Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 11 /18

I, Sarah Helen Linton, Coroner, having investigated the death of ***Theodore (Ted) Herbert Eric JOHANSEN*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***22 – 23 February 2018*** *find that the identity of the deceased person was* ***Theodore (Ted) Herbert Eric JOHANSEN*** *and that death occurred on* ***29 October 2014*** *at* ***45 James Street, Pinjarra****, as a result of* ***Drowning*** *in the following circumstances:*

Counsel Appearing:

Ms F Allen assisting the Coroner.
Mr A Mason (State Solicitor's Office) appearing on behalf of the South Metropolitan Health Service.
Mr M Williams (Minter Ellison) appearing on behalf of Ramsay Health Care Australia Pty Ltd operating as Peel Health Campus, Margaret Sturdy and Dr J Lee.

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INTRODUCTION

1. The body of Theodore Johansen, known to his family as Ted, was discovered by police in the water behind his home in Pinjarra late in the morning on 29 October 2014. The evidence indicates he deliberately entered the water sometime late in the evening of 28 October 2014 or in the early hours of the morning on 29 October 2014.

2. The day before his death Ted Johansen (who I will refer to as the deceased) had been psychiatrically reviewed at Peel Health Campus after he reported to a general practitioner that he had been experiencing suicidal thoughts and had formulated a plan. He had been sent by ambulance from the doctor's surgery to the hospital for assessment. The deceased had been discharged home from hospital that same evening after a psychiatric nurse concluded his suicidal ideation had resolved.

3. The manner in which the deceased died was identical to the suicidal plan he had described during his presentation to the GP and the hospital. The circumstances of his death raised questions about the appropriateness of the psychiatric assessment that was completed at Peel Health Campus, less than 24 hours prior to his death. The deceased's brother, Dr Paul Johanson, who practices as a GP in another state, in particular raised concerns about the care provided and why the deceased was not admitted.

4. I held an inquest at the Perth Coroner's Court on 22 to 23 February 2018 to explore the circumstances of the death further. At the inquest evidence was heard from the GP, Psychiatric Liaison Nurse (PLN) and Emergency Department (ED) doctor who reviewed the deceased on the day before his death. In addition, other medical experts gave evidence commenting upon the specific care given to the deceased, as well as speaking more generally about the mental health services available in the Peel region and the adequacy of those services. Finally, I heard from the deceased's de facto wife, Beverley Johansen.

BACKGROUND

5. The deceased was born in New Zealand but had lived in Australia for most of his life. He moved to Western Australia in 1986, leaving most of his extended family in the Eastern States. There were reports of some family history of mental illness in the deceased's background. The deceased indicated to his GP that one brother had schizophrenia and another had bipolar disorder but does not appear to have shared this information when later at the hospital.[1] Ms Johansen advised that in addition to what he told his GP, the deceased had experienced family tragedy through the suicide of one brother and the accidental death of another. After his death, information was provided to the Coroners Court from family of the deceased indicating that the deceased had significant grief issues in relation to his brother's suicide as he was asked to identify the body.[2]

[1] Exhibit 1, Tab 2, p. 4 and Tab 12.
[2] Exhibit 1, Tab 15 and Tab 16; Letter from Dr Paul Johanson to Principal Registrar dated 17 July 2016.

6. The deceased was a qualified civil engineer and worked as a project manager for a company based in Kwinana. He was generally in good physical health. He took medication to help him sleep but was not known to take any other regular medication.[3]

7. The deceased had a past history of anxiety/depression since 2001. He had been treated with antidepressant medication and counselling.[4] He had not attended his regular doctor, Dr Ali Khossousi of Pinjarra Surgery, with symptoms of anxiety or depression since 2005 and he ceased his antidepressant medication in 2003.[5]

8. In 2005 to 2006 the deceased regularly saw a clinical psychologist, Dr Paul Ryan, who diagnosed the deceased with episodic anxiety occurring in the context of ongoing stress, predominantly at work but also to a lesser degree at home. The deceased was a self-acknowledged perfectionist and was prone to thinking the worst and feeling judged by others. Cognitive strategies were employed for building his self-esteem. The deceased eventually decided to cease treatment.[6]

