Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 14/14

I, Barry Paul King, Coroner, having investigated the death of ***Lynn Desmond Ernest Church*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***28 and 29 April 2014*** *find that the identity of the deceased person was* ***Lynn Desmond Ernest Church*** *and that death occurred on* ***6 July 2010*** *at* ***Joondalup Health Campus Mental Health Unit*** *from* ***plastic bag asphyxia*** *in the following circumstances:*

Counsel Appearing:

Ms I Burra-Robinson assisting the Coroner
Mr P Quinlan SC (instructed by DLA Piper) appearing on behalf of Joondalup Hospital Proprietary Limited and its employees
Ms B Burke (Australian Nursing Federation) appearing on behalf of Ms Julie Armstrong and Mr Rogelio Kong

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INTRODUCTION

1. Lynn Desmond Ernest Church (the deceased) died on the morning of 6 July 2010 while he was a patient at the Joondalup Health Campus Mental Health Unit (JMHU).

2. As the deceased was an involuntary patient under the *Mental Health Act 1996* at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996*.

3. Section 22 (1)(a) of the *Coroners Act 1996* provides that a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.

4. An inquest to inquire into the death of the deceased was therefore mandatory. An inquest was held on 28 and 29 April 2014 at which the deceased's daughter, Ms Karon Sibbritt, and staff from the JMHU gave oral evidence. Documentary evidence comprised a report by Sergeant G M Hutchinson of the Coronial Investigation Unit of the Western Australian Police together with copies of relevant documents he had obtained.

5. Under s25(2) of the *Coroners Act 1996*, a coroner may comment on any matter connected with the death including public health. I have recommended by way of a comment that the JMHU investigate its procedures of managing communications with the families of patients to ensure that information is relayed to the relevant health professional.

6. Under s25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care. I have found that the relevant supervision, treatment and care provided to the deceased was reasonable in the circumstances.

THE DECEASED

7. The deceased was born on 10 December 1945 in Paulton, England.

8. He married Rita Haines in 1967 and they had their first daughter, Karon, while they lived in England.

9. In 1974 the deceased and his family moved to Western Australia where the second daughter, Joanne, was born.

10. The deceased worked as a builder and later as a painter.

11. Evidence of the deceased's first few decades in Australia is limited. It seems that in 1984 and 1985 he was working as a car park attendant.[1]

THE DECEASED'S MEDICAL AND PSYCHIATRIC HISTORY

12. The deceased began consulting neurologist Dr Joseph Scopa in 1977.[2] The deceased told Dr Scopa that he had suffered severe migraine-like headaches from the time he was 16 years old. By 1984 he had also had a duodenal ulcer for seven years and had been treated for depression.[3]

13. In 1984, the deceased began consulting Dr Joseph Lui, a general practitioner at Gumnut Family Practice in Wanneroo.

14. In 1985 Dr Lui referred the deceased to a consultant psychiatrist, Dr C L Teoh, who treated the deceased until 1992. Dr Teoh noted that the deceased had been succeeding in managing his migraines without medications but that he had been on the antidepressant amitriptyline for eight years.[4]

[1] Exhibit 1, Volume 1, Tabs 19 and 20
[2] Exhibit 1, Volume 1, Tab 18
[3] Exhibit 1, Volume 1, Tab 19
[4] Exhibit 1, Volume 1, Tab 20

15. Dr Teoh described the deceased as rather obsessional, with tremendous hate and anger for his brother and grief for the recent death of his father. Dr Teoh noted that the deceased had a psychiatric history of psychosomatic pain in the shoulder. The medical history included migraine, stomach ulcers, fluctuating blood pressure and disc trouble with his neck.[5]

16. Dr Teoh also described the deceased as having a premorbid personality, being sensitive but rather obsessional, quite stubborn with high pain tolerance, and rather emotional.[6]

17. In 1993 Dr Lui referred the deceased to another consultant psychiatrist, Dr Sanath de Tissera, who considered that the deceased had a personality disorder with a limited intellectual endowment. Dr de Tissera recorded that the deceased was a loner and an orderly, regimental perfectionist. The deceased apparently told Dr de Tissera that he was poor at communicating with people and that he was having problems in his marriage over the previous 25 years. He said that his wife no longer loved him.[7]

18. The deceased attended Gumnut Family Practice until 2003 when he started attending another general practitioner in Quinns Rocks. He returned to attending Dr Lui in 2008, still suffering from migraines, depression and insomnia. Dr Lui prescribed him Panadeine Forte and tramadol for the migraines and various antidepressants, including amitriptyline, for depression.[8]

19. The deceased continued to see Dr Lui until 16 June 2010. His prescription at that time included 750mg of tramadol and 25mg of amitriptyline daily.[9]

[5] Exhibit 1, Volume 1, Tab 20
[6] Exhibit 1, Volume 1, Tab 20
[7] Exhibit 1, Volume 1, Tab 21
[8] Exhibit 1, Volume 1, Tab 18
[9] Exhibit 1, Volume 1, Tab 18

20. Going back, in 2002 the deceased was taking a high dose of fluoxetine as well as amitriptyline. Over time he became overactive and agitated.[10] In about 2003 the deceased was working as a house painter. He became obsessed with a woman whose house he was painting. He threatened the woman's husband with a knife and overpowered him in a struggle, though it seems that he did not harm him.[11] The deceased's obsession with this woman led him to divorce his wife even though his feelings for the woman were not reciprocated.[12]

21. In 2006 he was referred by his then GP, Dr Lincoln, to Dr de Tissera, who at this stage diagnosed the deceased with personality disorder, hypochondriasis and abnormal illness behaviour.

