often say to his wife that he was going to kill himself. He said it so often his wife did not believe he would ever do it.

3. In September 1997, TMY's father took his own life by hanging. Immediately prior to this TMY had argued with his father. His father's death greatly affected TMY and his wife stated, *"he always blamed himself '*.[2]

4. In the lead up to his death, TMY was experiencing relationship difficulties with his wife and son as well as financial issues with his business. He became more depressed angry and constantly threatened th.at he would kill himself if his wife left him.

[1] TMY was generally known as TMY.
[2] Statement of BC, page 3.

Incident on 11th and 12th January 2011

5. On 11th January 2011, TMY had a physical altercation with his son, CR, at his workplace. TMY returned home, was very angry and started drinking and threatened to kill himself. During the evening, he poured petrol over his clothes, smashed a car windscreen, disclosed that he had been sexually abused as a child and held a knife to his own throat. CR became so concerned he phoned emergency services.

6. At approximately 10.20 p.m., police arrived to check on TMY, however he had left the house. Police advised the family to call them if he returned. Shortly after the police left TMY emerged from bushes where he had been hiding and returned home. He was upset and apologetic.

7. At around 1.00 a.m., police were informed that TMY was back home. They attended at the family home and at approximately 2.00 a.m., they apprehended TMY under section 10 of the *Mental Health Act 1986* (MHA) and took him to the Casey Hospital Emergency Department for assessment. By this time he had calmed down.

8. Police escorted TMY to the waiting room to wait for a psychiatric assessment. TMY and the police waited for an hour and a half before he was seen by an Enhanced Crisis Assessment and Treatment Team (ECATT[3]) clinician.

9. During his admission, TMY spoke to the police at length and appeared upbeat, engaged in conversation and joked. He denied any feelings of self-harm or suicidal ideation and was compliant and cooperative.

10. Registered Nurse (RN) Josie Davis was the ECATT clinician and assessed TMY. She considered that he did not exhibit any symptoms of depression or psychosis and determined that he did not meet the criteria for recommendation under the MHA. Further, RN Davis considered his level of risk to be low and allowed him to leave.

Between 12th January and 22nd January 2011

11. The situation between TMY and his wife remained tense after 12th January 2011, but TMY told his wife that he wanted to address his problems and asked her to make an appointment for him with their family doctor, Dr Roth from the Southern Cross Medical Centre in Hampton Park.

[3] The E in ECATT is also referred to as Emergency.

12. On 18th January 2011, TMY saw Dr Roth and discussed his issues at length. He described feeling depressed and complained of sleeping poorly and crying intermittently. He denied any suicidal thoughts. Dr Roth requested TMY complete a Kl 0 depression rating tool and return in two days. Dr Roth did not prescribe any medication.

13. On 20th January 2011, TMY returned to Dr Roth and stated that he felt considerably happier knowing that he was addressing his issues. Dr Roth recalled his demeanour to be *"brighter". TMY* scored a rating of 19 on the KIO assessment tool which was suggestive of *"mild to moderate depression"*. Dr Roth made a referral to Ana Schaper, a Mental Health Social Worker and Family Therapist for further consultation. TMY spoke to Ms. Schaper on 21st January 2011 and arranged to see her.

Events of Saturday 22nd January 2011

14. On Saturday 22nd January 2011, TMY became extremely angry after a minor disagreement with his wife. During the afternoon he started drinking and became more and more angry and intoxicated. During the evening he smashed holes in the plaster walls and threw items around the house.

15. At one point TMY made a noose in some rope and went to the back pergola area where he started to climb a ladder and throw the rope over the pergola joist. Both his wife and his son DX pushed him off the ladder. He went back inside, took a knife from the kitchen drawer, and stabbed himself two or three times in his stomach. Although he was bleeding a lot, he continued to damage the premises by banging his head into walls and knocking items over.

16. Because of her husband's behaviour, BC rang the police and at about 8.45 p.m. Acting Sergeant (AS) Bradley Cummins and Senior Constable (SC) Lisa Carroll attended the premises. TMY was initially hostile towards them; but Troy managed to restrain him so that they did not need to use capsicum spray.

