IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 005030

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of: PAIGE DENT

Findings of:	DARRN J. BRACKEN, CORONER
Delivered On:	22 December 2022
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank, Victoria, 3006
Cause of Death:	Injuries sustained in a single vehicle, motor vehicle incident in which Ms Dent was the driver.
Hearing Dates:	20 December 2022
Representation:	Ms B Wellington Solicitor Monash Health Ms B Iliff Solicitor Victorian Government Solicitor's Office

Assisting the Coroner:	Ms Thea Chee, Solicitor Coroner's Court of Victoria.
Keywords	"Motor vehicle collision", "Mental Health", "Drug Use" "In care", "Monash Health", "Dandenong Hospital", "Mental Health Act", "Inpatient Treatment Order", Inquest.

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INTRODUCTION

1. Ms Paige Dent was 25 years old when, on 6 October 2018, the car which she was driving and of which she was the only occupant, collided with a traffic-light pole on Nepean Highway, Cheltenham. Immediately before her death Ms Dent was reportedly homeless.

MS DENT'S MEDICAL HISTORY & CIRCUMSTANCES LEADING TO DEATH

2. At the time of her death Ms Dent had a significant history of illicit drug use, misuse of other drugs and serious mental health conditions all stretching back to when she was quite young. When she was 19 years old, Ms Dent was diagnosed with Schizophrenia and subsequently Borderline Personality Disorder and Substance Use Disorder. The results of a neuropsychology assessment in 2012, in the setting of a GHB[1] overdose, revealed an acquired brain injury. A repeat neuropsychology assessment in 2017 confirmed that diagnosis and revealed further deterioration of her condition as a result of that injury.

3. Ms Dent underwent a total of 19 inpatient admissions to hospital for psychotic episodes in the context of substance abuse and non-compliance with medication. Her usual presentation when unwell included somatic and grandiose delusions, perceptual disturbance, thought disorder and aggression. In the two years prior to her death, Ms Dent had been a compulsory patient at Dandenong Hospital ("the Hospital") Secure Extended Care Unit ("SECU"), having been transferred there from the Dandenong Hospital Mental Health Ward ("the Ward") for treatment of acute psychosis. While on the Ward, Ms Dent exhibited challenging behaviour, including using illicit substances, smoking, aggression including assaulting staff and other patients, irritability, refusing to allow both physical observations to be taken and to provide samples for drug screening. Ms Dent absconded from the Ward and failed to return from approved leave on a number of occasions.

[1] Gamma Hydroxybutyrate a neuro transmitter suppressant – a depressant.

4. Ms Dent's treatment included trials of several antipsychotic medications, including paliperidone,[2] aripiprazole,[3] and haloperidol[4] injections, and clozapine. Clozapine was ceased after 10 months due to erratic compliance (as a result of frequent absconding) and high risk of interaction with illicit substances. Pharmacogenomic testing identified that Ms Dent to be at a greater risk of side effects from haloperidol; however, she expressed concerns about weight gain associated with other antipsychotic injections and insisted on continued haloperidol injections. Efforts of treating clinicians to engage Ms Dent in outpatient drug rehabilitation and community outreach programs was met with difficulties including, and in particular, persistent illicit drug use.

5. At the time of her death, Ms Dent was subject to a 26-week Inpatient Treatment Order ("ITO") pursuant to the *Mental Health Act 2014* (Vic), which was due to expire on 21 November 2018. In the month prior to her death, Ms Dent absconded from the SECU and from the Hospital twice after presenting to the emergency department ("ED**"**). Ms Dent last absconded form the ED approximately 19 hours before her death.

6. Ms Dent's medical records for the month prior to her death describes her as:

   a. Being less aggressive.

   b. Continuing to smoke and to use illicit drugs.

   c. Being irritable and verbally aggressive.

   d. Refusing nursing interventions and

   e. Requesting discharge from the Hospital.

   f. Occasionally reporting auditory hallucinations (often settled with reassurance or with medication as required or both).

[2] Paliperidone is an antipsychotic and indicated in the treatment of schizophrenia, acute exacerbations of schizoaffective disorder and bipolar disorder. It is available in oral and slow-release depot injection.
[3] Aripiprazole is an antipsychotic medication indicated in the treatment of schizophrenia and bipolar affective disorder. It is available in oral and slow-release depot injection.
[4] Haloperidol is a first-generation antipsychotic medication used in the treatment of psychosis. It is available in tablets, slow-release depot injection and intravenous injection.

7. In August 2018, discussions and planning for Ms Dent's discharge from the SECU commenced. Complications arose due to the lack of appropriate post discharge accommodation.

8. The month leading up to Ms Dent's death was marked by her frequently absconding from the Hospital, as well as several attempts and suspicions by her treating clinicians that she would do so.

9. On 30 August 2018, Ms Dent's leave was cancelled except for any leave required to obtain post discharge accommodation, due to two episodes of her absconding and assaulting. On 3 September 2018, Ms Dent's leave status was reviewed at a clinical review meeting and the potential risks of her being given leave were discussed. The review concluded that Ms Dent was to be trialled on leave beginning the following day.