22. Later in July 2006, the deceased wrote a "Disclaimer" in which he stated that he had been suffering from chronic fatigue syndrome for three and a half years and that he had been treating it himself. He said that he had constant headaches and that he needed drugs. If the drugs did not work, he said that he was as good as dead and that he was, in fact, suicidal. He said that because he was suicidal, no blame could be laid against his doctors.[13]

23. On 24 July 2006 the deceased was referred by another GP to Clarkson Community Mental Health because of suicidal ideation. There he was seen by a duty officer whom he told that he was lonely and isolated. He was still working alone as a house painter. He was separated from his wife and had no friends. He said that his brother had died two weeks previously and that he was experiencing significant and constant migraines.

24. Four days later the deceased was seen by a psychiatric registrar at Clarkson Community Mental Health. He told the registrar about his experience three years previously

[10] Exhibit 1, Volume 1, Tab 31
[11] Exhibit 1, Volume 2, Tab 35, 2nd Admission integrated progress notes 31/7/06
[12] ts 8 per K Sibbritt
[13] Exhibit 1, Volume 2, Tab 35, 2nd Admission

when he fell in love with the woman whose house he was painting and about his plan to kill her husband. He described paranoid delusions and chronic suicidality. The registrar diagnosed the deceased with untreated chronic paranoid schizophrenia, depression and medication abuse. With the deceased's agreement, the registrar referred him under the *Mental Health Act 1996* to the JMHU for assessment.[14]

THE DECEASED'S 2006 ADMISSION TO THE MHU

25. The deceased was admitted into the JMHU on 28 July 2006. He remained there for a month under the care of psychiatrist Dr Petrus Claasen.[15]

26. The deceased's condition improved marginally as soon as he was admitted. He said that he felt safer and less stressed when in hospital and that his migraines had improved. He said that he was unlikely to abscond and that he had no active suicidal ideation.[16]

27. The deceased was kept in the JMHU as a voluntary patient in the open ward. He was initially considered a moderate risk of suicide and was monitored every 30 minutes but within three days was monitored every hour.[17]

28. During the first two weeks of the admission, the deceased was lonely, depressed and preoccupied with physical complaints. As time went on, his affect improved and he no longer had any suicidal ideation. His preoccupation with physical complaints remained, but by 24 August 2006 Dr Claasen considered that the deceased could be discharged with follow-up at the Clarkson Community Mental Health clinic.[18]

[14] Exhibit 1, Volume 2, Tab 35, 2nd Admission
[15] Exhibit 1, Volume 2, Tab 35, 2nd Admission
[16] Exhibit 1, Volume 2, Tab 35, 2nd Admission
[17] Exhibit 1, Volume 2, Tab 35, 2nd Admission
[18] Exhibit 1, Volume 2, Tab 35, 2nd Admission

29. The deceased's daughter, Ms Sibbritt, visited the deceased frequently while he was admitted at JMHU. She noted that he was a lot more upbeat when he was discharged. He wanted to join groups and make friends. However, his positive attitude dwindled away with time.[19]

30. Towards 2010 the deceased became more aggressive and had no humour or happiness in him. He was lonely and would say that he was constantly in pain. He was angry with his divorce and wanted to get back in his ex-wife's favour by renovating her house. His family saw that he was slowly deteriorating and that he was continually expressing suicidal ideations.[20]

THE DECEASED'S ADMISSION ON 24 JUNE 2010

31. The deceased was taken by ambulance to the emergency department of the Joondalup Health Campus (JHC) in the early afternoon of 24 June 2010 after he had overdosed on the benzodiazepine sedative nitrazepam, as well as tramadol and amitriptyline, at about 10.00pm the previous night. His ex-wife had showed up at his home for a visit and found him in a state of altered consciousness. He stated that he had had enough of the pain.[21]

32. In the emergency department the deceased was reviewed by a clinical nurse co-ordinator and the psychiatric registrar. He told them that the overdose was impulsive as he was fed up with the migraines. He was socially isolated and had had no psychiatric follow-up after his admission in 2006.[22]

33. The deceased described bizarre thought processes and related how he self-medicated for migraines and various physical complaints including chronic fatigue syndrome. He admitted being addicted to tramadol.[23]

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[19] ts 9 per K Sibbritt
[20] ts 10 per K Sibbritt
[21] Exhibit 1, Volume 2, Tab 35, 3rd Admission
[22] Exhibit 1, Volume 2, Tab 35, 3rd Admission
[23] Exhibit 1, Volume 2, Tab 35, 3rd Admission

34. The deceased said that he was feeling good and that he had no pain at that time. He denied current suicidal ideation, plan or intent and stated that he would not take any extra medication. He wanted to go home to sleep.[24]

