Coroners Act, 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 34/15

I, Barry Paul King, Coroner, having investigated the death of ***Frances May Cooper*** *with an inquest held at* ***Kalgoorlie Courthouse*** *on* ***22 and 23 September 2015*** *find that the identity of the deceased person was* ***Frances May Cooper*** *and that death occurred on* ***30 October 2011*** *at* ***a railway line near the intersection of Charlotte Street and St Albans Road in Piccadilly*** *from* ***head injuries*** *in the following circumstances:*

Counsel Appearing:

Sgt L Housiaux assisted the Coroner
Mr P R Gazia and Ms P N Castelli (Aboriginal Legal Service of Western Australia) appeared on behalf of the family of the deceased
Ms B E Burke (Australian Nurses Federation Legal Services) appeared on behalf of Gavin Yates and Veronica Petersen
Ms B J Buxton (Separovic Injury Lawyers) appeared on behalf of Sandra Jackson
Mr D J Anderson (State Solicitor's Office) appeared on behalf of the Western Australian Country Health Service

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INTRODUCTION

1. On 30 October 2011 Frances May Cooper (**the deceased**) was a patient in the mental health unit in Ward A at the Kalgoorlie Regional Hospital (**the MHU**) when she was struck by a train after being allowed to leave the MHU in order to smoke cigarettes. She died at the scene.

2. As the deceased was an involuntary patient under the *Mental Health Act 1996* at the time of her death, she 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.

5. Under section 25(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.

6. The evidence adduced at the inquest comprised documentary evidence and oral testimony. The documentary evidence consisted of a report and associated attachments prepared by Senior Constable Philip Johnson of the Western Australia Police.[1]

7. Included in those documents was an expert report provided to the Court by Consultant Forensic Psychiatrist Dr Victoria Pascu at the recent request of Sgt Housiaux.[2]

[1] Exhibit 1, Volumes 1 and 2
[2] Exhibit 1, Volume 2, Tab 51

8. Oral testimony was provided by (in order of appearance):

   a) Senior Constable Johnson;[3]

   b) Zoewella Cooper, the deceased's daughter;[4]

   c) Charlene Assan, the deceased's daughter;[5]

   d) Sandra Jackson RN, the after-hours coordinator at the Kalgoorlie Regional Hospital in October 2011;[6]

   e) Gavin Yates RN, a nurse in the MHU;[7]

   f) Veronica Petersen CN, a clinical nurse in the MHU;[8]

   g) Vicki Sutton, a patient care assistant at the MHU;[9] and

   h) Dr Roland Main, a psychiatrist and currently the acting Area Clinical Director for the WA Country Health Service.[10]

9. Sgt Housiaux had attempted to contact Dr Solomon Agbahowe, the deceased's treating psychiatrist at the time she was a patient at the MHU, in order to arrange for him to provide oral evidence, but was unable to contact him.

10. Following the taking of evidence, I invited counsel to make submissions on the basis that my then tentative inclination was to find that the quality of the care provided to the deceased at the MHU was, objectively speaking, inadequate, but that I would make no adverse comments or findings against any individual involved in her care. I said that one of the reasons for my tentative conclusion in relation to the care provided by individuals

[3] ts 10-20
[4] ts 20-25
[5] ts 25-29
[6] ts 29-52
[7] ts 52-92
[8] ts 92-105
[9] ts 105-111
[10] ts 2-19 on 23/9/15

was that the evidence did not allow me to determine conflicting testimony.

11. Apart from Mr Gazia, counsel understandably made only brief submissions or, in Ms Buxton's case, no submissions.

12. Mr Gazia identified the following issues for consideration:[11]

    a) whether the death was by suicide or accident/misadventure;

    b) whether the deceased should not have been allowed to leave the MHU to smoke cigarettes. He submitted that the decision to allow her to leave the MHU unaccompanied contributed to her death given her mental illness, the lack of a safe area to smoke and the fact that she was an involuntary patient;

    c) whether a smoke-free policy at Department of Health facilities, which at that time applied to patients at mental health units, contributed to the deceased's death. Mr Gazia noted that the policy has since been changed in relation to involuntary patients;

    d) whether the decision to allow the deceased to leave the MHU to smoke cigarettes was made by Dr Agbahowe or by Mr Yates, though Mr Gazia indicated that the question of who made the decision did not really matter. He submitted that it was an incorrect decision in any event; and

    e) whether the various health services who had contact with the deceased from 2003 to 2011 had failed to communicate adequately with the deceased's family.

13. After the holding of the inquest, Sergeant Housiaux and I attended the site of the deceased's death near the train

[11] ts 22-26 per Gazia, P R

line. While we were there, an SCT goods train passed by, travelling west.

THE DECEASED

14. The following background information about the deceased was obtained in records from Graylands Hospital (**Graylands**) pertaining to the deceased's admission there in 2002.

15. The deceased was born in Fremantle on 29 October 1963, making her 48 years old at the time of her death. She was raised in Norseman by adoptive parents. She had an older brother and a younger brother. Her older brother died in 1992 at the age of 32 from a myocardial infarction. Her biological mother died in October 2001 from a myocardial infarction and her adoptive mother died in 2002.

16. The deceased had an uneventful early childhood, did reasonably well in school and enjoyed doing school work. She left school in year 10 and began work as a teacher's aide in Norseman. She did some work experience in Esperance for two years and then worked in Kalgoorlie. She also obtained a qualification as a childcare worker in 1989.

17. The deceased married in 1984 and had four daughters with her husband before they separated in 1994. At some stage after the separation, the deceased's children began living with her husband's parents.