10. On 5 September 2018, after returning from escorted leave, accompanied by a social worker to inspect potential post discharge accommodation Ms Dent went on 30 minutes of unescorted leave at approximately 12.45pm. Despite assuring staff that she would return and, despite being provided with access to a taxi (paid for by SECU) to return, Ms Dent did not return at the required time. Ms Dent's stepfather returned her to the SECU ward at approximately 6.10pm; she denied using illicit drugs and refused a urine drug screen. Nursing and medical staff noted that Ms Dent's behaviour was then consistent with her having used illicit drugs.

11. On 6 September 2018, Ms Dent was cooperative with nurses and denied perceptual disturbance and suicidal ideation. She requested leave throughout the day to smoke cigarettes, having previously declined nicotine replacement medication. At approximately 12.40pm, staff located Ms Dent at a bus stop at the front of the hospital. Ms Dent agreed to return to SECU. It is not clear from the medical records whether Ms Dent absconded from the Ward or whether she was approved for leave but failed to return. Following review by a psychiatrist that afternoon, Ms Dent's 'MH120 Leave of Absence for Compulsory Patient' form was updated to allow her one hour of unescorted leave each day. Ms Dent was advised that if she did not comply with leave conditions she would have no further unescorted leave prior to discharge.

12. Ms Dent was subsequently reviewed by the Associate Nurse Unit Manager and permitted leave that afternoon at 4.10pm or 5.10pm. A subsequent progress note recorded that Ms Dent went on leave at 5.10pm, and in any case as at 6.52pm, she had not returned. Victoria Police were contacted at approximately 6.42pm.

13. In the days that followed, Ms Dent had intermittent phone contact with her mother and stepfather but declined to reveal her precise whereabouts; she was clear that she would not return to SECU. Hospital staff became aware that Ms Dent was in the Pakenham area and police were informed.

14. On 10 September 2018, Ms Dent contacted SECU requesting to speak to Mr Bothe, a social worker, and told him that she would return to SECU if she could be discharged to Broadmeadows. She was said to sound coherent and not drug affected.

15. By 21 September 2018, Ms Dent had not returned to SECU and was formally discharged, although she remained subject to the ITO.

16. On 24 September 2018, SECU and the Agile Complex Care team staff put a plan in place that provided for Ms Dent to be taken to the ED of the Hospital when located and admitted to an acute unit. SECU Nurse Unit Manager Elizabeth Fulco documented that SECU admission had no impact on reducing Ms Dent's impulsive behaviours, substance use or risk-taking behaviours, that her behaviours usually settled after periods of abstinence from illicit substances and the use of medication for anxiety. In terms of managing Ms Dent's challenging behaviour and risks, it was noted that crisis admissions may be most beneficial. It was also suggested that this management plan be shared with the police, ambulance services, the Clinical Early Response Team (**PACER**), Enhanced Crisis Assessment Team (**ECAT**), Crisis Assessment and Treatment Team (**CATT**) and acute adult services.

17. A family meeting was arranged for 27 September 2018 to discuss Ms Dent's ongoing treatment, though there was no documentation in the medical record of this meeting.

18. On 26 September 2018, Ms Dent's stepfather contacted Mr Bothe to advise that Ms Dent was then at home. Mr Bothe confirmed that Ms Dent had been discharged from SECU but

that she was still a compulsory patient and would need to be assessed if she returned to the ED.

19. On 28 September 2018, Ms Dent was apprehended by police at a residential address in Pakenham[5] and transported to the Hospital ED by ambulance, arriving at approximately 6.02pm. On arrival, Ms Dent was assessed by a mental health clinician who noted delusions and agitation. She was irritable, verbally abusive and declined diazepam. At approximately 7.24pm, a high dependency unit ("HDU") bed was requested. Between 7.15pm and 7.25pm, staff observed Ms Dent standing near the door looking outside towards the ambulance bay. Staff requested that she return to bed, but Ms Dent declined and became argumentative. Staff initiated a code grey and Ms Dent returned to her bed and accepted diazepam. At approximately 7.35pm, Ms Dent was observed to walk past the nurses' station. Staff requested that she return to bed and she declined. Ms Dent then ran out of ED through the ambulance bay. Staff immediately alerted Victoria Police.

IMMEDIATE SURROUNDING CIRCUMSTANCES

20. During the evening of 4 October 2018, Ms Dent attended Moe Police Station and reported being homeless. Police were aware of her circumstances, including that she was subject to an ITO and contacted Ambulance Victoria to transport Ms Dent to the Hospital. When paramedics arrived at the police station, Ms Dent became agitated and was given 5mg of midazolam and taken to the Hospital ED, arriving at approximately 2.16am on 5 October 2018.

21. At approximately 2.30am, a mental health clinician assessed Ms Dent and noted that she was reluctant to engage, presented as dishevelled but that there was no evidence of acute psychiatric symptoms. Shortly after arriving at the ED, Ms Dent was given 10mg diazepam but declined olanzapine when offered. Her treating clinicians were cognisant of her history of absconding from hospital and Ms Dent was recorded as being a medium to high risk of

[5] The medical record was unclear regarding how Ms Dent came to be at that address and how she came to the attention of police.

harm to herself through misadventure due to ongoing substance use, non-compliance with medication and homelessness.