9. The deceased lived in Pinjarra with his de facto wife, Beverley Johansen. They had been in a relationship for more than twenty years and had two sons together, a teenager and a younger boy. Their relationship had been deteriorating for several years at a time when they were also experiencing challenges with their older son, who had been diagnosed with Attention Deficit Hyperactivity Disorder. Despite their attempts to resolve their marital issues, in the year prior to his death the deceased and Ms Johansen had reached the stage where they were sleeping in separate bedrooms. Around the time of his death the couple were discussing separating at the instigation of Ms Johansen. The plan was to sell their home, which they had built together, and they would rent separate homes and each have one of their sons live with them.[7]

10. On 28 February 2013 the deceased saw Dr Hendrik van der Walt at Pinjarra Doctors and was diagnosed with depression and anxiety. He did not report feeling suicidal at that time. He was referred to a psychologist for counselling but it is not clear if he commenced counselling.[8]

11. The deceased was reviewed again on 24 January 2014 and 4 September 2014, where he reported he was going through a marital separation but felt his symptoms of depression were under control. He continued to deny any thoughts of suicide. He was referred to a different practitioner for psychological counselling, but again it is not clear whether he commenced.[9]

12. On 1 October 2014 the deceased saw his doctor again and reported ongoing anxiety due to family dynamics. A mental health plan was completed and he

[3] Exhibit 1, Tab 2, p. 5.
[4] Exhibit 1, Tab 11 and Tab 13.
[5] Exhibit 1, Tab 11.
[6] Exhibit 1, Tab 13.
[7] Exhibit 1, Tab 2, p. 4 and Tab 15.
[8] Exhibit 1, Tab 12.
[9] Exhibit 1, Tab 12.

denied any suicidal ideation or plan during a mental health assessment. The deceased was referred by Dr van der Walt to a psychologist, Mr Tony Graneri, for counselling.[10] The evidence indicates the deceased had recently begun to see Mr Graneri and had another appointment scheduled to see him after his death. Mr Graneri was unable to locate the deceased's medical records when later requested.[11]

13. Around this time the deceased's work project in Pinjarra had come to an end and he had commenced a new project with the same company.[12]

APPOINTMENT WITH GP - 28 OCTOBER 2014

14. The deceased booked annual leave for 27 October 2013. On 28 October 2014 the deceased went to work for a couple of hours.[13] The deceased then attended an appointment at Pinjarra Medical Centre at 1.37 pm. The evidence indicates the deceased had made the appointment after speaking to a 'men's helpline' about feeling suicidal and had been encouraged to see a doctor. The deceased was seen by Dr Priya Mohansunder as his regular GP was unavailable that day.[14]

15. The deceased reported to Dr Mohansunder that his wife had been talking of separation for many months and four days previously had begun to finalise documents. He reported feeling suicidal since then and indicated he had been browsing the internet for ways to kill himself. He described having set up a cinder block attached to a rope, which he planned to use to jump off his jetty and drown himself. However, when he saw his sons he was prompted to seek help and rang the helpline, which had led to the doctor's appointment.[15]

16. The deceased appeared calm and composed and was not teary. However, when he was talking about his personal issues and suicidal thoughts he did seem a bit sad. Dr Mohansunder noted the deceased had a number of risks, including:

    - active suicidal thoughts;
    - he had actually set up something to execute that plan;
    - he had a major life event happening at that time, being the separation; and
    - he had a known background of anxiety and depression.

    Based on these factors Dr Mohansunder considered the deceased was a "high risk"[16] of self-harm.[17]

[10] Exhibit 1, Tab 12.
[11] Exhibit 1, Tab 18 [43].
[12] T 14; Exhibit 1, Tab 15.
[13] Exhibit 1, Tab 15.
[14] T 8.
[15] T 8; Exhibit 1, Tab 12.
[16] T 8.
[17] T 8 – 9.

17. Dr Mohansunder discussed the deceased's case with another doctor and decided to send the deceased to the ED of Peel Health Campus to be assessed and for a management plan to be put in place. Dr Mohansunder requested a nurse organise an ambulance for the deceased to take him there. Dr Mohansunder explained at the inquest that she requested the ambulance as she realised the deceased was unaccompanied and she was concerned that if she sent him on his own he might change his mind and not attend the ED. Therefore, she sent him in an ambulance so that he had an escort to ensure that he definitely went to the hospital.[18]

18. It was put in submissions that this meant that Dr Mohansunder did not send the deceased by ambulance due to his level of risk, but rather to ensure that he did in fact attend the ED for assessment. That is true, but I don't see it is as a point of significance. Dr Mohansunder certainly agreed that if the deceased had been accompanied by an escort she would not have required an ambulance to take him to hospital, but that was because she was then confident that he would attend the hospital for assessment. Dr Mohansunder wanted the deceased to be assessed as she considered the deceased at high risk of self-harm. That is the important part of her evidence.[19]