THE DECEASED'S MENTAL ILLNESS HISTORY

18. On 18 June 2002 the deceased was referred to the Franklin Centre at Graylands following her attempted murder of her youngest daughter. She was reported to have placed a Bible on her daughter's side before stabbing her twice. She later explained that she did so

because of motherly jealousy: she did not want her daughter spending time with her ex-husband's new partner.[12]

19. The deceased told psychiatrists at the Frankland Centre that she had not experienced any past depression or psychosis and that she had no history of self-harm. She said that she regularly used two or three cones of cannabis a day but denied using any other drug. She said that she rarely drank alcohol but that, following the separation from her husband, she drank heavily for two years.

20. The deceased displayed no evidence of a psychotic illness during her admission to the Frankland Centre, and psychological testing did not reveal any abnormalities other than a borderline IQ.

21. On 12 July 2002 the deceased was again referred to the Frankland Centre. Again she showed no evidence of a psychotic illness or a major depressive illness. The psychiatrists who assessed her considered that their difficulty to comprehend the deceased's attempted murder of her daughter raised in their minds the possibility of an underlying mental illness, but they were not able to elicit any symptoms to support that hypothesis.

22. The deceased returned to the Frankland Centre on 9 August 2002. During the course of this admission she displayed symptoms which the assessing psychiatrists considered indicated an underlying psychotic disorder. They treated her with antipsychotic and antidepressant medication for about 10 weeks and noted only marginal improvement in her mental state, but re-testing of her IQ demonstrated a global improvement, suggesting that the earlier results were a consequence of the mental illness. She was discharged on 9 October 2002 with a final diagnosis of psychotic disorder.

[12] Psychological Report 9/07/2002 per Bob Evans, Senior Clinical Psychologist

23. The deceased had follow-up treatment in Bandyup Prison, but after being released on a community based order she stopped taking her medication. This led to a rapid deterioration in her mental state, with increasing paranoia and grandiose beliefs. She breached the community based order and, on 19 March 2004, she was returned to prison where a consultant psychiatrist, Dr Pascu, referred her under the *Mental Health Act 1996* to the Frankland Centre for assessment.

24. On this fourth admission to the Frankland Centre the deceased presented as acutely psychotic. She was expressing multiple paranoid delusions and was agitated, distressed, irritable and hostile. She was treated with an oral antipsychotic and a low dose of depot medication that was steadily increased over time. She became more pleasant, cooperative and compliant with treatment but had limited insight into her mental illness. She was discharged on 21 April 2004 on a community treatment order via the Mills Street Centre. Her final diagnosis was chronic paranoid schizophrenia.

25. After being discharged, the deceased apparently went to Norseman where she was treated at the mental health clinic and by her doctor. She then moved to Kalgoorlie to be closer to her daughters.[13]

26. On 3 August 2010 the deceased presented at the Community Mental Health Services (CMHS) clinic in Kalgoorlie accompanied by one of her daughters. A case manager was allocated and the deceased was offered an appointment with Dr Agbahowe on 19 August 2010, but she was difficult to engage because she missed fortnightly depot injections, avoided appointments and was not always available for home visits.[14]

27. The deceased's case at the clinic in Kalgoorlie was deactivated in May 2011 after she indicated that she was

[13] Exhibit 1, Volume 2, Tab 51
[14] Exhibit 1, Volume 2, Tab 51

moving back to Norseman. Her details were sent to her doctor in Norseman.[15]

28. On 9 September 2011 the deceased presented at the emergency department at Kalgoorlie Regional Hospital (**the ED**) with community staff following concerns from her family that her mental health had deteriorated due to a failure to comply with her depot medication since again moving to Kalgoorlie from Norseman. She had become delusional, believing there was a bomb under the police station and hearing voices commanding her to harm herself. She was admitted into the MHU for assessment as a voluntary patient. Ms Petersen conducted a risk assessment and recorded her risk level as low.[16]

29. The MHU was a small authorised unit of seven beds. It was not a secure facility but did have locked doors enabling involuntary patients to be admitted.[17]

30. The deceased was assessed by a psychiatrist, Dr J Rampono, as experiencing an early relapse of paranoid schizophrenia. Dr Rampono prescribed injectable risperidone consta and noted a need for a long term follow-up in the community. He noted that the deceased was not suicidal and had no current intent to harm herself or others. He indicated that the deceased was to be allowed walks outside the hospital.[18]

31. On 10 September 2011 the deceased spent long periods of time out of the MHU. After dinner she left the MHU to go for a cigarette and did not return. It was not possible for her to smoke in the MHU because of an operational directive by the Department of Health prohibiting smoking on all departmental premises and grounds. Late that night she rang the MHU to indicate that she had returned home due to a family circumstance and would

[15] Exhibit 1, Volume 2, Tab 51
[16] Exhibit 1, Volume 2, Tab 48
[17] Exhibit 1, Volume 2, Tab 45
[18] Exhibit 1, Volume 2, Tab 48

be sending a friend to the MHU to pick up her belongings.[19]

32. On 11 September 2011 the deceased was officially discharged from the MHU with follow-up at the community mental health clinic and fortnightly risperidone consta. However, late that night she was brought into the ED by the community mental health nurse and family members due to their concerns about her mental state. She was hearing voices and expressing thoughts about harming herself. A risk assessment indicated that she was at moderate risk of harm to herself.[20]