22. At approximately 3.04am, a Mental Health Clinician requested a HDU bed on the Ward at the Hospital and a continuous patient observer ("CPO") was assigned to Ms Dent. Ms Dent was said to have had settled overnight and slept well.

23. At approximately 9.45am, on-call psychiatrist Dr Ashish Ghandi was asked to review Ms Dent in the ED to determine whether an admission was required. Between approximately 10.25am and 10.29am and before Dr Ghandi reviewed Ms Dent, she got out of bed and, pretending to go to the toilet, ran out of ED. Staff called for her to return but she did not respond. At approximately 10.41am, hospital staff notified Victoria Police and a plan was documented in the event that Ms Dent returned to the hospital, for her to undergo a review by a consultant psychiatrist to determine whether an admission was required.

24. Sometime after approximately 7.35pm, on 5 October 2018 Ms Dent's friend, Mr J Binge, collected her from a Dandenong address and together they drove to Cheltenham, where they stopped and consumed illicit drugs. They then continued on to Mr Binge's grandmother's home in Mordialloc where they consumed more illicit drugs.

25. At approximately 2.00am on 6 October 2018, Ms Dent took Mr Binge's car keys and said that she wanted to drive to Dandenong. Mr Binge initially objected but eventually joined Ms Dent and she drove them towards Dandenong. In his statement to police, Mr Binge described being "*scared*"; Ms Dent was speeding and driving erratically. He asked her to let him out of the car and she pulled over to the side of Wells Road in Chelsea Heights. Mr Binge got out of the car and Ms Dent drove away.

26. At approximately 5.16am, Mr Binge went to a service station near to where Ms Dent dropped him off and contacted Victoria Police to report his vehicle as stolen. Police arrived at the service station at approximately 5.31am.

27. Shortly before the fatal collision, witnesses described Ms Dent driving Mr Binge's car erratically along the Nepean Highway, Moorabbin at estimated speeds of 130 kilometres per hour. Witnesses described seeing Mr Binge's car almost lose control and swerve into the

middle lane of Nepean Highway, shortly after which it executed a 'U-turn' and travelled in the opposite direction. Another driver witnessed Ms Dent pass his car at approximately 200 kilometres per hour, causing his car to *"shake"* as she passed him.

28. At approximately 5.21am, a speed camera photographed Mr Binge's car driving south along Nepean Highway at 175 kilometres per hour. Within a few seconds of this photograph, the car was recorded by closed-circuit television footage drifting from one side of Nepean Highway to the other and then colliding with a traffic light pole. The impact destroyed Mr Binge's motor car.

29. Ms Dent was ejected from the car and came to rest some 50 metres from the traffic light pole. Passing motorists contacted emergency services and Ambulance Victoria paramedics arrived a short time later. Responding paramedics were unable to revive Ms Dent and subsequently declared her deceased at 6.15am.

THE PURPOSE OF A CORONIAL INVESTIGATION

30. Ms Dent's death was reported to the coroner because it fell within the definition of a reportable death in the *Coroners Act* (2008) (Vic) ("the Act"). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury, or indeed because the deceased person is considered to have been 'in-care' pursuant to section 4 of the Act as was the case with Ms Dent.

31. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[6] The Act provides for reportable deaths to be independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[7]

32. For coronial purposes, the phrase 'circumstances in which death occurred'[8] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the

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6 *Coroners Act 2008* (Vic) s 89(4).
7 *Coroners Act 2008* (Vic) preamble and s 67.
8 *Coroners Act 2008* (Vic) s 67(1)(c).

death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

33. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[9] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[10] or to determine disciplinary matters.

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

35. Coroners are also empowered:

    a. to report to the Attorney-General on a death;[11]

    b. to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice;[12] and

    c. to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[13] These powers are the vehicles by which the prevention role may be advanced.

THE EVIDENCE

36. On Tuesday 20 December 2022, I held an inquest into Ms Dent's death.

37. This Finding is based on the totality of the material produced by the coronial investigation into Ms Dent's death.

38. This Finding does not purport to summarise all the material and evidence but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative

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9 *Keown v Khan* (1999) 1 VR 69.
10 *Coroners Act 2008* (Vic) s 69 (1).
11 *Coroners Act 2008* (Vic) s 72(1).
12 *Coroners Act 2008* (Vic) s 67(3).
13 *Coroners Act 2008* (Vic) s 72(2).

clarity. The absence of reference to any particular aspect of the evidence does not infer that it has not been considered.

STANDARD OF PROOF

39. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[14] In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw*.[15] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

IDENTITY

40. On 8 October 2018, Mr John Anthony Young identified the deceased as his partner's daughter, Paige Dent, born 31 January 1993.