17. TMY kept repeating to AS Cummins and SC Carroll that he was going to kill himself and they could not stop him. He said he had nothing to live for as his marriage of. 32 years was over. When told he would be taken to Casey Hospital, he said he had already been there and they did not help. He said that he would just tell them what they want to hear and then come back and kill himself. .When told by AS Cummins and SC Carroll that they would tell the hospital staff what he had just said, he said it would not matter and they would let him out anyway.

18. AS Cummins and SC Carroll found his behaviour very erratic, as he was one moment aggressive, the next crying or trying to hug them and or shake their hands.

19. An ambulance arrived and TMY was abusive to and uncooperative with the paramedics. At approximately 9.45 p.m. he was taken by ambulance to the Casey Hospital Emergency Department to be assessed under section 10 of the MHA and to treat his physical injuries. AS Cummins accompanied him in the ambulance and SC Carroll followed in the police car. The police advised DX that they would call the family to keep them informed.

Admission to the Emergency Department of Casey Hospital

20. TMY arrived at Casey Hospital at around 9.55 p.m. AS Cummins and SC Carroll explained the situation to the nursing staff and gave them the next of kin details, including DX's mobile phone number.

21. RN Jane Smith triaged TMY into the Emergency Department at 10.11 p.m. as a Category 3, which required him to be seen within 30 minutes. She told the paramedics and police to take him to Room 17, which was the usual place for people requiring assessment under section 10 MHA. RN Nicole Coombs and RN Jacqui McCullogh admitted TMY to Room 17 and received a handover from the police and paramedics.

22. Hospital staff described him upon his admission as intoxicated, loud, inappropriate, un-cooperative and noncompliant. A preliminary breath test was administered by a nurse which showed a blood alcohol concentration of 0.195%.

23. At 10.32 p.m. RN McCulloch notified RN Molly Te Kahu, the ECATT clinician on duty, that TMY had been admitted and required assessment.

24. AS Cummins and SC Carroll stayed with TMY whilst waiting for him to be assessed by a doctor. They managed to establish a rapport and TMY told them all about his life and issues. At approximately 11.15 p.m. they took him outside for a cigarette, telling nursing staff to come and get them if a doctor became available.

25. RN Te Kahu did not attend to assess TMY until 11.25 p.m. At this time he was outside with the police for a cigarette, but no-one went to get them. As he was intoxicated and not physically present in the Emergency Department, RN Te Kahu attended to another patient.

26. Dr Mei Ling Doery was a Junior Medical Officer in the Emergency Department. She first attended Room 17 to see TMY around midnight4, however he was uncooperative and abusive. She understood her role was only to assess TMY's physical condition, not his mental state[5]. Dr Doery told AS Cummins and SC Carroll the could not leave until the ECATT nurse had assessed him.[6]

27. Dr Doery saw TMY on approximately two further occasions and was satisfied he did not have any acute physical issues which required him to remain in the Emergency Department.

28. RN Te Kahu re-attended Room 17 at about 12.30 a.m. According to SC Carroll she told RN Te Kahu that she believed TMY was suicidal and that he had said he knew what to say so that he would be released and that he would then kill himself. RN Te Kahu then entered the room to speak to TMY.

29. As this was occurring, Dr Doery told AS Cummins that the police could now leave as TMY was being assessed and was in the custody of the hospital. According to SC Carroll she gave RN Te Kahu the hospital copy of the Mental Disorder Transfer Form by which the police formally transferred custody to the hospital.[7]

30. The police then left the hospital. Prior to leaving AS Cummins told one of the nurses to make sure that hospital security guarded the door to Room 17 to stop TMY from leaving.

31. According to RN Te Kahu she only spoke briefly to TMY when she went into Room 17 because she believed an assessment of his mental state and suicide risk would be more accurate once he was sober. She therefore asked RN McCulloch to do a repeat breathalyzer. This was at 12.40 a.m. RN McCulloch agreed to do this after completing her other tasks.