35. The deceased was offered voluntary admission at the JMHU but he refused. He was discharged with follow-up to his GP. His ex-wife was happy to take him home.[25]

THE DECEASED'S FINAL ADMISSION ON 26 JUNE 2010

36. On the morning of 26 June 2010 the deceased woke at about 6.00am and decided that he wanted to end his life. He later told medical staff that he had initially tried to cut his throat with a hacksaw but found that it was not sharp enough, so he went to his ex-wife's home to ask for a sharp knife. His ex-wife called for an ambulance, and the deceased was taken to the emergency department at JHC.[26]

37. The deceased was assessed by a psychiatry registrar and offered voluntary admission to hospital, which he refused. The registrar then admitted the deceased involuntarily for assessment due to his significant suicide risk. The deceased was placed in the open ward of the JMHU on 15 minute observations. He underwent a mini-mental state examination (MMSE) in which he scored 22/30.[27]

38. The deceased was relatively settled over-night and was reviewed by a psychiatrist on call, Professor Paul Skerritt at 2.00pm the next afternoon. Professor Skerritt admitted the deceased involuntarily to clarify his complicated presentation. After the review the deceased absconded from the JMHU and went home. He had told his ex-wife where he had planned to go and she notified staff at the JMHU who contacted police.[28]

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[24] Exhibit 1, Volume 2, Tab 35, 3rd Admission
[25] Exhibit 1, Volume 2, Tab 35, 3rd Admission
[26] Exhibit 1, Volume 2, Tab 35, Emergency Department Medical Assessment
[27] Exhibit 1, Volume 2, Tab 35, Integrated Progress Notes; Exhibit 1, Volume 1, Tab 30, p.2
[28] Exhibit 1, Volume 2, Tab 35, Integrated Progress Notes; Exhibit 1, Volume 1, Tab 30, p.3

39. Police attended the deceased's home. The deceased refused to leave the house and threatened police with samurai swords.

40. The deceased left a message on Ms Sibbritt's answering machine to the effect that he had absconded from the JMHU. Ms Sibbritt rang the police who asked her to come to the deceased's house to speak to him. She and her husband drove there but, fortunately, by the time they arrived the deceased had let the police in without anyone being hurt.[29] With the deceased's agreement, the police returned him to the JMHU where he was placed in the closed ward, known as the Psychiatric Intensive Care Unit (PICU), on 15 minute observations.[30]

41. The next day, 28 June 2010, the deceased was medically examined by the resident medical officer, Dr Irene Broichhausen, and was assessed by a trainee psychiatry registrar, Dr Anne O'Sullivan.[31]

42. Dr Broichhausen noted that the deceased had a possible conduction problem with his heart and that he may have had a urinary tract infection. He kept asking her for tramadol.[32]

43. The deceased told Dr O'Sullivan that he no longer wanted to kill himself. He gave a detailed history of his physical complaints, especially his migraines, and told her about his renovations of his ex-wife's house. He described how he was taking high doses of tramadol and Panadeine Forte. He talked about how lonely and isolated he felt, but repeated that he did not intend to kill himself.

44. Dr O'Sullivan gained the impression that the deceased had experienced a major depressive episode and she believed that he was a high risk of suicide. She planned to conduct another MMSE on the deceased, to prescribe an antibiotic for the urinary tract infection, to organise a

[29] Exhibit 1, Volume 1, Tab 5, p.3-4
[30] Exhibit 1, Volume 2, Tab 35, Integrated Progress Notes; Exhibit 1, Volume 1, Tab 30, p.3
[31] Exhibit 1, Volume 2, Tab 35, Integrated Progress Notes; Exhibit 1, Volume 1, Tab 30, p.3-4
[32] Exhibit 1, Volume 2, Tab 35, Integrated Progress Notes; Exhibit 1, Volume 1, Tab 30, p.4

full organic screen to identify or rule out any medical issues that may have caused or contributed to the deceased's presentation, and to cease the deceased's use of tramadol.[33]

45. Dr O'Sullivan was concerned that the levels of tramadol taken by the deceased while he was taking anti-depressants could have caused a condition known as serotonin syndrome, which can cause symptoms including headache, hypomania, confusion, hallucinations and agitation. She asked Dr Broichhausen to call Dr Lui to clarify the deceased's pain and medication history. Dr Lui confirmed that he had prescribed tramadol slow release and Panadeine Forte for migraines.[34]

46. Dr O'Sullivan was concerned of the deceased's risk of suicide and further absconding, so she directed the clinical co-ordinator at the JMHU to keep the deceased in the PICU at 30 minute observations. The deceased told her that he did not want her to call his ex-wife or Ms Sibbritt, though he did not explain why.[35]

47. Ms Sibbritt called the JMHU to see how her father was. She was told that he was a little more lucid and was being very quiet. She asked for a doctor to call her, but no-one did.[36]

48. On 29 June 2009 Dr O'Sullivan did not assess the deceased again, but she kept him on 30 minute observations. The deceased underwent another MMSE in which he scored 25/30.