41. Identity is not in dispute and requires no further investigation.

MEDICAL CAUSE OF DEATH

42. On 8 October 2018 Dr H Bouwer, a specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination of Ms Dent's body and in his written report dated 3 December 2018 opined that the cause of Ms Dent's death was 'Injuries sustained in a motor vehicle incident (driver)'.

43. Toxicological analysis of post-mortem samples identified the presence of methylamphetamine (and its metabolite, amphetamine),[16] delta-9-tetrahydrocannabinol

[14] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[15] (1938) 60 CLR 336.
[16] Amphetamines is a collective word to describe central nervous system (**CNS**) stimulants structurally related to dexamphetamine. One of these, methamphetamine, is often known as 'speed' or 'ice'. Methamphetamine is a strong stimulant drug that acts like the neurotransmitter noradrenaline and the hormone adrenaline. In drivers of motor vehicles, amphetamines can produce aggressive and dangerous driving, and even produce rebound fatigue when the effects of amphetamines are waning.

(cannabis),[17] diazepam (and its metabolite, nordiazepam),[18] hydroxyrisperidone,[19] and haloperidol.[20]

CORONERS PREVENTION UNIT – MENTAL HEALTH TREATMENT AND MONASH HEALTH REVIEW

44. Given Ms Dent's extensive medial history, I requested the Coroners Prevention Unit ("CPU")[21] review that history and Ms Dent's treatment at the Hospital.

45. In reviewing the appropriateness of Ms Dent's approved leave, the CPU also had regard to statements and annexures received from the Mental Health Clinician, the Monash Health Senior Social Worker; Monash Health SECU Nurse Manager; Dr Neil Goldie, Director of Emergency Medicine of Dandenong Hospital; and Dr Neil Coventry, Chief Psychiatrist.

46. Based on Ms Dent's significant and lengthy history of absconding, the CPU considered that her mental illness did not significantly increase her absconding risk. Instead, the CPU considered that Ms Dent's absconding was behavioural in nature and related to her acquired brain injury and substance use disorder. The CPU found no evidence that Ms Dent absconded more frequently when acutely psychotic than she did when her mental state was settled. The CPU identified several behavioural interventions that were implemented to reduce her risk of absconding and did not consider that these interventions reduced her long-term absconding risk. Such behavioural interventions included discussing and addressing with Ms Dent the reasoning behind her desire to abscond; providing brief and regular periods of leave for her to smoke (but not long enough for her to use illicit substances); negotiating leave conditions, and cancelling or restricting leave when she did not comply with these conditions; providing longer periods of unescorted leave to visit

[17] Delta-9-tetrahydrocannabinol (**THC**) is the active form of cannabis (marijuana). Epidemiological studies have shown that recent use of cannabis does increase crash risk when driving motor vehicles.
[18] Diazepam is a sedative/hypnotic drug of the benzodiazepines class.
[19] Hydroxyrisperidone is an antipsychotic drug prescribed for schizophrenia.
[20] Haloperidol is a butyrophenone derivative used therapeutically as an anti-psychotic agent.
[21] 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. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

family; providing meaningful activity for Ms Dent to engage in while on leave; and staff asking Ms Dent to move away from doors when they suspected she was planning to abscond.

47. The CPU explained that[22] providing leave to patients who are in the discharge planning phase of an admission is good practice, particularly after lengthy admissions. Providing such leave, it was said, supported by the 'inpatient team' helps the patient gradually integrate back into the community, reduces the anxiety of the patient around having a significantly decreased level of support on discharge, assists the treating team to identify any potential issues that may arise after discharge and plan for these, and increases the likelihood of a successful discharge. The Chief Psychiatrist's 'Leave of Absence from a Mental Health Inpatient Unit Guideline' also supports this strategy explaining that leave provides an opportunity for patients, carers and the treating team to evaluate the patient's recovery prior to discharge.

48. The CPU considered that restricting Ms Dent's leave, in the absence of acute psychiatric symptoms and immediate risk of harm for the purpose of preventing behavioural absconding would not have been appropriate and would have adversely impacted her recovery.

49. The CPU did not identify any prevention opportunities in connection with Ms Dent's absconding from the ED on 28 September 2018. The CPU considered that Ms Dent displayed signs on this occasion that she may abscond and given that she was subject to an ITO and had recently absconded, it was prudent to consider the imposition of a CPO. The CPU considered that Ms Dent's management in ED on this occasion was reasonable and appropriate; she was triaged and reviewed by a mental health clinician in a timely manner and an HDU bed was sought

50. The CPU identified alternative options available to staff to prevent Ms Dent from absconding, including seeking an HDU bed at another hospital (an out-of-area ("OOA") bed) or admitting Ms Dent to a low dependency unit ("LDU") bed with a CPO. Whether these options were explored on 5 October 2018 remains unclear.

[22] An explanation that was echoed in statements form staff at the Hospital.

51. The CPU described the mental health worker having received handover at the commencement of her shift at 10.00pm on 4 October 2018 and that an OOA HDU bed may have become available in the intervening period before Ms Dent absconded.