19. Dr Mohansunder spoke to the duty doctor at the local hospital ED to facilitate his assessment and also wrote an accompanying referral letter for the attending doctor, which was similar to the brief summary she had given to the ED doctor over the telephone.[20]

20. Dr Mohansunder noted in the letter that the deceased had presented to the clinic feeling suicidal for the past three to four days and had mentioned 'browsing the internet for ways to commit suicide"[21] and had set up a cinder block and rope in his garage to drown himself. He had indicated he had a lot of personal life issues that he felt unable to cope with, hence why he felt suicidal.[22] She noted that the deceased was currently on Endep and Temaze.[23] It appeared from the medical notes that both had been prescribed to treat the deceased's ongoing insomnia as the dose of Endep was not sufficient to act as an antidepressant.[24]

21. The nurse noted the deceased was calm and compliant while waiting for the ambulance to arrive.[25] He was taken to Peel Health Campus by ambulance without incident.[26]

[18] T 9; Exhibit 1, Tab 12.
[19] T 8 – 9.
[20] T 9.
[21] Exhibit 1, Tab 12.
[22] Exhibit 1, Tab 12.
[23] Exhibit 1, Tab 12.
[24] Exhibit 1, Tab 12 and Tab 16 [15], [37].
[25] Exhibit 1, Tab 12.
[26] Exhibit 1, Tab 7B.

CONSULTATION WITH DR LEE

22. The deceased was seen for triage assessment at 1.51 pm on 28 October 2014. He was given a low triage score of 4 (semi urgent), although I note another triage form completed for a psychiatric nurse review later in the day indicated the triage severity as urgent for that review.[27]

23. The deceased's history of suicidal ideation with a plan was noted and that he had significant social stressors. The deceased reported wanting to be in hospital even though he felt embarrassed by the situation. His current medications were noted to be Endep and temazepam.[28]

24. The deceased was seen in the ED by Dr Jennifer Lee. Dr Lee qualified as a doctor in 2008 and worked in various hospitals before she began working in the ED at Peel Health Campus in 2014. Dr Lee has been involved in the management and treatment of patients with mental health concerns during the course of her work as a doctor.[29]

25. Dr Lee saw the deceased after he was triaged. Dr Lee's original contemporaneous written notes were misplaced, so Dr Lee's medical notes in the medical file were written in retrospect the following day. I accept that Dr Lee did not know the deceased had died at the time she re-wrote the notes.[30]

26. Dr Lee completed a risk assessment with the deceased, which took approximately one hour. The deceased told her that he had separated from his partner and that he was upset about the relationship breakdown and the fact that the family home was going to be put on the market. He was concerned about where he was going to live and wanted help dealing with his current situation.[31]

27. Dr Lee was aware that the deceased had a past history of depression and had been sent to the ED by his GP due to expressing suicidal ideation. He told Dr Lee that he had researched suicide plans on the internet to find the least painful method of ending his life. He described the block and harness he had put together with the intent of chaining himself to the block and jumping in the river, but said that he wanted the weather to be warmer so that the water would not be cold. The deceased also told Dr Lee he had dismantled the block and harness after he heard one of his sons in the driveway.[32]

28. At the time he was speaking to Dr Lee the deceased said that "he knew his plan to suicide was a bad idea and that he no longer felt suicidal."[33] Dr Lee noted the deceased presented very well. He was well dressed and well groomed. He made good eye contact, engaged well and even made jokes at

[27] Exhibit 1, Tab 17.
[28] Exhibit 1, Tab 17.
[29] Exhibit 1, Tab 20.
[30] Exhibit 1, Tab 20 [66] – [71].
[31] Exhibit 1, Tab 20 [22] – [24], [46].
[32] T 12; Exhibit 1, Tab 20 [18], [21], 25] – [27].
[33] Exhibit 1, Tab 20 [28].

times.[34] He described a number of protective factors that were preventing him from suicide, including his children and his work.