32. At 12.45 a.m., RN Te Kahu and Dr Doery spoke. In her statement, RN Te Kahu recorded the conversation this way: *"I spoke briefly with Dr Mei Ling Doery regarding the most likely*

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[4] She said it was 23.21 p.m. and the police said it was shortly after midnight.
[5] According to her statement dated 24 March 2014, she had been specifically. instructed by the Director of Emergency Department that it was the role of ECATT, not the Emergency Department medical practitioners, to assess the mental state of patients with mental illness.
6 The Department of Health and Victoria Police Protocol for Mental Health (printed September 2010) provides that a person apprehended under section 10 MHA remains in police custody until the occurrence of one of three scenarios. Relevantly, police custody ends when a registered medical practitioner formally accepts responsibility for the person in order to conduct a psychiatric examination.
[7] Dr Mei Ling Doery was listed as the doctor.

outcome of an assessment and indicated that it may be appropriate to discharge TMY',;,,. Dr Doery stated: *"[RN Te Kahu] told me that she had seen TMY*

….that he was not high risk for suicide, that 'Hes done this before, he should be right to go' and 'I don't want to see him until he is sober. ' "[9]

33. Dr Doery further stated that based on this conversation she believed that RN Te Kahu had assessed TMY and that he would be followed up by the ECATT team in the community. On this basis, she proceeded to discharge him.

34. TMY was discharged on the computer system by a clerk at 12.48 a.m.

35. When RN McCulloch attended Room 17 to do the repeat breathalyzer requested by RN Te Kahu she was surprised to find that TMY had already left. At 2.00 a.m. when RN Te Kahu returned to further assess TMY she was also surprised to find that he had left. However, neither RN McCulloch nor RN Te Kahu did anything about TMY's absence.

36. According to Dr Doery if she had been informed after her discharge of TMY that he had not in fact been assessed by RN Te Kahu she would have asked Victoria Police to bring him back to the Emergency Department.

TMY's return home

37. SC Carroll and AS Cummins stayed in the hospital car park for about 5 to 10 minutes. As they were driving out, they were flagged down by a man who claimed to have been verbally abused by another man. The police drove towards this other man and realised it was TMY.

38. AS Cummins stated:

> *'As I pulled up beside this male I recognized that it was TMY. I enquired what he was doing, to which he explained that he was pissed off at the hospital because they released him and when he enquired with them how he could get home they told him because he had no money he had to walk. TMY was fine talking with us, he was not intoxicated any longer and stated that the hospital staff had spoken with him and released him from their care.* '[10]

39. SC Carroll stated:

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[8] Statement dated 17 March 2011.
[9] Second statement dated 24 March 2014.
[10] Statement dated 20 May 2011.

"At this time I was thinking he had walked out of the emergency department of his own accord. [AS] Cummins spoke to TMY and enquired as to what he was doing. TMY was again agitated in his response that the hospital had done nothing for him and released him. He stated they wouldn't even organise for a lift home for him they told him to walk as he had no money for a taxi. When I asked him if the hospital had called his family his response was they told me to walk. [AS} Cummins and I decided that in the safety of TMY and the public it was in his best interested to be driven home ....TMY was upset by not being helped by the hospital but was no longer affected by alcohol and was calm and appreciated the fact that we would take him home."[11]

40. AS Cummins stated that during the trip home TMY was apologetic, polite and respectful. He told them he intended to go to bed. They dropped him off outside his house. He thanked them and left.

41. BC was very surprised to see her husband when he returned home at 12.45 a.m. He told her he had walked home from Casey Hospital. She stated: *'T'was shocked when he came home because I didn't expect him home because the police told me they would call me if he was released.* '[12] According to BC, her husband was still furious when he got home and said that he knew how to get around the doctors. He started throwing things around the house and tore his shirt off. He kept threatening to kill himself. Prior to him going to bed, he threw money at his wife and told her it was for his funeral. He eventually went to bed in the spare room.

42. The following morning, 23rd January 2011, at approximately 7.15 a.m., TMY kissed his wife goodbye and told her to *"have a good life"*. He also said *"Sorry"* to his son as he left the house. BC later located a handwritten note at the end of the bed. The note detailed that TMY had *'tried'* and was sorry, and that his wife could now be free.

43. At 8.09 a.m. BC received a text message from her husband saying he was sorry which she took to mean that he was sorry about his behaviour the previous night.

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[11] Statement dated 14 April 2011.

[12] Statement dated 13 February 2011. SC Carroll's evidence was that she expected the Hospital to contact the family as she had given them the details.

44. At 4.40 p.m., BC and their sons, DX and CR, attended TMY's car-yard as they had not heard from him. Troy opened the doors to the factory and saw his father hanging from a beam. TMY appeared to be deceased.