52. The CPU was unable to ascertain whether the Mental Health Clinician, when finishing her shift at 8.30am on 5 October 2018, handed over a request for the oncoming shift to enquire about an OOA bed or whether the oncoming shift ultimately made such an enquiry. The CPU considered that if a request for an OOA bed had been made in a timely manner, another hospital may have alerted the Hospital ED that an HDU bed was available and Ms Dent could have been transferred.

53. The CPU considered that it would have been more appropriate for the mental health worker to request an OOA or LDU bed for Ms Dent with the imposition of a CPO, rather than presenting a higher risk of absconding by remaining in ED with a CPO.

54. During the course of its review of Ms Dent's mental health treatment, the CPU requested a statement from Professor David Clarke, Monash Health Program Director of Mental Health.

Professor D Clarke

55. In his statement Professor Clarke described a review conducted by Monash Health of Ms Dent's mental health management ("the Monash Review"). The Monash Review found that the plan to discharge Ms Dent from SECU could have been executed in a more timely manner and her discharge plan revised accordingly.

56. The Monash Health Review noted several challenges that Ms Dent's treating clinicians faced during her discharge planning, including a complex presentation, difficulty finding suitable accommodation and differences of opinion among family members regarding possible discharge arrangements.

57. Monash Health adopted a number of recommendations made by the Monash Review:

    a. The Mental Health Program to develop a strategy for regularly reviewing revising discharge plans for long-stay patients. As of March 2020, the treating team formally

review a patient's therapeutic gains and recovery plan every six months after admission to SECU.

b. The Mental Health Program to review the Absent Without Leave procedure with the purpose of improving communications about missing persons on compulsory orders. The relevant procedure was updated and endorsed by Monash Health in July 2020.

c. The Mental Health Program to develop an AWOL/Absconded status resource that is prominently displayed on the ward and provides immediately available status updates on patients who have absconded on a daily basis, including contacts and communication with Victoria Police. The AWOL procedure was updated and endorsed by Monash Health in July 2020. Following Ms Dent's death, Monash Health transitioned to electronic medical records on SECU for ease of identifying a patient's AWOL/absconded status.

d. The Mental Health Program to review the procedure for patient leave from inpatient units to ensure that next of kin are aware of what to do when a patient is on leave; due dates for antipsychotic drug dosing are considered when granting leave; and that the procedure clearly identifies detailed contraindications for granting leave. The relevant procedure was updated and endorsed by Monash Health in July 2020.

58. In October 2019, the Program Director presented Ms Dent's case at the program quality meeting, disseminated the learnings to the ward governance group, and shared outcomes of the review with mental health units and nurse managers

59. In February 2020, the Head of the Mental Health Program met with Ms Dent's family to discuss the outcome of the Monash Review.

60. In his statement, Professor Clarke indicated that the review identified two issues with regard to Ms Dent's management in the ED. The first was that in light of her status pursuant to the *Mental Health Act 2014* (Vic), Ms Dent could have been admitted in a more expeditious manner when she attended ED while absent without leave from SECU. Professor Clarke

noted that when Ms Dent presented to the ED on 5 October 2018,[23] there were no HDU beds available. Professor Clarke considered it reasonable for Ms Dent to remain in ED overnight with a CPO, with a view to admitting her to the HDU the following day bearing in mind her agreement to remain in ED overnight, that she was not violent and initially did not give any indication that she would attempt to leave.

61. Professor Clarke further acknowledged that Ms Dent's long-acting antipsychotic medication could have been administered by ED staff when she came to the ED on 5 October 2018. Professor Clarke noted however that the decision not to administer Ms Dent's antipsychotic medication in ED was reasonable because of the planned psychiatric review the following day. Because the antipsychotic medication was 'slow release', the CPU considered it unlikely that its administration when Ms Dent first arrived at the ED would have reduced her absconding risk.

62. Professor Clarke also explained that the Mental Health Patient Assessment, Treatment, Transfer and Discharge procedure in the ED was a part of the Monash Review particularly in relation to safely keeping patients who are on compulsory treatment orders from absconding and administering overdue anti-psychotic medication to them. The Monash Review concluded that the current procedure satisfactorily addressed the need for observation of patients and the administration of vital medications, and that no amendments to the procedure were required.

EVIDENCE OF ATTEMPTS TO FIND MS DENT A SECURE BED, 5 – 6 OCTOBER 2018

63. Police escorted Ms Dent in an ambulance to the Hospital on 5 October at about 2.16am. She was triaged and reviewed by a 'mental health worker' who made two statements for the coronial brief detailing, amongst other things her unsuccessful search across the Monash Health system, including SECU for a suitable bed in a mental health ward for Ms Dent and her recollections of what she was told about the availability of such beds.[24]

[23] She had then been discharged from SECU
[24] A qualified social worker. The statements were dated July 2019 and 20 June 2020.

64. The Hospital commissioned a report from Dr Anne-Maree Kelly dated 3 July 2020 in relation to whether Ms Dent's treatment at the Hospital on 5 – 6 October 2018 was reasonable. I will deal further with this report later in this finding. I note here however that Dr Kelly refers to when Ms Dent was triaged on 5 October 2018 that she was assigned Australasian Triage Scale category 2 – target maximum time to see a doctor of 10 minutes. Dr Kelly makes no reference to Ms Dent having seen a doctor within the nominated time frame.