33. The deceased was re-admitted into the MHU as a voluntary patient and was diagnosed with paranoid schizophrenia with delusions and hallucinations, complicated by alcohol and cannabis use. She spent the afternoons of 13 September 2011 and 14 September 2011 at home with family. She remained confused and paranoid over the next two days but her delusions were less intense. She was discharged home on 16 September 2011 with intensive follow-up with depot medication and an appointment with Dr Agbahowe on 4 October 2011. She was assessed to be at low risk of suicide at the time of discharge.[21]

34. Dr Agbahowe was a psychiatrist in training for acceptance for fellowship. He was employed as a consultant and was able to provide a full range of psychiatric services but was under supervision from two visiting psychiatrists.[22]

35. The deceased attended the community mental health clinic on 31 September 2011 with her daughters, who expressed concerns that she was using cannabis and was

[19] Exhibit 1, Volume 2, Tab 48
[20] Exhibit 1, Volume 2, Tab 48
[21] Exhibit 1, Volume 2, Tab 48
[22] Exhibit 1, Volume 2, Tab 49

not compliant with her medication. She denied acute risk of harm to herself or others.[23]

36. On 4 October 2011 and 10 October 2011 a nurse from the community mental health clinic visited the deceased's home to provide the deceased with her depot medication but on each occasion the deceased was not there.[24]

37. The nurse tried again on 11 October 2011 and this time found the deceased at home. The deceased said that she had run out of oral medication and could not afford to pay for it. Again she denied acute risks of harm.[25]

38. On 21 October 2011 the deceased was brought into the ED by police. She had awoken with the belief that she had been sexually assaulted while asleep, but no evidence was found on examination.[26]

39. On 25 October 2011 the deceased was taken to the community mental health clinic by a case manager from the Goldfields Esperance GP Network after the deceased told police officers that her brother in Norseman was locking children in a dungeon in his home. She had also told her daughters that she wanted to go to heaven but that she wanted them and their children to go with her.[27]

40. The community mental health nurse assessed the deceased as experiencing acute psychosis with a moderate risk to herself. She referred the deceased under the *Mental Health Act 1996* to the MHU for examination by a psychiatrist and took her to the ED. The deceased was admitted into the MHU on the same day with a diagnosis of exacerbation of paranoid schizophrenia.[28]

41. At the MHU the deceased was reviewed by consultant psychiatrist Dr Stella Fabrikant who assessed the

[23] Exhibit 1, Volume 2, Tab 47
[24] Exhibit 1, Volume 2, Tab 47
[25] Exhibit 1, Volume 2, Tab 47
[26] Exhibit 1, Volume 2, Tab 48
[27] Exhibit 1, Volume 2, Tab 48
[28] Exhibit 1, Volume 2, Tab 48

deceased with chronic paranoid schizophrenia with significant risk to family when unwell due to the nature of her delusions, poor insight and poor compliance with treatment. Dr Fabrikant noted that the deceased needed a longer admission in the MHU to ensure that the delusions were settled prior to discharge. Dr Fabrikant completed a Form 4 under the *Mental Health Act 1996* to detain the deceased in the MHU involuntarily until 28 October 2011 for further assessment.[29]

42. The deceased slept well overnight and during the next day, 26 October 2011, she had a couple of smoke breaks off the ward, though it is not clear from the integrated progress notes whether she was escorted when she took these breaks. Dr Fabrikant again reviewed her and noted that she seemed more reactive and able to disclose her delusions. The deceased said that she was distressed by her delusions and that she did not feel that she could go on living while being worried that she may be a risk to herself and others. She asked whether she could be committed to Graylands forever to make sure that nothing bad happened.[30]

43. The deceased told Dr Fabrikant that she was keen to be treated and that she wanted to stay on depot medication since it had kept her well for eight years and stopping it had led to the current problems. The deceased indicated that she was willing to remain in the MHU for two weeks. Dr Fabrikant noted that the deceased's psychotic symptoms were improving, that present medication should continue, and that the deceased could have accompanied leave from the MHU to get things from home. Dr Fabrikant also noted that the deceased should have urine drug screening if there were any concerns that she was using cannabis.[31]

[29] Exhibit 1, Volume 2, Tab 48
[30] Exhibit 1, Volume 2, Tab 48
[31] Exhibit 1, Volume 2, Tab 48

44. By the evening of 26 October 2011 the deceased was leaving the MHU without supervision to go out to smoke cigarettes and was returning to the ward as promised.[32]

45. On the morning of 27 October 2011 the deceased was out of bed by 8.00 am. She did not display any overt delusional behaviour though she did show some preoccupation. At about 1.00 pm her daughter took her home for two hours. The deceased called the MHU to say that she was having a plumbing crisis at home and would return later in the afternoon. The nurse who entered the information in the integrated progress notes indicated that the deceased's risk to herself was low and her risk to others was moderate.[33]

46. The deceased returned to the MHU at 7.30 pm with poor memory and poor concentration. She was experiencing auditory hallucinations and grandiose delusions. Her risk to herself and others was noted as low.[34]

47. At about 7.00 am the next morning, 28 October 2011, the deceased requested to be allowed to go home to sort out her leaking pipes. Her nurse, Mr Yates, told her that she would not be able to leave the hospital grounds until she had been reviewed by Dr Agbahowe. She indicated that she accepted that, but she went out for a cigarette at 7.15 am and did not return. Mr Yates left a message with the deceased's daughter, Zoewella Cooper, to ask her to bring the deceased back to the MHU at 5.00 pm that afternoon.[35]

48. Zoewella Cooper called Mr Yates back and reported that the deceased did not plan to return to the MHU and instead had been using cannabis and lying about the leaking plumbing. She said that the deceased was still unwell. Mr Yates completed a Form 3 under the *Mental Health Act 1996* to authorise police to apprehend the