45. Ryan then approached police and paramedics who were at a nearby traffic accident and they attended at the factory and saw TMY hanging from a piece of nylon rope tied around his neck and attached to one of the roof frames of the shed. He was confirmed to be deceased. An aluminum ladder was on the ground nearby. A suicide note was also found on the ground beneath him.

CORONIAL INVESTIGATION AND INQUEST

46. On 24th January 2011, Dr Michael Burke, Senior Pathologist at the Victorian Institute of Forensic Medicine performed an external examination of TMY. There were no significant injuries and Dr Burke concluded that a reasonable cause of death was l(a) Hanging. Toxicology results revealed the presence of ethanol at a concentration of ~0.04g/100ml.

47. A brief of evidence was compiled for the Coroner, which included medical records and statements of family members, friends, various police officers, medical practitioners, ambulance paramedics, nurses and hospital staff.

48. I assumed control of the investigation into the death of TMY in January 2014. The previous Coroner left the jurisdiction at the end of 2013 having indicated that the matter would proceed to inquest.

49. I held a directions hearing on 23rd January 2014 to discuss the scope of the inquest. At that hearing it was conceded by Monash Health[13] that the police had discharged their obligations in terms of formally handing over the care of TMY to the hospital and that the hospital had failed to follow its own policies and procedures in allowing TMY to leave the Emergency Department prior to a Proper Mental Health Assessment.

50. A proposed inquest date in March 2014 was vacated as new counsel was sought for Monash Health due to a perceived conflict issue raised by counsel for Dr Doery.

51. An inquest was ultimately held on 21st May 2014. The issues for examination were:

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[13] Monash Health being the successor of Southern Health. Southern Health was the entity which existed at the relevant time.

- how it was that TMY was discharged prior to a Mental Health Assessment;
- what measures could be implemented to prevent a repeat of that situation; and
- the adequacy of the police response upon locating TMY outside of the hospital.

The Hospital

52. I indicated at the outset of the inquest that it was not my role as Coroner to attribute blame, particularly in the case of individuals. Rather, I was concerned with failures in systems and procedures and how to improve them. Further, it was my view upon reading the materials that it appeared that Dr Doery had discharged TMY as a result of a miscommunication and misunderstanding between herself and RN Te Kahu. Both Monash Health and Dr Doery accepted that this is what had happened[14].

53. Mr. Cash for Monash Health then repeated the concessions made at the directions hearing and further conceded that upon realising that TMY had departed without a Formal Mental Health Assessment, steps should have been taken to locate him.

54. As a result of these preliminary discussions and concessions, the inquest proceeded, in so far as Monash Health was concerned, with the focus being on prevention. A single witness was called being Jeremy Sheppard who was the current Operational Manager for Acute Mental Health at Monash Health. This role incorporated the operational oversight of Monash Health's three Emergency Department ECATT functions[15]

55. As at January 2011, there were two relevant hospital protocols for dealing with patients with mental health issues, namely the 'Southern Health Mental Health Program Assessment and Review Procedure' and the 'Southern Health Mental Health Program Transfer/Discharge Procedure'[16]. These protocols were not specific to the Emergency Department and were directed at mental health practitioners, not emergency physicians[17]. As TMY was discharged prior to ECATT assessment, neither protocol was followed.

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[14] Submissions filed at the conclusion of the Inquest did advance argument as to who was responsible for the misunderstanding, however given the course of the Inquest I make no finding on this issue.
[15] These being at Casey and Dandenong Hospitals and Monash Medical Centre.
[16] The adequacy of those protocols, had they been complied with, was not considered at the Inquest.
[17] They therefore did not apply to Dr Doery who claimed she had no orientation to, or knowledge of them.

56. There also existed at this time a 'Southern Health Section 10 Flow Chart'[18], which purported to govern the process for dealing with people brought to the Emergency Department by police pursuant to Section 10 of the MHA. However, this document was very crude, only stating "Patient assessed in MHl and Plan Formulated" as the procedure to be followed after the patient's arrival.

57. Monash Health did not bring to my attention any other relevant protocols that existed as at 2011 and I infer there were none.