65. In her first statement, the mental health worker stated that:

    a. She enquired with the Hospital's HDU and was told that a bed was not available for Ms Dent; and

    b. A request was made for a bed in the Hospital's psychiatric HDU.

66. The statement contains no reference to other searches having been made for a bed for Ms Dent.

67. In her second statement, when asked for details regarding actions taken to access a gazetted Victorian mental health bed for Ms Dent on 5 October 2018, the mental health worker stated that:

    a. She placed a request for a HDU bed;

    b. Enquired with all mental health units at Monash Health, including at Dandenong Casey and Clayton campuses that would have access to a HDU bed and found that none was available;

    c. She enquired at the ECU where Ms Dent had been previously admitted and no bed was available;

    d. Her routine practice was to seek an OOA bed if there are not beds available at Monash facilities and to note any such enquiries;

    e. She was unable to recall if she had made any enquiries for an OOA bed but because she was unable to locate any notes in relation to her making such enquiries, she

assumed that she did not. She assumed that she did not make any enquiries for an OOA bed because she assumed that she had been told on 4 October 2018 that none were available;

f. She assumed that a bed would become available for Ms Dent at Monash Health during the day on 5 October (there is no evidence of the basis of this assumption) or that "…*a request would be escalated for an OOA bed if there was no bed available at Monash Health*"; and

g. As she recalled, there were no LDU beds available on 5 October 2018.

Beds

68. In relation to the provision of beds for persons assessed as requiring inpatient treatment, the Chief Psychiatrist's 'Access to Beds Guidelines' ("Access to Beds Guide") states that, at first instance, a bed should be provided in the area of origin. Where the mental health service of origin is unable to provide a bed, a bed within the same network or region must be made available on request. Finally, if a bed is not available within the same network or region, a bed should be requested in the nearest most appropriate mental health service. In accordance with the Chief Psychiatrist's guidelines, the 'Monash Health Capacity Management and Escalation Mental Health' procedure states:

> "*Where Monash Health is unable to admit a patient due to capacity or inappropriate staffing or environment at the time, ECATT* [Enhanced Crisis Assessment and Treatment Team] *are responsible for contacting out-of-area services in an attempt to access a bed.*"

69. In his statement to the Court, Chief Psychiatrist Dr Neil Coventry agreed that EDs are rarely an ideal setting for the care and treatment of people with a mental illness because they don't provide the level of care provided in a mental health inpatient unit, due in large part to EDs frequently being busy and noise and involving multiple urgent demands on clinicians and lengthy wait times. Dr Goldie added that there are no dedicated zones for mental health clients in the Hospital ED.

70. Dr Coventry stated that once acute medical issues have been excluded or managed and an HDU bed is not available, an LDU within a mental health inpatient unit is likely to offer more specialist nursing care and faster access to mental health treatment. For patients at a high risk of absconding, Dr Coventry stated that one-on-one nursing may be required as LDUs are easier to exit than an HDU.

71. Dr Coventry stated that in the event that a LDU bed is also unavailable locally or regionally, other options to manage patients in circumstances such as Ms Dent's on 5 October 2018 include starting active treatment in ED to reduce frustration and agitation that might cause the patient to abscond and to move the patient to an area that is closest to a staff hub and further from exits. Dr Coventry further stated that the use of a CPO, one-on-one nursing, security and/or police presence may be appropriate depending on the circumstances.

72. Dr Goldie concurred with the alternatives proffered by Dr Coventry, adding that the length of time the patient in these circumstances is required to remain in ED awaiting an HDU bed is a factor that warrants consideration. According to Dr Goldie, due to Ms Dent's risk of absconding, she was placed geographically furthest from the exit to allow her to be more easily observed and a CPO considered appropriate. Dr Coventry considered that regardless of the options adopted, where a patient remains in ED awaiting admission, it is important that they are regularly checked by a clinician so as to ensure their comfort, with adequate food and fluids, and to be kept informed of bed availability and any plans for their transfer.

MONASH HEALTH RESPONSE TO THE COURT'S REQUEST FOR A RESPONSE

73. A number of issues in relation to Ms Dent's treatment at the Hospital over 5 – 6 October 2018 arose during my assessment of the evidence. On 12 April 2022, the court wrote to Monash Health raising these issues and providing the opportunity for Monash Health to respond.

74. By letter dated 15 July 2022 Monash Health submitted that:

    a. It acknowledged that Ms Dent would ideally have been admitted to a ward directly following her assessment at the Emergency Department on 5 October 2018;

b. The challenges faced by the mental health worker are reflective of broader, systemic challenges faced in the mental health system;

c. The weight of the evidence suggests the steps taken by the mental health worker to locate a bed were consistent with reasonable practice and relevant guidelines;

d. Even if OOA bed had been identified it is unlikely that Ms Dent would have been transferred out of the area before further attempts could be made to locate a Monash Health bed given her long history of treatment at the Hospital; and

e. The coroner cannot be satisfied that the attempts made to locate a bed fell below a reasonable standard of care: or that there is any real prospect that further attempts would have averted the death.