[32] Exhibit 1, Volume 2, Tab 48
[33] Exhibit 1, Volume 2, Tab 48
[34] Exhibit 1, Volume 2, Tab 48
[35] Exhibit 1, Volume 2, Tab 48

deceased to return her to the MHU for review by Dr Agbahowe.[36]

49. Dr Agbahowe reviewed the deceased at about 11.00 am after police had brought the deceased back to the MHU. Dr Agbahowe noted that the deceased was calm and cooperative but still had auditory hallucinations and delusions. He noted that he had previously learned that the deceased tended to put up a good appearance when with clinicians, but to others she expressed self-harm and suicidal ideations with reports of hallucinations and other paranoid ideas of a bizarre nature. He completed a Form 6 under the *Mental Health Act 1996* to keep the deceased in the MHU as an involuntary patient.[37]

50. At 12.30 pm that afternoon, Mr Yates noted in the integrated progress notes that the deceased was denied unescorted leave for cigarettes due to current risk of absconding and the deceased accepted the situation.[38]

51. At 8.00 pm that evening, Ms Petersen noted that the deceased remained psychotic but denied any self-harm or suicidal ideation. She noted that the deceased was escorted for smoke breaks due to high absconding risk. She noted that the deceased was a moderate risk to self and a low risk to others.[39] The risk to self was because of the absconding.[40]

52. The deceased appeared to sleep through that night and she seemed settled during the morning of 29 October 2011. In the afternoon her daughters Charlene and Shelley and Shelley's son Riley visited her in the afternoon to celebrate her birthday.[41] The deceased was restricted from leaving the hospital grounds. Her delusions persisted but she was considered a low risk to herself at that time.[42]

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[36] Exhibit 1, Volume 2, Tab 48
[37] Exhibit 1, Volume 2, Tab 48
[38] Exhibit 1, Volume 2, Tab 48
[39] Exhibit 1, Volume 2, Tab 48
[40] ts 104 per Petersen, V R
[41] ts 26 per Assan, C
[42] Exhibit 1, Volume 2, Tab 48

53. Although it is not clear if it happened on this day, Ms Assan recalled an instance where the deceased appeared to have a moment of clarity and said that she could not live with voices taking over her brain.[43]

54. At 8.00 pm that evening, Ms Petersen noted that the deceased went on escorted leave for smokes and that she was at moderate risk to self (due to the risk of absconding)[44] and a low risk to others. The deceased went to bed early and apparently slept all night. [45]

EVENTS LEADING UP TO DEATH

55. On the next morning, 30 October 2011, the deceased appeared to be more insightful into the need for her to remain in the MHU, to continue with medication and to stop using cannabis. She went on an escorted smoke break with Ms Sutton, a patient care assistant, without any problem.[46]

56. At about 11.25 am the deceased was allowed to go for cigarettes unescorted. She was expected to return by 12.00 pm. By 12.20 pm she had not returned and Ms Sutton was unable to find her in the area outside the hospital's rear car park where patients usually went to smoke cigarettes.[47]

57. At about 12.00 pm the deceased had been seen by train drivers of an SCT goods train passing through Kalgoorlie from Adelaide to Perth. She was standing on the bank about three metres above the train line, 50 or 60 metres west of the hospital car park. She was watching the train as it passed.[48]

[43] ts 27 per Assan, C
[44] ts 104 per Petersen, V R
[45] Exhibit 1, Volume 2, Tab 48
[46] ts 107 per Sutton, V A
[47] ts 108 per Sutton, V A
[48] Exhibit 1, Volume 1, Tab 23

58. At about 12.45 pm that day another train passed along the same train line. The train driver did not see anyone near the track in the vicinity of the Kalgoorlie Regional Hospital,[49] but a train security guard who was looking out of a window noticed the deceased lying beside the tracks. The guard notified the train drivers who called police.[50]

59. At about the same time, a hospital guard assigned to the car park learned from four young men who had been riding motorcycles near the train line that there was a body near the track. The guard told her supervisor what she had learned and then called Ms Jackson at the hospital while her supervisor called police.[51]

60. Ms Jackson went to the train line and, after speaking by phone with Mr Yates who informed her that the deceased was missing, went down to the track and confirmed the deceased's identity from her hospital wrist band.[52]

61. At about 1.15 pm, a member of the public telephoned police to advise that, about an hour previously, her grandson had seen a body lying next to the train line.[53]

62. Photos taken by police forensic investigators of the train line near the deceased's body show foot prints and marks on the steep embankment consistent with the deceased having slid down the embankment onto the area near the tracks.[54]

63. In the late afternoon and evening of 30 October 2011, forensic investigators examined the engines and the goods wagons of the first train and found no areas of forensic interest.[55]

[49] Exhibit 1, Volume 1, Tab 24
[50] Exhibit 1, Volume 1, Tab 25
[51] Exhibit 1, Volume 1, Tab 30
[52] Exhibit 1, Volume 1, Tab 27
[53] Exhibit 1, Volume 1, Tab 21
[54] Exhibit 1, Volume 1, Tab 44
[55] Exhibit 1, Volume 1, Tab 20

CAUSE OF DEATH

64. On 7 November 2011 forensic pathologist Dr D. M. Moss conducted a post mortem examination of the deceased's body and found a non-survivable head injury and no evidence of significant natural disease.

65. Toxicological analysis detected risperidone at therapeutic levels and tetrahydrocannabinol at a level consistent with the smoking of one cannabis cigarette between half an hour and 24 hours or more.

66. Dr Moss formed the opinion, which I adopt as my finding, that the cause of death was head injury.

WHO MADE THE DECISION TO ALLOW THE DECEASED TO LEAVE THE MHU UNESCORTED?