58. According to Mr. Sheppard the Emergency Department would have several doctors working but only one ECATT clinician. The usual practice when a section 10 patient was brought in was that a doctor would be assigned to cover any physical injuries and the patient would be referred to the ECATT clinician for an assessment of the patient's mental state and suicide risk. This accorded with Dr Doery's understanding of the position. Dr Chan, the Director of Emergency Medicine at Casey Hospital since 2004, also confirmed that this was the procedure, although he stated that a comprehensive mental health assessment might be performed by the emergency doctor if an ECATT clinician was unavailable.[19]

59. The upshot of Mr. Sheppard's evidence was that although best practice dictated that any decisions in relation to a Section 10 patient should be collaborative, only a medical practitioner could actually discharge a section 10 patient[20].

This was so even if that medical practitioner only had a notional role in the assessment and treatment of the patient. Submissions filed on behalf of Dr Doery at the conclusion of the inquest supported the proposition that Section 10 patients remained the responsibility of the assigned emergency physician until discharge.

60. After the death of TMY, Monash Health introduced several new written protocols, including "Patients arriving with Police Escort to the Emergency Department Procedure".[21] This protocol is mostly comprised of a new and more detailed flowchart. According to Mr. Sheppard's statement, this new protocol "if complied with, should eliminate the possibility

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[18] Attachment JSl to the Statement of Mr. Sheppard.

[19] Statement dated 19 May 2014.

[20] Mr. Sheppard appeared to have difficulty in answering the question of who has the authority ‘to discharge a section 10 patient. T 35, 41, 96 - 102. This fact alone illustrates the need for the roles and responsibilities of doctor and ECATT clinician to be precisely defined.

[21] Attachment JS2 to the Statement of Mr. Sheppard, marked as 'approved' on 17 April 2013.

of a patient being discharged from the ED until a comprehensive mental health assessment has been conducted and documented on the 'Mental Health Assessment' ... Form'.[22]

61. Despite this bold assertion, Mr. Sheppard readily agreed the new protocol and the flow chart could be improved.[23] In particular:

- the process for police handover/patient transfer could be clarified, particularly the flowchart requirement for the "police paperwork" to be signed by hospital staff when there is no space on the Mental Disorder Transfer Form to do this;
- the flow chart does not refer to the Mental Health Assessment Form;
- the Department of Health Mental Health Services guidelines in relation to the assessment of intoxicated persons should be incorporated, in particular the fact that intoxication does not preclude early assessment and in fact increases the risk of suicide;[24]
- the procedure for discharge of a Section 10 patient could be specifically articulated, particularly the roles and responsibilities of ECATT clinician and medical staff; and
- the process to be followed if a patient does leave prior to mental health assessment should be formalised.

62. Mr. Sheppard agreed that whilst the new flow chart emphasised a collaborative approach, involving all Emergency Staff, the exigencies of the emergency department could make it difficult for this to occur. He did not know whether the flow chart was displayed anywhere in the Emergency Department.

63. In relation to discharge procedure, to ensure a doctor did not mistakenly discharge a patient prior to a Mental Health Assessment by an ECATT clinician, Mr Sheppard agreed that the flowchart might be amended to contain a box to the effect that the discharging doctor had to sign the Mental Health Assessment Form.

64. According to Mr. Sheppard, in addition to the above protocol, Monash Health instigated new practices in Emergency Departments across the Monash Health network. Generally, these

[22] The Mental Health Assessment Form was attachment JS3 to Mr. Sheppard's statement and was in existence, in some version, in 2011.
[23] In any event the flow chart has typographical errors.
[24] Exhibit E, Assessment of intoxicated Persons - Policy Issue Number 2 (December 1999).

new practices provided for greater accountability of more junior health practitioners and more involvement of senior doctors. These practices have not been reduced to writing.

The police

65. Both AS Cummins[25] and SC Carroll gave evidence. The thrust of their evidence was that when they saw TMY outside the hospital, they believed him when he said he had been discharged[26]. This was because TMY was very angry about the fact the hospital had released him with no means of getting home. Further, they had just been talking about how they thought the hospital was going to discharge him despite their concerns, so they were not surprised to see him there.

66. The police evidence was also that whatever they may have thought about TMY'S discharge, there was nothing they could do about it. They were not in a position to challenge the result of his assessment and there was no basis to further apprehend him under Section 10 of the MHA as he was not displaying suicidal behaviour. To the contrary, he told them he was exhausted and wanted to go to bed. He no longer appeared intoxicated.