75. Ms Wellington appeared at the Inquest for Monash Health. I asked her explicitly if she put that Dr Kelly's report asserted that the Hospital had acted reasonably when searching for a bed for Ms Dent on 5 October 2018 or whether it asserted that it had acted in accordance with the 'Monash Health Capacity Management and Escalation Mental Health Procedure' ("MHMHP") and the Chief Psychiatrist's Access to Beds Guide or whether her submission was that there was some combination of this. Ms Wellington submitted that Dr Kelly's report asserted that the Hospital had both acted reasonably when searching for a bed and in accordance with the MHMHP and the Access to Beds Guide. I am unable to see where in Dr Kelly's report Dr Kelly asserts that Hospital acted in accordance with the MHMHP or the Access to Beds Guide. It is, however, clear that Dr Kelly asserts that the Hospital acted reasonably.

CONCLUSIONS

76. The standard of proof for coronial findings of fact as that of the civil standard of proof on the balance of probabilities, as effected by the principles set-out by his Honour Justice Dixon (as he Honour then was) in *Briginshaw*.[25] Adverse findings or comments in relation to

[25] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362-363: 'The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular

individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

77. Ms Dent had a considerable history of acquired brain injury, mental illness, the effects of which were aggravated by substance, including illicit drug abuse and non-compliance with prescribed medication. In the two years prior to her death, Ms Dent's treatment was frequently interrupted by periods of absconding from treatment and substance abuse even while undergoing an inpatient admission. Ms Dent presented an ongoing risk of absconding from hospitals in which she was being treated due to her substance use, personality factors and an acquired brain injury. This risk was not associated with her mental illness and would not have been reduced by prolonging her admission or withholding periods of leave.

78. It was appropriate for SECU to approve leave for Ms Dent as she was in the discharge planning phase of her admission and she was not exhibiting acute psychiatric symptoms or risks associated with psychiatric symptoms. Further, her previous episodes of absconding were not secondary to psychiatric symptoms. On the day of her final absconding incident, she was reviewed by the Nurse Unit Manager immediately prior to being granted leave. As was the case with previous approvals for leave, the conditions of her leave were clearly explained to her, as were the consequences of not adhering to the leave conditions.

79. Ms Dent's re-admission to the Ward at the Hospital was delayed because there was no appropriate bed available for her at the Dandenong Hospital or elsewhere in the Monash Mental Health network on 5 – 6 October 2018. In her second statement, the mental health worker refer to her being unsure if she searched for an OOA bed for Ms Dent but because, she said, her usual practice was to make notes of any such searches she conducted, and there being no such note she assumed that she did not make any such search. The worker further assumed that she had been told at 'hand-over 'that there were no OOA beds available. The

finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…'

CPU considered that a prevention opportunity existed on this occasion as alternative options for Ms Dent's admission could have been considered that would ultimately reduce her risk of absconding including searching for a bed.

80. Not only must staff take into account risks patients pose to themselves, but risks that they also pose to other members of the community.

81. It is to be recalled of course that as at 2.30am 5 October 2018 when the mental health worker assessed Ms Dent, she knew of Ms Dent's lengthy history of illicit drug abuse serious mental health issues and an acquired brain injury as well as absconding from hospital. The mental health worker had assessed her before.

    a. On 5 October 2018 the mental health worker noted that Ms Dent's main risks were:

        i. High risk of absconding;

        ii. Ongoing substance abuse;

        iii. Vulnerability to homelessness;

        iv. Non-compliance with medication and treatment; and

        v. History of psychosis and violence particularly to clinical staff and an assessed her as being a medium to high risk of harm to herself through misadventure due to ongoing substance use, non-compliance with medication and homelessness.

    b. Factors which minimised the risks and indicated that Ms Dent may be more likely to comply with her treatment plan included:

        i. Ms Dent presented to the police station the night before knowing that she subject to a compulsory inpatient treatment order and so the police would take her to hospital; and

        ii. She agreed to stay in the ED overnight and take provided medication (diazepam).

82. I note that the mental health worker assessed Ms Dent at 2.30am 5 October 2018 as being a medium to high risk of harm to herself through misadventure due to ongoing substance use, non-compliance with medication and homelessness.

83. By the time Ms Dent absconded between 10.29am and 10.41am on 6 October, she had been in the ED for some eight hours. EDs are places of high and unpredictable levels of activity with high patient turnover; they are not secure hospital units. While the presence of a CPO in the ED may reduce the risk of absconding, if a patient attempts to abscond, the CPO is not expected to physically restrain them and must await assistance from other staff, during which time the patient may abscond. The CPU acknowledged that it would not have been reasonable to use physical restraint to prevent Ms Dent from absconding from ED, in the absence of evidence that she was at immediate risk of harm to herself and/or others.