67. Mr Yates is a registered nurse who has been practising in the area of mental health for about 20 years. At about 12.20 pm on 30 October 2011 he made an entry in the integrated progress notes in relation to the decision to allow the deceased to leave the MHU for an unescorted smoke break. The entry records:

> More animated this shift. Insightful into need to remain on ward and continue medication/stop using THC etc. D/W Dr Solomon unescorted leave for cigarettes approved – F aware of repercussions if not returning – police will be notified.
>
> Went for smoke at 11.25 as yet has not returned. PGA had looked around grounds. Presents as low risk however due to poor compliance + family concerns is at risk to reputation.

> Difficult to remain on ward due to her behaviour. Dr Solomon to file review and ? place on Form 8 and discharge.[56]

68. As I understand it, the meaning of the entry is:

> The deceased was more animated this shift and was more insightful into the need to remain in the MHU and to continue to receive medication and to stop using cannabis, etc. I discussed with Dr Agbahowe whether the deceased could have unescorted leave for cigarettes, which he approved. The deceased was aware of the repercussions of not returning: police will be notified.
>
> The deceased went for a smoke at 11.25 and has not returned. The patient care assistant has looked around the hospital grounds for the deceased.
>
> The deceased presents as low risk, but due to poor compliance with her treatment and family concerns, she is at risk to her reputation.
>
> It is difficult to manage the deceased on the ward due to her behaviour. Dr Agbahowe will complete a review of the deceased's file; query whether she could be placed on a Form 8 (order that a person is no longer an involuntary patient) and discharged.

69. Mr Yates had later added an addition to the side margin of the entry, saying 'edit: Dr Agbahowe was present on ward'. Ms Jackson was critical from a procedural perspective about Mr Yates making the addition,[57] but it was clear that there was nothing sinister about it. In a debriefing he had been asked by the Director of Nursing to make the addition to the entry to clarify that

[56] Exhibit 1, Volume 2, Tab 48
[57] ts 37, 38, 42 per Jackson, S

Dr Agbahowe had been present in the MHU rather than having made a decision over the telephone.[58]

70. Dr Agbahowe was not available to give oral testimony as he was overseas and not contactable, but in a detailed statement signed on 14 March 2014 he said that his opinion as to whether the deceased could go on an unescorted smoke break was not sought and that he was unaware that she had been allowed to leave.[59]

71. Dr Agbahowe said that, in his experience at the MHU, mental health nurses were able to grant unescorted leave for involuntary patients and that it was only with extreme high risk patients who were pushing for leave that psychiatrists were involved in the decision. He said that he had reviewed the deceased's progress on the ward on 29 October 2011 and 30 October 2011, and the general reports were that she was mentally stable with improved risk levels, and not posing any immediate risk of self-harm or harm to others, and was compliant with medication and the nursing care plan. [60]

72. Mr Yates said that he was present when Dr Agbahowe assessed the deceased. He said that Dr Agbahowe was lying by saying that he had not discussed the plan with Mr Yates and that his opinion was not sought about unescorted breaks for the deceased.[61] He said that, because the deceased was an involuntary patient, the decision to allow unescorted leave had to be made by a psychiatrist.[62]

73. However, Mr Yates said that he agreed with Dr Agbahowe's assessment of the deceased, agreed that she should go on unescorted leave and supported his decision.[63] He said that that the deceased presented as quite well at the time Dr Agbahowe assessed her.

[58] ts 77 per Yates, G E
[59] Exhibit 1, Volume 1, Tab 33
[60] Exhibit 1, Volume 1, Tab 33
[61] ts 67 and 87 per Yates, G E
[62] ts 67 per Yates, G E
[63] ts 80 per Yates, G E

She guaranteed her safety. She had already been out a few times with staff without incident and she understood what would happen if she did not come back.[64]

74. Mr Yates said that he did not believe that the deceased was going to be harmful to herself or anyone else at the time.[65] A trial leave of half an hour seemed quite reasonable to him.[66] In hindsight it would have been better for the deceased not to have been allowed to leave the MHU unescorted at the time, but he stood by the decision that she was at low risk.[67]

75. Ms Petersen is a clinical nurse and was Mr Yates' supervisor at the MHU.[68] She is a qualified mental health nurse with much experience.

76. Ms Petersen was present in the MHU on the morning of 30 October 2011 but was not present at a discussion between Dr Agbahowe and Mr Yates about unescorted leave for the deceased.[69] However, she saw Dr Agbahowe talking to the deceased in the office that morning. She said that Mr Yates had told her that leave had been granted due to the deceased's settling mental status.[70]

77. Ms Petersen also thought that an unescorted cigarette break for the deceased was reasonable because on escorted leave the deceased had been quite stable and had not been voicing any suicidal or self-harm ideation. During the deceased's last admission she had never told Ms Petersen that she wanted to harm herself or anyone else. [71]

78. Ms Petersen said that when the deceased did not return from the smoke break she was concerned that the

[64] ts 64, 67, 69 and 70 per Yates, G E
[65] ts 70 per Yates, G E
[66] ts 67 per Yates, G E
[67] ts 85 per Yates, G E
[68] ts 94 per Petersen, V R
[69] ts 96 per Petersen, V R
[70] ts 96 per Petersen, V R
[71] ts 99 per Petersen, V R

deceased might have absconded again, but she was not concerned that the deceased might harm herself or someone else. She said that the deceased had given no indication at all that she was feeling suicidal.[72]

79. Ms Petersen's view was that the deceased was not suicidal on 30 October 2011, and went so far as to say that the deceased's death occurred by accident.[73]

80. Ms Petersen was in the courtroom during Mr Yates' testimony and agreed with what he had said.[74]

81. In the foregoing circumstances and given Dr Agbahowe's unavailability to give evidence and be tested on the contents of his statement, I am unable to determine whether he had made the decision to allow the deceased to leave the MHU unescorted for a smoke break.