29. The deceased expressed embarrassment about being in the ED and kept saying that he was wasting everybody's time. Dr Lee said that she continually reassured him that he was not.[35]

30. Dr Lee found no obvious organic reason for the deceased's presentation and her impression was that the deceased was having a situational crisis. The deceased specifically denied any family history of suicide, so that was not raised as a risk factor.[36]

31. Despite the deceased's statement that he was no longer suicidal and his noted protective factors, Dr Lee was sufficiently concerned to want him to be assessed by a PLN. Dr Lee explained in her evidence that her primary concern was that being suicidal was new behaviour for the deceased and he had actually made a plan and build an apparatus to do it.[37] Dr Lee was aware a PLN could undertake a more focused risk assessment, which she considered necessary. As a result, the deceased was referred to a PLN for an urgent assessment. The PLNs come from the Peel and Rockingham Kwinana (PaRK) Mental Health Service but are based in the ED and work until late in the evening every day, so Dr Lee knew one would be available.

32. Dr Lee told the deceased that if he attempted to leave without being further assessed, she would put him on 'forms' under the *Mental Health Act* that would mean he was no longer a voluntary patient. Dr Lee explained that she often did this, and wrote it in the medical notes, so that if the patient attempted to leave while she was with another patient, it would prompt ED staff to have a discussion with the patient.[38] I will return to this issue later.

33. Dr Lee recalled that the deceased was very compliant and indicated he was happy to stay and be assessed by a PLN. Dr Lee indicated the deceased actually seemed "quite eager to have some kind of plan." Dr Lee did a handover to the PLN on shift, Coral Silk, and then left to attend other patients.[39] As per hospital policy, the deceased remained Dr Lee's patient, so she understood Ms Silk would discuss the deceased with her after she completed her assessment.[40]

PSYCHIATRIC REVIEW BY PLN SILK

34. Dr Margaret Sturdy is the CEO and Director of Medical Services of the Peel Health Campus. Dr Sturdy provided an outline of the Mental Health Services at Peel Health Campus as at February 2018. Dr Sturdy explained that Peel Health Campus is operated as a private/public partnership under a contract

[34] T 15; Exhibit 1, Tab 20 [31] – [33].
[35] T 12; Exhibit 1, Tab 20 [29] – [30].
[36] Exhibit 1, Tab 20 [36] – [39].
[37] T 15.
[38] T 13, 15; Exhibit 1, Tab 20 [43].
[39] T 15.
[40] T 14 - 17.

between Ramsay Health Care Australia Pt Ltd and the Department of Health through the South Metro Health Service. This contract has never included inpatient mental health services, although there is an 'in-reach service' provided to the campus by PaRK.[41] This is the process by which a PLN is available to the ED from 8.00 am to 11.00 pm seven days a week and there is access to 0.5 FTE Consultant Psychiatrist based in the ED, which effectively equates to afternoons on weekdays only, with access to an on-call psychiatrist from the PaRK service at other times and possible emergency attendance from one of the psychiatrists consulting in the community mental health building that is next door to the ED. The process is the same today as it was in 2014.[42]

35. Ms Silk works for the PaRK Mental Health Service and is located within the ED of Peel Health Campus. Ms Silk has been working as a psychiatric nurse since 1978 and had previously worked at a number of other hospitals, including Graylands Hospital and Heathcote Hospital, before she came to work at the Peel Health Campus.[43]

36. Ms Silk described her role as a PLN as a consultation and liaison role. Within the ED her role is to focus on full mental state and risk assessments on anyone who comes into the ED with a suspected mental illness and appropriate triaging of care and discharge planning.[44] Ms Silk is an authorised mental health practitioner under the *Mental Health Act*, which means she has powers to place people on involuntary forms under the Act where necessary.

37. The PLN conducts an assessment of whether a person is at risk of harming themselves or others. If they are assessed as a high risk, they are admitted to hospital. If they are not assessed as a high risk, then the role involves referring the person to other hospital and community support services.[45] Ms Silk estimated she assesses over 200 persons per year.[46] By the nature of her location within the ED, she only has a limited amount of time with each patient.[47]

38. When Ms Silk came to review the deceased at about 4.00 pm that day, she understood that he had been 'medically cleared' by Dr Lee in terms of any physical health issues and had been provided with the GP referral and a verbal handover from Dr Lee. Ms Silk said she did not attempt to contact the GP personally at that time as it was after surgery hours and, in any event, GP's are generally difficult to contact.[48] Ms Silk also explained that the deceased had told her that the GP who referred him to the ED was not his regular GP.[49] Dr Mohansunder confirmed in her evidence that she would not