84. As highlighted by Professor Clarke, Dr Goldie and the mental health worker, it would not have been appropriate to use restrictive interventions (physical or chemical restraint) under the *Mental Health Act 2014* (Vic) to prevent Ms Dent's absconding from ED in the absence of immediate risks. That the mental health worker had her mind specifically directed to what enquiries she made about a bed for Ms Dent as a part the request for a second statement may go some way to explaining inconsistencies between her first and second statements.[26]

85. I have been unable to determine whether the mental health worker searched for an OOA bed for Ms Dent but not searching for one is inconsistent with the MHMHP and the Chief Psychiatrist's Access to Beds Guide. It is not known whether an HDU or LDU bed was available anywhere within the Victorian Public Mental Health network between approximately 2.16am 5 October 2018 and 10.25am on 6 October 2018.

86. The evidence leaves me unclear about what precisely what efforts were made to locate a secure bed, or at least one more secure than accommodation in the ED allowed for. Bearing in mind Professor Clarke's evidence that even if such a bed had been found on 5 or 6 October 2018, there was some real possibility that Ms Dent would not have been transferred to it. As is at least possible, according to Monash Health because Ms Dent was to be

[26] For the sake of clarity, this is not a criticism.

psychiatrically assessed during the morning of 6 October 2018. This assertion is made in the context of Monash Health's assertion that as much as could have reasonably been done to provide Ms Dent with some security and care overnight 5 – 6 October 2018. This included moving her to the back of the ED and allocating a CPO to her, bearing in mind her imminent psychiatric assessment in the morning of 6 October 2018. Had such a bed been located it may not have averted Ms Dent's death; Ms Dent may not have been transferred to it anyway overnight.

87. That medical staff at the Hospital were working under considerable stress on 5 and 6 October 2018 is clear and bed availability was undoubtedly tight. Ms Dent's death was too distant in time from when she left the ED to conclude that had she been provided with more secure accommodation than the ED that her death would not have occurred as it did. I take into account too that much happened between when she left the Hospital on the morning of 6 October 2018 and when Mr Binge's car collided with the traffic light pole.

88. I have included some recommendations below that, if adopted, may aid busy hospital staff when they are dealing with patients who have considerable mental health issues in circumstances when the ED is very busy.

89. Mr Binge's motor car's collision with the traffic light pole was an accident and Ms Dent's resultant death a tragedy. The collision fortuitously involved no other road users. It is not clear to me that Ms Dent was seen by a doctor as was required by her 5 October 2018 triage classification albeit that even if she had been, it is not clear to me that her death would not have occurred as it did. Ms Dent's life was beset by adversity. The ravages of drug abuse and mental ill-health made life precarious and eventually took their toll despite the efforts of her family and physicians.

90. I have read Mr Dent's and Ms Foster's poignant statements both of which recount the exigencies of trying to help their daughter deal with long term serious mental health problems and illicit drug use.

FINDINGS

91. Pursuant to section 67(1) of the Coroners Act 2008 I find that:

a. The identity of the deceased is Paige Dent, born 31 January 1993;

b. Ms Dent died on 6 October 2018 on Nepean Highway in the vicinity of 1251 Nepean Highway, Cheltenham, Victoria, from injuries sustained in a single motor vehicle incident in which she was the driver; and

c. the death occurred in the circumstances described above.

RECOMMENDATIONS

92. Pursuant to section 72(2) of the Act, I make the following recommendations:

a. That Monash Health formulate a policy for formally documenting enquiries in relation to accessing high and low dependency beds for patients subject to an Inpatient Treatment Order who present to the hospital's emergency department, in accordance with the following stepped process of elimination some of which is outlined in the Chief Psychiatrist's Access to Beds Guide:

i. At first instance, clinicians should provide active treatment of the patient in the emergency department to reduce the patient's frustration and agitation that may ultimately cause them to abscond.

ii. Source an in-area (within the Monash Health Mental Health network) high dependency unit bed.

iii. If unavailable, source an out-of-area (outside of the Monash Health Mental Health network, but within the Victorian Public Mental Health network) high dependency unit bed.

iv. If unavailable, source an in-area low dependency unit bed.

v. If unavailable, source an out-of-area low dependency unit bed.

vi. If unavailable, and as a last resort in the absence of suitable high and low dependency unit beds, situate the patient in the ED with a continuous patient observer, positioned the furthest away from exits.

PUBLICATION OF FINDING

93. Compliant with section 73(1B) of the *Coroners Act 2008* (Vic), I direct that the Findings be published on the internet.

DISTRIBUTION OF FINDING

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

a.	Mr Michael Dent	Senior Next of Kin
b.	Ms Robyne Foster	Senior Next of Kin
c.	Mr Peter Ryan	Monash Health
d.	Ms Bethany Wellington	K&L Gates
e.	Ms Belinda Iliff	Victorian Government Solicitor's Office
f.	Inspector Susan Nolan	Victoria Police
g.	Senior Constable Andrew Campbell	Coroner's Investigator

Signature:

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DARREN J. BRACKEN

CORONER

Date: 22 December 2022.

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.