82. However, it seems to me that Mr Gazia was correct in submitting that the issue of who made the decision did not really matter.[75] That is so because, irrespective of who made the decision, the relevant question is whether the decision, as part of the deceased's treatment as an involuntary patient, was appropriate in all the circumstances.

EVIDENCE RELATING TO THE DECEASED'S TREATMENT AND CARE

The Deceased's Family

83. The deceased's daughters described several concerns about the deceased's care in Kalgoorlie from the time she moved there from Norseman.

84. Ms Zoewella Cooper was the deceased's primary carer in Kalgoorlie. She said that, when the deceased moved to

[72] ts 98 per Petersen, V R
[73] ts 99 per Petersen, V R
[74] ts 104 per Petersen, V R
[75] ts 25 per Gazia, P on 23/9/15

Kalgoorlie, her case was transferred from Norseman to the Kalgoorlie community mental health team, but no case manager had been appointed in Kalgoorlie. Because of that, the deceased did not get her medication and her mental health deteriorated.[76]

85. Ms Cooper said that she and her sisters were really concerned that the deceased was going to hurt herself around her birthday on 29 October 2011. Ms Cooper said that she had spoken to a male nurse at the MHU and had expressed the family's concerns. The nurse assured her that the deceased would be monitored to make sure that she did not leave.

86. Ms Charlene Assan visited the deceased on her birthday as noted above. She described how the visit was restricted to the hospital grounds and how the nursing staff appeared to be security conscious. Ms Assan said that she knew that the deceased was high risk, so she knew that the deceased had to be returned to the MHU so that she would be safe and secure inside.[77]

87. Ms Assan said that she understood that the deceased was not allowed unsupervised leave, especially because of her birthday and because she, Ms Assan, and her sisters had repeatedly told nursing staff that they did not want the deceased to be allowed out unless it was with one of them.[78]

88. Unfortunately, the evidence of Ms Cooper and Ms Assan was not put to either Mr Yates or Ms Petersen for their response. However, the evidence of Dr Pascu and Dr Main addressed the concerns of Ms Cooper and Ms Assan and those raised by Mr Gazia.

[76] ts 22 per Cooper, Z
[77] ts 27 per Assan, C
[78] ts 28 per Assan, C

Dr Pascu

89. Dr Pascu's view was that, with the lack of consistent psychiatric care in Kalgoorlie from May 2011, it is not surprising that the deceased's mental state deteriorated, especially with her use of cannabis, to which her mental state was highly sensitive.

90. Dr Pascu noted that there were entries in the integrated notes which together suggested that the deceased was at significant risk to herself, though that risk fluctuated with underlying psychotic phenomena which she did not disclose. Dr Pascu considered that the focus on risk factors at the MHU was more on those concerning the safety of others, mainly the deceased's family.

91. Dr Pascu noted that the deceased had responded to most instructions not to leave the MHU unaccompanied, and perhaps the risk assessments conducted by ward staff relied too much on the deceased complying with requirements placed on her, when she was unable to do so due to her unstable mental state, impaired insight and judgment.

92. Dr Pascu believed that the use of escorted times off the ward for smoking would possibly have been justified.

93. Dr Pascu considered that, though the concerns of the deceased's risk to herself in the weeks leading up to her death appeared to be more significant, more unpredictable and more difficult to deal with, the treating team had ongoing informal reviews of her risk factors and attempted to maintain her in the least restrictive environment while encouraging her to be involved in her own care.

94. Dr Pascu addressed the issue of smoking at mental health units generally and the effect of Department of Health Operational Directive OD0128/09, which prohibited smoking on all departmental premises and grounds in WA. She considered that the directive created

significant problems for all mental health units, especially in smaller units where staff escorts were not available to accompany patients. In secure wards, not being allowed to smoke created a potential for increased risk for patients to themselves and others.

95. In considering whether the care provided to the deceased at the MHU was satisfactory, Dr Pascu identified a number of difficulties facing the MHU at the time, particularly related to a lack of clinical leadership and a lack of continuity of psychiatric care due to a difficulty in maintaining permanent psychiatrists in the Goldfields region.

96. Dr Pascu considered that, in relation to the deceased's care during her last admission, there was a lack of formal risk assessment and management plans. The level of risks to the deceased and others warranted reviews by a psychiatrist and possible closer monitoring of her mental state, closer observations and frequent reviews of her risks regarding community access and smoking.

97. Dr Pascu believed that a more multidisciplinary, holistic approach involving a psychologist may have been more appropriate in any attempts to engage the deceased in order to deal with some of her psychological difficulties.

Dr Main

98. Dr Main has been the head of clinical service at the Stirling Catchment, North Metropolitan Health Service, Adult Mental Health Program since April 2014. From October 2011 to April 2014 he was the Clinical Director for the WA Country Health Service – Goldfields Mental Health Service (**GMHS**). He is a consultant psychiatrist.[79]

99. In his capacity of Clinical Director of the GMHS Dr Main was responsible for clinical governance and he provided

[79] Exhibit 1, Volume 1, Tab 45

assistance to the GMHS Regional manager in strategic planning and operational functions.

100. Dr Main took part in a root cause analysis of the death of the deceased in order to identify causal factors relevant to her death with a view to making recommendations dedicated to obviating similar circumstances occurring in future.