49. At some stage about this time, Ms Sibbritt visited the deceased while he was in the PICU and noted that he appeared more lucid and coherent than he had been in the past. He was a lot calmer and was looking forward to a pending CT scan.[37]

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[33] Exhibit 1, Volume 2, Tab 35, Integrated Progress Notes; Exhibit 1, Volume 1, Tab 30, p.5
[34] Volume 1, Tab 30, p.6
[35] Exhibit 1, Volume 1, Tab 30, p. 6
[36] Exhibit 1, Volume 1, Tab 5, p. 4
[37] ts 15 per K Sibbritt

50. On the next day, 30 June 2010, the deceased was feeling unwell with aches and pains and feeling hot and cold. Dr Broichhausen and Dr O'Sullivan were concerned that the deceased had been displaying symptoms of serotonin syndrome. They reviewed the deceased together and confirmed with him that he had been using double the recommended daily dosage of tramadol. While any serotonin syndrome the deceased was suffering was apparently resolving, it was important to control his agitation and depression as soon as possible with the use of an anti-depressant.[38]

51. Dr O'Sullivan discussed the deceased's case with a consultant psychiatrist, Dr Amatul Uzma, who agreed with the current management plan and advised her not to start an anti-depressant until the deceased's physical signs were settled. The most significant risk at the time was seen to be that of the deceased absconding from the JMHU.

52. That evening the deceased had a CT scan of his head.

53. At that stage the deceased still maintained that Dr O'Sullivan was not to contact his family.[39]

54. The next day, 1 July 2010, Dr O'Sullivan held a long interview with the deceased during which the deceased went into detail about the renovations he was carrying out on his ex-wife's house. He said that he wanted to appease the guilt he felt about the breakdown of the marriage and to win back his ex-wife's affections. He denied being suicidal at the time. He agreed that Dr O'Sullivan could call Ms Sibbritt and hold a family meeting.[40]

55. On the same day, the results from the CT scan were provided. They showed that the deceased had greater than expected involutional changes to his brain indicating an ageing process that was advanced for his years.

[38] Exhibit 1, Volume 1, Tab 30, p. 7-8; Exhibit 1, Volume 2, Tab 35, Integrated Progress Notes
[39] Exhibit 1, Volume 1, Tab 30, p. 8-9
[40] Exhibit 1, Volume 1, Tab 30, p.10

Dr O'Sullivan was concerned that the changes might represent a dementia illness, so she asked Dr Broichhausen to arrange for an MRI brain scan.[41]

56. Dr O'Sullivan had intended to call Ms Sibbritt that day, but was unable to do so because another patient required an urgent review and because she had to leave work early due to a personal appointment. On the next day, a Friday, she was unwell and was unable to attend work.[42]

57. The deceased was kept in the PICU on 30 minute observations over the weekend. He remained settled and did not express any suicidal ideation or intentions to leave the ward.[43]

58. On Sunday 4 July 2010 the deceased called Ms Sibbritt. He asked her to bring him razor blades so that he could slit his wrists because he was being tortured and was not getting medical help. He said that he was in constant pain but was only being given Panadol.[44]

59. Ms Sibbritt called the JMHU and spoke to a nurse about what her father had told her. The nurse told her that she would leave a note for the duty doctor because Dr McAndrew was on leave.[45]

60. On the morning of Monday 5 July 2010 Ms Sibbritt again rang the JMHU after her father had left her a message on his ex-wife's answering machine asking about the razor blades she had brought him because he was being moved into the open ward. Ms Sibbritt spoke to a nurse who said that there was no record of her telephone call from the day before or of her concerns about her father's talk of self-harm. The nurse undertook to leave a message for a doctor to call her.[46]

[41] Exhibit 1, Volume 1, Tab 30, p.11
[42] Exhibit 1, Volume 1, Tab 30, p.11
[43] Exhibit 1, Volume 1, Tab 30, p.11-12
[44] Exhibit 1, Volume 1, Tab 5, p.6
[45] Exhibit 1, Volume 1, Tab 5, p.7
[46] Exhibit 1, Volume 1, Tab 5, p.8

61. That morning Dr O'Sullivan returned to work and her supervisor, Dr Mark McAndrew, also returned after annual leave. As was usual for a Monday morning, the clinical nurse co-ordinator asked Dr O'Sullivan if there were any patients in the PICU who could be transferred into the open ward to make room for acute patients who were awaiting a bed in the PICU. The deceased was discussed as a possible candidate.[47]

62. Dr O'Sullivan reviewed the deceased for possible transfer. He appeared more relaxed and less confused than previously and was less focused on his physical complaints. He told her that he was not feeling suicidal and that he wanted to remain in hospital and would not attempt to leave. He said that he wanted to move to the open ward because some of the acutely unwell patients in the PICU had upset him.[48]

63. The clinical nurse co-ordinator arranged for one of the nurses on duty, Amanda Traval RN, to speak to the deceased about how he felt about being transferred to the open ward. He told her that he was fine with transferring and that he would stay on the open ward. He said that he was keen to have his physical complaints checked out.[49]

64. Dr O'Sullivan arranged for the deceased to be transferred to the open ward with a staff escort on a trial basis to ascertain his suitability to remain there. He was provided with a single room and kept on 15 minute observations as was the usual protocol for transfer from the PICU to the open ward.