[41] T 52.
[42] T 53 – 53.
[43] T 30 – 31; Exhibit 1, Tab 18 [4] – [8].
[44] Exhibit 1, Tab 18 [9] – [11].
[45] Exhibit 1, Tab 18 [103].
[46] Exhibit 1, Tab 18 [97].
[47] Exhibit 1, Tab 18 [104].
[48] T 33.
[49] Exhibit 1, Tab 18 [98].

have been able to give any more information than she had included in her letter of referral, given she was only seeing the deceased for the first time.[50]

39. Ms Silk consulted with the deceased for approximately one and a half hours.[51] During that time the 'Psychiatric Assessment Care and Evaluation Plan' were completed by Ms Silk and the history, mental state examination diagnosis, differential diagnosis and management plan were documented.

40. The history given by the deceased to Ms Silk was consistent with the history given to Dr Mohansunder and Dr Lee. Ms Silk recorded that the deceased had rung the 'Men's Helpline' that day and, on their advice, had seen his GP urgently. This had led to his referral to Peel Health Campus. He reported having suicidal thoughts three days previously and had set up a block and chain with the intention to drown himself in the river. As previously noted, he said he had then dismantled it.[52] Ms Silk understood that the deceased was worried about the effect that suicide would have on his sons and that was stopping him from continuing with his earlier plan.[53]

41. Ms Silk gave evidence that in her experience it was not unusual for a person to fluctuate in suicidal intent and that following a crisis, "once they get to a place where they can talk to someone and sit and reflect on what's happening and maybe develop a plan for the future that they can see is doable, that crisis abates."[54]

42. The deceased denied any previous psychiatric history or self-harming behaviour and denied any drug or alcohol abuse. He spoke of his marriage breakdown and the plan to sell the marital home. Ms Silk recalled that the deceased did not want the relationship to end and was concerned about what he was going to do next in terms of accommodation.[55] He appeared to feel isolated, reporting that all his close friends were his wife's friends and he had no close family in Perth. To improve his situation he was trying to engage in some new activities and get to know some of his work colleagues for support.[56]

43. The deceased was also concerned about the effect of the break up on his sons, particularly his older son, and how he was going to organise custody of them. The deceased was unsure whether it would be better to keep the boys together or have each live with a different parent. The deceased was worried about how he and they were going to cope with all the changes.[57]

44. The deceased was embarrassed about his situation and concerned that his presentation at the ED would impact on his child custody access arrangements when finalising his marriage breakdown. Ms Silk specifically

[50] T 10.
[51] Exhibit 1, Tab 18 [23] – [29].
[52] Exhibit 1, Tab 17.
[53] T 35.
[54] T 36.
[55] T 34; Exhibit 1, Tab 18 [31].
[56] T 34.
[57] T 34 – 35.

remembered the deceased saying that he did not want her to discuss anything with his wife.[58]

45. Ms Silk asked the deceased about any family history of mental illness, in particular depression, and he denied any such history.[59]

46. The deceased presented as a neat and trim man and Ms Silk noted he was smiling readily with good eye contact, although he was feeling a bit embarrassed about being in the ED.[60] He was polite and cooperative. Ms Silk stated that in her view the deceased's demeanour was "inconsistent with a person who was at risk of committing suicide."[61] Ms Silk explained that by this she meant that indicators of a person who is suicidal, such as being tearful, avoiding eye contact, looking miserable and poor self-care, were absent in the deceased. Ms Silk said that the deceased's whole demeanour at the time she saw him was of a man who was coping reasonably well but with a brief period of distress as he didn't want his marriage to end.[62]

47. The deceased described an intermittent low mood. He was anxious about having poor coping skills and low self-esteem. He was trying to adapt to thinking independently and making his own decisions regarding his finances, property, access to his sons and other practical matters. There was no sign of any formal thought disorder; he denied any perceptual disturbances and his judgment appeared good. It was also noted that the deceased was motivated to seek out support and contact support agencies, which was a positive sign.[63] Ms Silk felt he appeared "forward focussed and did not appear to be in despair."[64] Ms Silk also felt that the deceased "appeared to have good insight and saw that he was currently going through a transitional stage in his life."[65]

48. A Risk Assessment Form was completed by Ms Silk, which evaluated the deceased's risk of suicide and self-harm as low. His sons were noted to be protective factors against the deceased carrying out such an act.[66] Ms Silk indicated in her statement that she took into account the deceased's answers indicating that he did not have any family history of mental illness or suicide when considering his risk of self-harming.[67] He had given no indication that he was not telling the truth about his family history although he was reluctant to provide collateral information.[68]