101. The root cause analysis identified the following causal factors:

a) gaps in the deceased's community based care resulted in the undetected deterioration of the deceased's mental health;

b) the informal process for conducting and documenting risk assessments on the deceased influenced the decision to grant her unescorted leave;

c) the Department of Health's operational directive, OD0182/09 did not permit smoking in the MHU so the deceased made a request to smoke and the request was granted; and

d) due to lack of psychiatrist oversight of the decisions to discharge the deceased from care, discharge decisions were inconsistent with a psychiatrist's written recommendations for long-term admission and may have led to the deceased's premature discharge and contributed to the deterioration of her mental state and subsequent re-admission.

102. The root cause analysis resulted in the following recommendations:

a) development of a process to transfer case management within the Goldfields Mental Health Service;

b) development of improved processes to transfer information with the patient with daily communication between the Mental Health Inpatient Service and the Community Mental Health Service;

c) development of processes to ensure case management of patients including follow-up of overdue medication;

d) development of a process to ensure information from family and carers is documented and included in care planning;

e) development of a standard process for risk assessment and documentation of this over the course of treatment;

f) development of training for mental health staff, ED staff and hospital co-ordinator staff in mental state examination and including this as an annual core competency for GMHS staff;

g) development of a process for recording leave of absence of involuntary patients from the MHU;

h) ensuring that treatment planning and review includes wherever possible the treating psychiatrist and is consistent with the psychiatrist's documented intentions; and

i) a review be undertaken of the procedure for the discharge of patients from the MHU.

103. In his statement, Dr Main described how each of those recommendations had been implemented. He also noted how in January 2013 the operational guideline prohibiting smoking on Department of Health property has been replaced by OD0414-13, which provides a partial exemption to involuntary mental health patients of 18 years and over. He also noted that a designated

smoking area has been constructed in the MHU courtyard.[80]

104. As to the decision to allow the deceased to have unescorted leave on 30 October 2011 for a cigarette, Dr Main agreed that it was the wrong decision. He said that in hindsight it was clearly wrong because it is the one incident where the deceased's leaving the ward led to an adverse outcome.[81]

105. Dr Main identified two broad influences on the decision to allow the deceased to leave to the MHU unsupervised: deficiencies in her community based mental health care which led to an increased risk in the relapse of her condition and an increase in the likelihood of inpatient admission, and inpatient care issues which included the MHU's physical environment, the staffing mix, the non-smoking policy and a lack of the necessary procedure.[82]

106. Dr Main noted that the deceased had been reasonably stable when she was receiving her depot medication in Norseman from her doctor, but that did not continue in Kalgoorlie.

107. He also explained that the MHU is a small, seven bed unit and that it is not a secure facility. The inpatient team consists of nursing and medical staff only and the latter are not on the ward all day. There was one resident psychiatrist, Dr Agbahowe, who also worked at the CMHS half-time, and visiting fly-in, fly-out psychiatrists from Perth. The deceased had been treated by four different psychiatrists in her admissions in 2010 and 2011, creating continuity and handover issues.[83]

108. Dr Main noted that the staff at the MHU trusted the deceased's guarantee to return and that the trust may have been misplaced. The staff were aware that the

[80] Exhibit 1, Volume 1, Tab 45
[81] ts 15 per Main, R N
[82] Exhibit 1, Volume 1, Tab 45
[83] ts 9 per Main, R N on 23/9/15

deceased had not been truthful in reporting the reasons for previous leave, so it may have been foreseeable that further leave would provide her with the opportunity to abscond. The staff may have relied too much on her appreciating the consequences of absconding as a driver of her return.[84]

109. A lack of collaboration with the deceased's family was another potentially lost opportunity identified by Dr Main to improve the deceased's safety.[85]

110. Lastly, he noted that the processes of risk assessment were poorly developed at the time.[86]

111. However, Dr Main said that he could not say that the decision to allow the deceased unescorted leave to smoke was wrong from the standpoint of the deceased's condition at the time. Similar decisions had been made a number of times before. The deceased had been made involuntary because of her absconding (not because of her risk of self-harm).[87]

112. Dr Main explained that a decision to grant leave is one which is made to try to balance the requests of the patient against the need to keep every patient locked up indefinitely, which is impossible, impractical and not therapeutic.[88]

113. Dr Main said that the assumption that involuntary patients are kept locked up is one of the most widely held misconceptions about mental health care and that involuntary patients across the State regularly have ground access and leave from mental health wards as an important component of their therapy. There is always a time where the patient needs to be given some leeway to exercise some of her rights.[89]

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[84] Exhibit 1, Volume 1, Tab 45
[85] Exhibit 1, Volume 1, Tab 45
[86] Exhibit 1, Volume 1, Tab 45
[87] ts 16 per Main, R N on 23/9/15
[88] ts 16 per Main, R N on 23/9/15
[89] ts 16 per Main, R N on 23/9/15

COMMENTS ON THE TREATMENT, SUPERVISION AND CARE OF THE DECEASED AT THE MHU

114. In my view the evidence establishes that the standard of supervision, treatment and care of the deceased while an involuntary patient at the MHU in October 2011 was unsatisfactory for the reasons identified by Dr Pascu and Dr Main; especially the lack of collaboration with the deceased's family, the lack of formal risk assessments, lack of a multidisciplinary team, and the lack of a secure place to smoke at the time of the prevailing prohibition on smoking on hospital grounds.

115. Each of these failures was systemic or environmental, in the sense that MHU staff provided the deceased with treatment and care within the environment existing at the time.