65. After his trial on the open ward went well, Dr O'Sullivan transferred the deceased there fully.[50]

66. At some stage of the morning, Ms Traval assisted the deceased to move to the open ward by unlocking his

[47] Exhibit 1, Volume 1, Tab 30, p.12
[48] Exhibit 1, Volume 1, Tab 30, p.12-13
[49] Exhibit 1, Volume 1, Tab 8, p.4-5
[50] Exhibit 1, Volume 1, Tab 30, p.13

wardrobe and directing him to organise his belongings to carry them to his new room. Ms Traval did not remember whether the deceased had his own bag or case for his belongings. If not, she said that she would have provided him with a black rubbish bag, but she did not recall doing so. She said that she would not, and could not have, provided him with an orange dissolvable laundry bag.[51]

67. In the afternoon of 5 July 2010 Dr McAndrew reviewed the deceased in company with Dr O'Sullivan and Dr Broichhausen. The deceased was still pre-occupied with his physical complaints and was mildly incoherent, but he said that he had no suicidal ideation and that he was pleased with the JMHU's plans for his treatment. Drs O'Sullivan and Broichhausen felt that he had improved significantly from the previous week. Dr O'Sullivan and Dr McAndrew discussed the transfer of the deceased from the PICU to the open ward and Dr McAndrew agreed that it was appropriate. They kept him on 15 minute observations in accordance with the JMHU protocol.[52]

68. Following that review of the deceased, Dr O'Sullivan rang Ms Sibbritt to inform her of her father's progress. Ms Sibbritt told her that the deceased had called her the day before to request that she bring him razor blades so that he could cut his wrists. She said that she had passed that information on to nursing staff the day before. Ms Sibbritt was concerned about the deceased's current risk and said that the deceased could go under the radar and be very secretive. She was also concerned about the deceased's transfer from the PICU to the open ward.[53]

69. Dr O'Sullivan told Ms Sibbritt about the deceased's improvements over the last three days and about the implementation of 15 minute observations. She explained how she, Dr McAndrew and nursing staff

[51] Exhibit 1, Volume 1, Tab 8, p.7-8
[52] Exhibit 1, Volume 1, Tab 30, p.14
[53] Exhibit 1, Volume 1, Tab 30, p.14

agreed that he was ready for transfer and that they would have transferred him to the open ward even if a bed were not needed in the PICU.[54]

70. Ms Sibbritt expressed her concerns again about her father's risk. Dr O'Sullivan assured her that she would speak to the nurse co-ordinator to ensure that the deceased was closely monitored overnight. She assured Ms Sibbritt that the deceased was very settled and that staff had no current concerns.[55]

71. During the afternoon of 5 July 2010 the deceased spent most of his time lying on his bed. He left his room only for short periods of time. The 15 minute observations were maintained.[56]

72. At about 8.00pm that evening, a mental health support worker in the JMHU spoke to the deceased about his diet and his menu for the next day. The deceased appeared particular about what he liked to eat and gave no indication that he would not be having further meals.[57]

73. During the evening, the deceased was monitored with 15 minute observations by nurses who included Rogelio Kong CRN and Julie Armstrong MHRN. When observations were conducted, the nurses recorded the results on forms labelled Mental Health Special Observation Records, but commonly called observation charts.[58]

74. The method of conducting the observations at night generally involved the nurse looking at the patient from the door of the patient's room with the assistance of a torch if necessary. In order to minimise the likelihood of disturbing the patient's sleep, the torch was directed at the wall above the patient rather than at the patient's face.[59]

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[54] Exhibit 1, Volume 1, Tab 30, p.15
[55] Exhibit 1, Volume 1, Tab 30, p.15
[56] Exhibit 1, Volume 2, Tab 35, Integrated Progress Notes
[57] Exhibit 1, Volume 1, Tab 9, p.3-5
[58] Exhibit 1, Volume 1, Tab 11, p.3; Exhibit 1, Volume 1, Tab 12, p.4
[59] Exhibit 1, Volume 1, Tab 12, p.5; Exhibit 1, Volume 1, Tab 33, p.3-4; ; ts 102 per R Kong

75. Mr Kong conducted his first observation of the deceased at 11.00pm after he had finished undertaking a one-to-one watch over a patient who was at risk of falls. That patient's room was close to the deceased's room. An agency assistant in nursing (AIN) had arrived to take over the one-to-one watch.[60] She sat in the passage adjacent to the deceased's room.[61]

76. Mr Kong observed that at 11.00pm, 11.15pm, 11.30pm and 11.45 the deceased was in bed sleeping.[62] The deceased was wearing a beanie on his head as he had done on previous nights in the PICU.[63]

77. Ms Armstrong conducted the 12.00pm observation at which time she saw that the deceased was in bed but awake. Prior to that, the deceased had approached the nurses' station seeking pain relief. He was provided with paracetamol and he returned to his room.[64]

78. At some stage during the evening, the AIN told Ms Armstrong that she had heard sounds from the deceased's room consistent with him re-arranging things. Ms Armstrong went to the deceased's room and saw him moving around his bedclothes. He complained of feeling hot and then cold and said that he was trying to get comfortable.[65]