49. After his death, Ms Silk was informed of the deceased's brother's suicide, and the impending anniversary of his birthday. She was surprised to hear that he had lied about his family history and indicated that it was an important omission as it would have affected her risk assessment. Since that time there has been a change in practice that allows Ms Silk to insist on

[58] Exhibit 1, Tab 18 [48].
[59] T 34.
[60] Exhibit 1, Tab 17.
[61] Exhibit 1, Tab 18 [83].
[62] T 36.
[63] Exhibit 1, Tab 17 and Tab 18.
[64] Exhibit 1, Tab 18 [84].
[65] Exhibit 1, Tab 18 [92].
[66] Exhibit 1, Tab 16 [25].
[67] Exhibit 1, Tab 18 [94], [106].
[68] Exhibit 1, Tab 18 [107] – [108].

breaching confidentiality to obtain a collateral history from a significant other, in case the patient omits to provide key information such as this, which she feels is of benefit.[69]

50. Ms Silk felt that the deceased's main concern at the time of her review was that he was embarrassed that he was in hospital.[70] Nevertheless, Ms Silk asked the deceased if he would like to stay in hospital for a few days.[71] Ms Silk indicated that she always offers voluntary admission to a person being assessed as it is "a way of gauging how people feel underneath."[72] The deceased responded that he did not want to be admitted and would be embarrassed if he had to do so.[73] Ms Silk's assessment was that the deceased did not necessarily need an admission and her sense was that it would distress him if that option had been pursued further.[74]

51. Ms Silk recorded the deceased's diagnosis as suicidal ideation, which was resolved at the time of the assessment, on a background of situational crisis secondary to the relationship break up. The management plan was to provide the deceased with information regarding counselling and support services, emergency numbers and men's support groups.[75]

52. Ms Silk advised that she developed a specific plan of action in consultation with the deceased, which she wrote down and gave to him at the end of the consultation. She did not, however, keep a copy for the medical records.[76] It is worth making an observation at this time that it would be beneficial that such information was in future properly documented in the medical notes, even if it just a photocopy of what is written. The omission of this information affected the review of the deceased's medical records by this Court and perhaps initially caused a less favourable position to be taken as to the management plan prepared by Ms Silk, as it was not apparent that she had gone into the detail that her evidence later demonstrated.

53. Based on her memory, Ms Silk described the plan as generally split into two parts. The first part of the plan discussed things the deceased could do the following morning, such as reducing his work hours so that he had time to look for accommodation. Ms Silk recalled the plan also provided that the deceased would book himself in for another appointment with his GP so that the GP could review the deceased's anti-depressant dosage and prepare a mental health plan. It was also proposed that the deceased would continue to attend his counselling session with Mr Graneri.[77]

54. In terms of the change to his medication, Ms Silk indicated that she referred him to his GP to increase the dosage as she cannot make those changes as a nurse. It is not clear why she did not request Dr Lee to do so but I am aware

[69] Exhibit 1, Tab 18 [108] - [109].
[70] Exhibit 1, Tab 18 [88].
[71] Exhibit 1, Tab 18 [89].
[72] Exhibit 1, Tab 18 [121].
[73] Exhibit 1, Tab 18 [89].
[74] T 37.
[75] Exhibit 1, Tab 17.
[76] Exhibit 1, Tab 18 [54] – [55].
[77] T 34 – 35; Exhibit 1, Tab 18 [57] – [58], [62] – [63].

now that Ms Silk did mention it to the deceased's regular GP when she saw him later that night.[78]

55. The second part of the plan provided the deceased with information about access to services for his sons, should they be required. She also gave him some pamphlets on community services and emergency numbers.[79]

56. Ms Silk recalled that the deceased seemed happy with the plan and said, "Oh, this is good. I can really follow this."[80] The deceased had already told her he had disposed of the block and put the chain away and indicated he no longer intended to commit suicide if he could get advice on how to manage his divorce and his sons, which the plan provided.[81]