67. The police decided to take TMY home, which was possibly 10 kilometers away; as they knew he had no money and no means to get there. SC Carroll stated she was also concerned because Casey Hospital was adjacent to a railway line where she had previously attended 17 or 18 suicides by train.

68. Both police officers agreed that based on their experience, whilst the Mental Disorder Transfer Form was an internal police document, it would be a good idea for it to be signed by the receiving doctor.

CONCLUSIONS AS TO CAUSE AND CIRCUMSTANCES OF DEATH

69. I formally find that TMY took his own life by hanging on 23rd January 2011.

70. The previous night he had been apprehended by police under Section 10 of the MHA as a result of suicidal behaviour and taken to the Emergency Department of Casey Hospital. He was erroneously discharged from Casey Hospital at 12.48 a.m., prior to a mental health assessment. This occurred as a result of miscommunication and misunderstanding between the attending ECATT clinician and the Emergency Department doctor who discharged him.

[25] By the time of the Inquest AS Cummins had in fact left the police force, however for convenience, I shall continue to refer to him as AS Cummins.

[26] AS Cummins said that he would have taken him back to the hospital if he had thought he had not been assessed.

71. Whilst it is abundantly clear that TMY should not have been discharged from Casey Hospital when he was, had that not occurred, I am not satisfied that his death would have been prevented. This jurisdiction tends to inspire examination of the hypothetical, however any such examination must proceed cautiously. It is difficult for any retrospective analysis to be untainted by the known outcome.

72. TMY was an articulate man who, by his own account, knew what to say to ensure his release from hospital. I accept that if he had been detained at hospital overnight it is likely he would have been released following assessment by a psychiatrist some time the next morning. It is impossible to say what then would have happened. It may be that he would not have taken his own life that day, or at all. However, I am not satisfied as to the likelihood of any particular outcome.

73. I therefore accept the submissions filed on behalf of Monash Health in relation to causation and accordingly I am not satisfied that any failure on the part of Casey Hospital or its staff caused or contributed to the death of TMY.

74. As to the police, I initially queried the stated position of AS Cummins and SC Carroll that they believedTMY's assertion that he had been discharged when they saw him in the car-park. However, having heard their explanation, I accept it. I also accept they had no lawful power to re-apprehend TMY at that stage. I am satisfied their actions were reasonable and appropriate at all times and they did not cause or contribute to the death of TMY.

COMMENTS

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

1. AS Cummins and SC Carroll are to be commended for the care and attention they demonstrated. TMY's behaviour was extremely challenging and yet they persisted in trying to calm him and establish a rapport. They alerted the hospital to the fact he knew what to say to ensure his release and asked that his room be guarded when they left. Recognising the danger posed by his release in the middle of the night, next to a train line and without any money, they then drove him home.

2. TMY's discharge arose from a miscommunication. In a busy Emergency Department on a Saturday night it is not hard to imagine how a quick verbal exchange might be misunderstood. Nevertheless, it appears there were no systems in place to minimise the

risk of such a misunderstanding. The precise roles of ECATT clinicians and doctors in dealing with Section 10 patients were informally understood, but they were not documented, particularly the responsibility and procedure for discharge. A requirement that the discharging doctor view or sign a completed Mental Health Assessment Form might have prevented the error that occurred here, as it then would have become obvious that no assessment had occurred.

3. I am not satisfied that the measures introduced since the death of TMY adequately deal with the problem. Counsel assisting has filed submissions in which she stated: "There appears to be an over reliance on 'accepted good clinical practice' and 'common sense' dictating how to manage persons brought into the [Emergency Department] by way of Section 10 of the MHA". I agree.

4. The flow chart, which is attachment JS 2 to Mr. Shepard's statement, is confusing. Its references to police handover and police paperwork are unclear. The process and responsibility for discharge is still not clear. The fact the flowchart contains typographical errors suggests insufficient attention has been given to its drafting. In any event, to be of practical utility the flow chart should be placed in a conspicuous position in the Emergency Department, not just available on the intranet.

5. The new practices introduced by Monash Health, whilst good practices, are just that. They have not been implemented as written hospital policies and further, they do not specifically address the process and procedure for discharge of Section 10 patients. I am not satisfied these practices would have prevented the erroneous discharge of TMY and they certainly would not have ensured his retrieval.