79. Mr Kong conducted observations on the deceased at 1.15am and 1.30am on 6 July 2010. On each occasion he recorded in the observation chart that the deceased was in bed, sleeping, as had other nurses at other times that morning.[66]

80. When conducting an observation at 2.45am Mr Kong was curious about the fact that the deceased was in the same position in which he had been earlier in the shift. He asked Ms Armstrong, who was more familiar with the

[60] Exhibit 1, Volume 1, Tab 12, p.3-5
[61] Exhibit 1, Volume 1, Tab 11, p.6
[62] Exhibit 1, Volume 1, Tab 12, p.6
[63] ts 87 per G Farrington
[64] Exhibit 1, Volume 1, Tab 11, p.5-6
[65] Exhibit 1, Volume 1, Tab 11, p.6
[66] Exhibit 1, Volume 1, Tab 12, p.6, 12

deceased, to come into the deceased's room to check that the form in the deceased's bed was consistent with what she knew the deceased to look like. They both approached the bed and Ms Armstrong shone a torch on the blankets. Ms Armstrong was satisfied that the form was that of the deceased, and they both believed that they saw the blankets rise and fall, consistent with the deceased breathing. Mr Kong noticed a white towel around where the deceased's neck and shoulder would be.[67]

81. Mr Kong and Ms Armstrong conducted further observations of what they believed was the deceased until 7.30am.[68]

82. In fact, at some stage during the night, the deceased had used bedding to make a bulge on his bed to create the impression that he was asleep in the bed. It seems that he did so in order to be undisturbed by nurses while he went into his ensuite bathroom to asphyxiate himself with a plastic bag.

83. At 7.00am on 6 July 2010 JMHU staff for the next shift attended and went through a handover with the previous shift. The nurse conducting the 7.45am observation of the deceased was Gail Farrington RMHN. She saw the shape on his bed and she assumed that it was the deceased, as had staff before her. She knew from the handover that he had been up reasonably late asking for Panadol, so she was not surprised that he was still asleep.[69]

84. Ms Farrington conducted her other observations and then went back to the deceased's room to rouse him so that he could have blood taken for analysis. When she walked around to the side of the bed he appeared to be facing, she could see that what she thought was his head was a folded up towel with a beanie placed on it. Her immediate

[67] Exhibit 1, Volume 1, Tab 11, p.7-8
[68] Exhibit 1, Volume 1, Tab 11, p.9; Exhibit 1, Volume 1, Tab 12, p.9
[69] Exhibit 1, Volume 1, Tab 14, p.6

thought was that he may have absconded from the JMHU again.

85. Ms Farrington checked the room's ensuite bathroom and found the deceased on the floor with a plastic bag on his head. She pressed the alarm and tore the bag from the deceased's head, which was easily done because the bag was reasonably thin. The deceased had no pulse and was stiff, cold and purple-blue with lividity on his right cheek. The deceased's hands were clenched, gripping the bag closely around the base of his neck.[70]

86. Other staff arrived in answer to the alarm and, with Ms Farrington, commenced cardiopulmonary resuscitation. Members of the medical emergency team, who included an anaesthetist, then arrived. When it was determined that the deceased could not be intubated because his jaw was clenched closed, the anaesthetist called an end to the resuscitation attempt.[71]

CAUSE AND MANNER OF DEATH

87. Forensic pathologist Dr G A Cadden conducted a post-mortem examination of the deceased on 9 July 2010. Dr Cadden found multifocal and generalised atherosclerosis and pulmonary congestion.

88. Having regard to the deceased's mental health history and the context in which the deceased was found, Dr Cadden determined that the cause of the deceased's death was consistent with plastic bag asphyxia, and I so find.

89. Given the circumstances described above, I am satisfied that the death occurred by way of suicide.

[70] Exhibit 1, Volume 1, Tab 14, p.8
[71] Exhibit 1, Volume 1, Tab 14, p.10-11

QUALITY OF THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED AT THE JMHU

90. In my view, the facts described above suggest the following issues for consideration:
    a. the JMHU's management of communication between the JMHU and Ms Sibbritt;
    b. the transfer of the deceased to the open ward despite the warning from Ms Sibbritt;
    c. the use of 15 minute monitoring of the deceased;
    d. the quality of the monitoring by nurses; and
    e. the availability of plastic bags on the open ward.

91. In relation to the management of communication, the evidence suggested that the process in place at the time of the deceased's admission in 2010 was somewhat ad hoc.

92. Dr McAndrew, who was the head of the department of psychiatry at the JHC, said that if a nurse has a telephone conversation with a family member of a patient, the nurse would need to contact the medical staff on the treating team if it is on a week-day, or other on-duty staff on weekends, and relay the information to them. The nurse should have a discussion about the best way to respond to the family member and usually make a note in the records also.[72]

93. Ms Armstrong said that she considered that a record of a telephone communication should be made in the patient's integrated progress notes,[73] but as noted, Ms Sibbritt's phone calls were not recorded in the notes and her request for a doctor to call her on 28 June 2010 was not answered.