57. The ACE-R Review-Checklist and Audit part of the Psychiatric Assessment Care and Evaluation Plan indicated that the case was discussed with a Consultant Psychiatrist, although further details were not provided. Ms Silk indicated in her statement that this notation referred to a brief conversation she had with the Consultant Psychiatrist on shift, Dr Daniela Vecchio. When the deceased was preparing to leave Ms Silk saw Dr Vecchio and introduced the deceased to her. Dr Vecchio spoke briefly to the deceased but did not assess him as she had just finished with a patient and was at the end of her shift. Ms Silk asked the deceased to wait and went into an office and briefly discussed the deceased's case with Dr Vecchio. Ms Silk's evidence was that Dr Vecchio agreed that she thought the deceased was 'fine' and that he was going to be safe with the plan Ms Silk had provided him.[82]

58. Dr Vecchio was not asked about this incident until 21 February 2018. Not surprisingly, by that time Dr Vecchio had no recollection of having any conversation or discussion with Ms Silk about the deceased.[83]

59. I am advised that the current standardised forms now in use have a space to enter the name of the psychiatrist and notes about that discussion, which is a positive step.[84]

60. Ms Silk had also discussed her observations of the deceased with Dr Lee, as it is ultimately the medical officer's decision as to whether the patient is at risk and should be subject to further medical intervention (for example, in-patient admission) or is fit for discharge. Ms Silk recalled that Dr Lee agreed with her conclusion that the deceased did not appear to be at risk of self-harm.[85]

61. Dr Lee recalled that Ms Silk told her that she had spoken to the psychiatrist on call and the psychiatrist was satisfied that the deceased did not need to be admitted and could be discharged home.[86] Dr Lee accepted that if she

[78] Exhibit 1, Tab 18 [127].
[79] T 35; Exhibit 1, Tab 18 [59].
[80] Exhibit 1, Tab 18 [60].
[81] Exhibit 1, Tab 18 [72], [86].
[82] T 38; Exhibit 1, Tab 18 [64] – [67].
[83] Exhibit 1, Tab 21.
[84] Exhibit 1, Tab 14A.
[85] Exhibit 1, Tab 18 [69] – [71].
[86] Exhibit 1, Tab 20 [50].

had not agreed with Ms Silk's assessment of risk she could have altered the plan and arranged a psychiatric evaluation, but she did not see any need to do so based upon the information that was known to them at the time. Dr Lee considered the deceased had appeared to present as "a completely normal person,"[87] and there was nothing before them to suggest that he was not telling them the truth.[88]

62. Ms Silk gave evidence that she happened to see the deceased's regular GP, Dr van der Walt, later that night at the hospital. She told him that she had referred the deceased back to him to talk about his antidepressants and Dr van der Walt did not raise any concerns about this plan.[89]

DISCHARGE

63. Dr Lee's evidence was that she met Ms Johansen in the ED prior to his discharge. Dr Lee said in her witness statement she recalled that the deceased wanted to go home and Ms Johansen "appeared comfortable with him being discharged into her care."[90] In her oral evidence Dr Lee said she could not clearly recall what she spoke to Ms Johansen about because she was aware that the deceased did not really want her to speak to Ms Johansen about what was going on. He was very embarrassed about the situation and didn't want them talking to Ms Johansen about his circumstances.[91]

64. Dr Lee recalled that she then spoke to Ms Silk in Ms Silk's office and they agreed to a plan to discharge the deceased with follow-up in the community.[92]

65. Ms Silk's evidence was that after speaking to Dr Vecchio she returned to the deceased and at that time he was expecting his wife was going to come and pick him up. Ms Silk asked the deceased to let her know when his wife arrived as she wanted to explain the plan she had provided to him with Ms Johansen. He nodded in response, which she took to mean that he agreed for Ms Silk to speak to his wife. He had earlier declined to give Ms Silk his wife's telephone number on the basis that she would already be on her way to the ED. Ms Silk also told a nurse caring for the deceased that she wanted to be told when Ms Johansen arrived.[93]

66. It would seem that Ms Silk spoke to Dr Lee after this time, as Dr Lee was aware that Ms Silk had spoken to Dr Vecchio. However, Ms Silk's evidence was not to the effect that Ms Johansen was present at this time. Ms Silk's evidence was that, contrary to her request, she was not contacted when the deceased was collected and she did not get an opportunity to speak to Ms Johansen. About half an hour after going to her office Ms Silk came out

[87] T 26.
[88] T 25 – 27.
[89] T 43.
[90] Exhibit 1, Tab 20 [55].
[91] T 19.
[92] T 18, 20; Exhibit 1, Tab 20 [58].
[93] T 46; Exhibit 1, Tab 18 [74] – [75].

and asked where the deceased was. She was told that he had already left with his wife.[94]

67. If Ms Silk had been able to speak to Ms Johansen at the time, she was uncertain as to how much information she would have been able to communicate, or indeed obtain. Ms Silk said that given the deceased would not give her permission to speak to his wife, she was placed in a difficult position because she was required to respect his confidentiality. However, Ms Silk agreed that this situation was unsatisfactory and since that time Ms Silk indicated that the general practice has changed and the PLNs now "insist on being provided with a family member who we can contact."[95] This change in practice arose out of amendments to the new *Mental Health Act* and from the "Stokes Report," both of which advocate for more family involvement.[96] This is a positive change and Ms Silk saw it as such from her personal experience.