6. In its written submissions, Monash Health indicated that it proposes to review and amend its written procedures even further[26], particularly clarifying the flow chart largely comprising the 'Patients arriving with Police Escort to the Emergency Department Procedure' and establishing a clear dispensation procedure as well as a procedure in the event of erroneous discharge. Further, it intends to consider how best to record the transfer of custody of mental health patients from police to hospital staff, including the possibility of dual sign-off of the Mental Disorder Transfer Form. It also intends to incorporate the new practices outlined by Mr. Sheppard into [written] procedures 'as appropriate'.

[26] The introduction of the new Mental Health Act 2014 necessitates such a review in any event.

7. By virtue of its written submissions, Monash Health would appear to acknowledge that it needs to do more to prevent a repeat of what happened with TMY. The final paragraph states: 'The most important consideration is whether steps have been put in place, or are proposed, that will seek to ensure that, in future, no patient brought to the hospital by police pursuant to the [MHA] will be discharged prior to being formally psychiatrically assessed.' TMY died on 23rd January 2011. It is concerning that three and a half years later Monash Health is yet to get its house in order.

8. This case also highlights the importance of accurate and contemporaneous record keeping by hospital staff. The only entries in the nursing notes were made by RN Coombs. A simple note by RN Te Kahu at 12.30 a.m. that she was going to return to do an assessment may have prevented the misunderstanding'. I accept that in a busy hospital setting it may be difficult for staff to make contemporaneous notes, but their importance cannot be overstated. Not only do they serve as a means of communication, but they also ensure accountability, which in turn promotes best practice. Note-making should not be seen as a liability. Comprehensive notes allow for a proper assessment of events, should that be required. In these days of ever-increasing scrutiny of hospital patient management, accurate notes can operate to protect a clinician whose conduct is under challenge.

9. For the same reason, it would appear desirable that the Mental Disorder Transfer Form, which documents the outcome of Section 10 apprehensions, be signed by both the doctor and police. Acknowledging that the Form is an internal police document, a copy is nevertheless given to the hospital and I can see no reason why it cannot serve the purpose of being a clear record of the police and hospital interaction. In this case, whether the police had transferred custody of TMY to a medical practitioner appeared to be a live issue until the concession at the directions hearing. A simple signing of the Mental Disorder Transfer Form by Dr Doery would have clarified the situation from the start.

10. As at 1 July 2014, the *Mental Health Act 2014* replaced the MHA. Section 351 of the 2014 Act replaces section 10·of the MHA. Section 351(6) specifies when police custody ends, but the circumstances are still open to interpretation. It therefore remains desirable that the transfer of custody from police to healthcare provider is precisely documented. Since the Mental Disorder Transfer Form will need revision to take account of the 2014 Act in any event, the timing is opportune.

11. Submissions filed on behalf of the Chief Commissioner of Police recognise the utility of dual sign-off of the Mental Disorder Transfer Form, however, submit that the burden of

compliance with any such new procedure should not be confined to police. That is, the Chief Commissioner submits that any recommendation for amendment of the Form be accompanied by a complementary recommendation to the Department of Health.

RECOMMENDATIONS

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

1. Monash Health introduce a clear written procedure whereby patients brought into an Emergency Department by police pursuant to Section 351 *Mental Health Act 2014* cannot be discharged prior to a mental health assessment and completion of a Mental Health Assessment Form.

2. Monash Health introduce a clear written procedure in the event a patient brought into an Emergency Department by police pursuant to Section 351 *Mental Health Act 2014* absconds or is discharged without a mental health assessment. Particular consideration should be given to requiring immediate notification of Emergency Services Telecommunications Authority (ESTA) and the on-call consultant psychiatrist.

3. The Chief Commissioner of Police, Monash Health and the Department of Health investigate the feasibility of requiring the Mental Disorder Transfer Form to record the signature of the person to whom custody has been transferred, as well as the date and time of transfer.

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

The Family of TMY;
The Chief Commissioner for Police, Ken D. Lay APM;
Monash Health;
Dr Mei Ling Doery;
The Honourable David Davis, Minister for Health;
Emergency Services Telecommunications Authority (ESTA); and
Detective Sergeant Garry Kear, Coroner's Investigator, Victoria Police.

Signature:

ROSEMARY CARLIN
CORONER
Date: 10 July 2014