94. Dr O'Sullivan said that the registrar is usually the first point of contact for family members, and nurses will usually inform the family of the identity of the registrar and will pass along to the registrar that the family want to talk to him or her. She said that she did not know if

[72] ts 44
[73] ts 115

there was an actual procedure, but in her experience when family members tell nurses that they want to talk to someone on the medical team, the registrar is the port of call. If the family member had significant concerns, the nurses would be expected to pass along those concerns to the relevant treating team. Dr O'Sullivan was unaware of a written policy in relation to this expectation.[74]

95. That Ms Sibbitt's concerns were not passed along to Dr O'Sullivan could have led to decisions being made about the care of the deceased in the absence of potentially crucial information; namely, that the deceased was requesting razor blades from Ms Sibbritt on the day he was transferring to the open ward.

96. As it turned out, Dr O'Sullivan called Ms Sibbritt who informed her of the deceased's requests, so medical staff could take that information into account in managing him. However, that occurred despite the procedures at the JMHU for managing information, not because of them.

97. In my view, this is an area that may benefit from investigation by medical administrators. It may be that a tightening of procedures or the implementation of targeted training could reduce instances where relevant information about patients is not passed along as required. As this issue is of a procedural nature that could affect the administration of public health, I make the following recommendation.

Recommendation 1

That the JMHU investigate its procedures of managing communications with the families of patients with a view to ensuring that information is relayed to the relevant health professional.

[74] ts 69-70

98. As to the transfer of the deceased to the open ward despite Ms Sibbritt's warning to Dr O'Sullivan, it is apparent that the initial motivation to transfer him was a request from the nurse co-ordinator to Dr O'Sullivan that she consider whether any of the patients in the PICU could be transferred to the open ward.[75]

99. Dr O'Sullivan made clear that the deceased would have been reviewed regardless of the request because he had been settled on the ward, had not expressed any suicidal ideation and had been compliant with his medication and treatment on the ward.[76] Dr McAndrew also expressed the view that Dr O'Sullivan would likely have assessed the deceased for transfer that morning because he was on her list of patients that she needed to see. The deceased was an unusual case that they 'hadn't got a handle on.'[77]

100. Once the deceased had been transferred on a trial basis, Dr McAndrew assessed him during a lengthy interview. He was satisfied that it was appropriate to move the deceased to the open ward because, primarily, of the deceased's overall settled state in the PICU.[78]

101. Dr McAndrew considered that the deceased was at risk of absconding but was not acutely suicidal. He was not aware of the contents of Ms Sibbritt's discussion with Dr O'Sullivan, but said that had he been aware, it would not have affected his decision to move the deceased. This, he explained, was because of knowledge of the fact that the expressing of suicidal ideas or threats by patients in mental health units has no correlation to in-patient suicides. This may have been particularly pertinent in relation to the deceased, who according to Ms Sibbritt had spoken openly of suicidal ideation for many years.[79] Because of that, other factors had to be considered.[80]

[75] ts 38 per M McAndrew; ts 70 per A O'Sullivan
[76] ts 71 per A O'Sullivan
[77] ts 39 per M McAndrew
[78] ts 39 per M McAndrew
[79] ts 7
[80] ts 43 per M McAndrew

102. The other factors Dr McAndrew considered in the deceased's case were that: the deceased was in the PICU to stop him from absconding, not because of suicidal ideation, his behaviour in the PICU was reasonable and calm, acutely disturbed patients in the PICU were having a detrimental effect on the deceased, and it was important to maximise the deceased's autonomy and use the least restrictive alternative in treatment.[81]

103. Also relevant to this issue are the facts explained by Dr McAndrew that it was very common for patients at high risk of suicide to be in the open ward, and that the egress from the open ward was controlled so that the deceased did not have access to the grounds of the hospital.[82] Given that, and given that the deceased was on 30 minute observations in the PICU, his transfer to the open ward on 15 minute observations might be seen to be an increase of his security rather than a decrease.

104. In the circumstances described above, it appears to me that the decision to transfer the deceased to the open ward was reasonable. Doctor O'Sullivan and Dr McAndrew spent a considerable amount of time with the deceased. They took into account the information available to them and made a justifiable professional decision which they considered to be in the deceased's best interests.

105. As to the implementation of 15 minute observations of the deceased in the open ward, Dr O'Sullivan explained that the protocol at the time provided for that level of monitoring. A copy of the protocol was included in the documentary evidence.[83]

106. That a patient may commit suicide in much less time than 15 minutes was well-recognised.[84] While it would have been possible for the deceased to have been placed on one-to-one monitoring instead, there were

[81] Exhibit 1, Volume 1, Tab 31, p.4
[82] ts 59 per M McAndrew; ts 73-74 per A O'Sullivan
[83] Exhibit 1, Volume 1, Tab 15
[84] ts 53 per M McAndrew

considerations militating against that course. In particular, Dr McAndrew indicated that the intrusion associated with close monitoring of mental health patients could cause more harm than good. He noted the oppressiveness of one-to-one specialling and the balance act that is undertaken in trying to keep patients from self-harm.[85]

107. Following the deceased's death, the JMHU changed its protocol to require 24 hours of one-to-one specialling of all patients transferred from the PICU to the open ward. That change may be seen as something of a knee-jerk reaction when the counter-productive factors of that level of monitoring are considered. In any event, the requirement for 24 hours of one-to-one specialling following transfers from the PICU is no longer in place, possibly because of resourcing issues.[86]

108. In my view, the decision to place the deceased on 15 minute observations was reasonable.

109. As to the quality of the monitoring of the deceased, the purpose of the observations was to prevent him from absconding or self-harming. The protocol in place at the time did not require those carrying out the observations to be satisfied that he was alive.