116. I am satisfied that the GMHS has implemented steps to address those failures.

117. It is apparent that treating severe mental illness is imprecise, complicated and ever-changing. When things go terribly wrong, as they did with the deceased, it is easy in hindsight to see how the tragedy could have been prevented, with an attendant temptation to attribute fault to the relevant clinician.

118. While the decision to allow the deceased unescorted leave was, from the perspective of the result, ultimately mistaken, in my view the evidence indicates that, in making that decision, staff balanced the risks and the therapeutic benefits to the deceased. It is clear that this balancing exercise was a difficult one, and is one which mental health clinicians must make regularly. It is not possible on the evidence to conclude that the decision was inherently wrong at the time it was made.

119. I am satisfied that staff acted in what they considered to be the best interests of the deceased in providing her

care, including when making the decision to allow her to have unescorted leave.

HOW DEATH OCCURRED

120. The evidence indicates that the deceased was struck on the head by the train passing through Kalgoorlie near mid-day on 30 October 2011, causing severe head injury which caused her death.

121. There is no evidence to suggest that another person was involved in her death.

122. Did death occur by accident or suicide?

123. Given the deceased's history of mental illness and the nature of the injury which caused her death, it might be assumed that she committed suicide.

124. There is no doubt that the deceased had a chronic mental illness that was characterised by auditory hallucinations and delusions. On the basis of Dr Pascu's opinion, in the context of the deceased's ongoing psychotic symptoms it is certainly possible that she impulsively formed an intention to end her life.[90]

125. It is also possible, as Dr Pascu identified, that at some level the deceased may have developed intermittent emotional insight into the chronic nature of her illness and its impact on her life, including the risk she posed to herself and others when unwell. This together with the existential crisis of her birthday may have contributed to a desire to end her life.[91]

126. However, over the two or three days before her death, the deceased had been assessed as a risk of absconding, but not as a risk of suicide. She had been considered a low risk of suicide for over a month. On the morning of the

[90] Exhibit 1, Volume 2, Tab 51
[91] Exhibit 1, Volume 2, Tab 51

day of her death, the deceased was informally assessed and was considered to be at low enough risk to leave the MHU without an escort.

127. I appreciate that the assessments may have been mistaken, and that at the time of her assessment the deceased may have been presenting better than she actually was. However, on the face of the available clinical evidence it appears to me likely that she was not acutely suicidal before she left the MHU.

128. I also appreciate that people suffering from mental illness who experience suicidal ideation may act impulsively and unexpectedly and that their moods may change rapidly. Given the deceased's impulsivity, it is possible, as noted, that she acted on an impulse when she saw the train going by.

129. In some circumstances, it is possible to infer a person's likely intention from the nature of the act that led to death; for example, when a person hangs herself or places herself directly in front of an oncoming train, the likely consequences in each scenario are clear.

130. However, the precise details of what the deceased did at the train line are not known. What does appear clear is that the deceased was near the train line while a train was passing by and, before the train had passed by completely, the deceased slid down the embankment and went close enough to the train so that part of the train struck her head and caused a fatal injury.

131. My inspection of the embankment and train line after the formal hearing of the inquest has led me to conclude that it is at least possible that the deceased lost her footing as she slid down the embankment and that, when she reached the bottom, she pitched forward causing her head to go into the path of part of the passing train.

132. Some of the wagons on the SCT train that Sergeant Housiaux and I observed on 23 September 2015 had

metal components, such as short ladders, which protruded from the side of the wagons and provided surfaces that could have struck the deceased's head and caused fatal injury.

133. It is also possible that the deceased slid down the bank, arrived at the bottom safely and intended to cross the tracks immediately after the train had passed, but miss-timed the manoeuver and was struck by one of those protruding surfaces.

134. It is also possible that the deceased was attempting to climb onto the seemingly slow moving train when she was struck.

135. In circumstances where the details of what occurred are unclear and the deceased's state of mind is unknown, I am unable to determine whether the deceased intended to be struck by the train or whether she was struck by accident. I therefore make an open finding as to how death occurred.

CONCLUSION

136. In my view, severe mental illness such as that experienced by the deceased is a tragedy in itself, both to the victim of the illness and the victim's family.

137. In his report of 2012,[92] Professor Bryant Stokes noted that:

(1) in the context of limited resources, the WA mental health system was under considerable stress, particularly in relation to staff already stretched;

(2) demand for services was outstripping provision of acute inpatient facilities, step-down units and rehabilitation services;

[92] Review of the Admission or Referral to and the Discharge and Transfer Practices of Public Mental Health by Professor Bryant Stokes

(3) in Australia, one-third of the population experienced mental illness at some time of their lives; mental illness accounted for 13 per cent of the total burden of disease and was the largest single cause of disability;

(4) mental illness in WA at the time ranked as the fourth highest burden of disease for men and the second highest for women, but by 2016 these rankings were expected to be reversed with mental disorders accounting for the greatest burden;

(5) mental health clinicians were dedicated and committed to work in often-complex scenarios and volatile environments;

(6) the mental health workforce at the time was inadequate to meet the mental health needs of WA; and that

(7) mental health clinicians were severely overworked in almost all areas.

138. The deceased was the recipient of care during the time relevant to that report. Her family may take some comfort from Dr Main's evidence to the effect that, partly as a result of her death, there have been real improvements in relation to the care provided to patients at the MHU.

139. However, comments made by Professor Stokes at an inquest in May 2015 indicating that only 35 per cent of recommendations made in his report have been implemented suggests that, after four years since the deceased's death, much still needs to be done.

B P King
Coroner
30 November 2015