110. Mr Kong and Ms Armstrong took the initiative to check that the deceased was in the bed and that he was breathing, and for that they should be commended. There is no evidence to indicate that either nurse was incompetent or derelict in his or her duty.

111. The issue of whether the deceased was still alive at the time they checked on him together is somewhat unclear. Both nurses thought that they saw him breathing, but Mr Kong's evidence that he noticed that the deceased had not moved for some time and that he saw a white towel at the location of the deceased's neck and shoulder suggests that the deceased was no longer in the bed.

[85] ts 43-44, 51, 53
[86] ts 54 per M McAndrew

112. While I am satisfied that both Mr Kong and Ms Armstrong were telling the truth as they saw it, it is possible that, in poor light and in circumstances where they believed the form in the bed to be the deceased, they perceived what they expected to see.

113. It is not clear from the evidence whether including checks for a patient's respirations was the accepted practice in other mental health facilities in Western Australia at the time of the deceased's death. It is therefore difficult to know whether such checks might have been expected. In hindsight, they seem a reasonable precaution.

114. Following the deceased's death, the JMHU changed the protocol for observations to require that a patient on 15 minute observations be sighted at close proximity to confirm that the patient is breathing. Respirations are now recorded.[87]

115. In these circumstances, I make no recommendation about the matter of observation procedures.

116. As to the availability of plastic bags on the open ward, similar considerations applicable to the use of one-to-one specialling apply. Dr McAndrew explained the problem facing the JMHU in determining which objects patients were allowed to have and which should be kept away from them. He pointed out that articles of clothing could be used as ligatures, but that it would be cruel and would restrict the autonomy of a patient suffering an emotional or psychiatric disorder to remove every item that could be used for self-harm. At the same time, it was logical to remove dangerous items and to minimise hanging points, so it was a conundrum.[88]

117. Dr McAndrew said that the risk of patients at the JMHU using plastic bags to self-harm had not been considered in the past. He said he had been at the JMHU since it

[87] Exhibit 1, Volume 1, Tabs 15 and 16
[88] ts 54 per M McAndrew

began and there had not been a previous attempt by a patient to asphyxiate with a plastic bag.[89]

118. In my view the practice of not removing plastic bags from the open ward at the time of the deceased's death was not unreasonable.

119. Following the deceased's death, all plastic bags were removed from the open ward and replaced with paper bags. Senior staff discussed the pros and cons of removing further items from the open ward and a list of forbidden items was compiled. It turned out that the list was consistent with the ward policy already in place so no new items were added.

120. In these circumstances, I make no recommendations about the use of plastic bags in the JMHU.

121. Of note is the fact that the bag used by the deceased to asphyxiate himself was not a rubbish bag of the sort that had been available on the open ward at the time. It was an orange dissolvable laundry bag, a type of bag that was not readily available to patients. The evidence did not reveal how the deceased obtained the bag.

122. Of further note is the fact that the orange laundry bag was made of flimsy, easily tearable material. The fact that the deceased did not give in to the instinct to tear the bag away from his face when he placed it over his head may reflect the strength of his commitment to take his life.

123. One final health-related matter was the quantity of tramadol the deceased was prescribed, though I should note in passing Dr McAndrew's evidence that serotonin syndrome is not associated with suicidal behaviour, so it is unlikely that the deceased's possible serotonin syndrome was connected to his death.

124. Dr McAndrew's opinion was that the causes and effects of serotonin syndrome are probably not widely understood

[89] ts 54 per M McAndrew

and appreciated in the general medical field. While in his experience serotonin syndrome is infrequently seen, it seems to me to be of concern that its causes and effects are not more generally known.

CONCLUSION

125. Dr McAndrew, who is a clinical senior lecturer at the University of Western Australia as well as a consultant psychiatrist and the head of the Department of Psychiatry at the JHC, provided some sobering information relevant to the difficulty of identifying patients most at risk of suicide in a mental health facility.

126. Dr McAndrew said that it is not possible to predict which patients will commit suicide. He also noted that only one in 300 high-risk patients, that is, patients who have a history of depression and suicide attempts, will suicide. I have already mentioned his evidence that there is no correlation between expressed suicidal ideation and the suicide of a patient.

127. As submitted by Ms Burra-Robinson, the death of the deceased is a tragic reminder of just how real is the ongoing risk of death by suicide in a person suffering a major depressive disorder, despite that person receiving a high level of care in a major hospital equipped with specialist psychiatric staff.[90]

Barry King
Coroner
3 June 2014

[90] ts 118