68. I note Ms Silk's evidence about expecting the deceased's wife to arrive later is not consistent with Dr Lee's evidence that she spoke to Ms Silk about the deceased's discharge while Ms Johansen was present in the ED.

69. Ms Johansen addressed the court and was adamant that no meeting with Dr Lee occurred. The possibility that she did not speak to Ms Johansen was put to Dr Lee and she referred to her notes referring to "ex-wife came to pick up" and said she recalled walking over to the cubicle and speaking to Ms Johansen very briefly, in the presence of one of the couple's sons, but Dr Lee also acknowledged that the events occurred three and a half years ago and she had not made a note of the conversation.[97]

70. According to Ms Johansen, she phoned her husband at around 3.30 pm after returning home from work and finding he was not at home. He explained to her that he was at Peel Hospital as he was feeling suicidal and had been sent to hospital by his doctor. He declined her offer to attend with their sons and said he would call her when he needed to be collected.[98]

71. Ms Johansen said she later spoke to the deceased again when he called her from the car park.[99] She then went to pick him up from Peel Health Campus with their younger son. They arrived at the hospital between 6.30 pm and 7.00 pm. When they arrived the deceased "was smiling and appeared quite happy. He said he was feeling a lot better."[100]

72. There is an inconsistency in the evidence as to whether Dr Lee spoke to the deceased in the presence of Ms Johansen prior to the deceased's discharge, but does not dispute that Ms Silk did not meet Ms Johansen or speak to the deceased in her presence. Ms Johansen's statement in court that her sons were in school at the time is not consistent with the time of night and her indication that her younger son accompanied her. However,

[94] T 38; Exhibit 1, Tab 18 [76].
[95] T 46; Exhibit 1, Tab 18 [51].
[96] Exhibit 1, Tab 18 [50] – [52].
[97] T 21, 24.
[98] Exhibit 1, Tab 15.
[99] T 107,
[100] Exhibit 1, Tab 15 [25].

she was quite clear in her recollection that she did not go into the hospital and, rather, met the deceased in the carpark. Dr Lee clearly recalled briefly meeting Ms Johansen and her son in the ED.

73. It was submitted that I must prefer the evidence of Dr Lee as her evidence was given on oath and subject to cross-examination whilst Ms Johansen's address to the court was not. It certainly does go to the weight that I give their evidence, but I note that I have a broad discretion as a coroner to consider evidence taken outside the rules of evidence as I reasonably think fit.[101] Dr Lee was properly given an opportunity to answer Ms Johansen's contention that they did not meet, as she had notified Counsel Assisting of her position in advance, so it was not a case that Dr Lee was uncontested and she was unaware of Ms Johansen's position.[102]

74. In this case I do not consider I need to resolve the dispute as to whether Dr Lee spoke to Ms Johansen or not as, even taken on the version most favourable to Dr Lee, there is no evidence Ms Johansen was provided with details about the deceased's diagnosis and management plan, which was the important part of her evidence from my perspective. Ms Johansen's concern was that the deceased was sent home with her without Ms Johansen having been told any detailed information about what had occurred and the plan forward, so that she could look out for any concerning behaviour.

75. Dr Lee's evidence was that she couldn't recall if she ran through the management plan with Ms Johansen. Dr Lee said she spoke very briefly to Ms Johansen and she "skirted around"[103] information and details of the plan as Dr Lee was aware that the deceased did not want her to disclose information to his wife and she was required to respect patient confidentiality.[104] Dr Lee did not document her conversation with Ms Johansen other than to note "ex-wife came to pick up" and she did not have a clear recollection of what was said.[105] There is no evidence that she provided any significant detail to Ms Johansen about the deceased's circumstances that had led him to be in the ED and what were considered to be his risks and things that Ms Johansen might need to monitor.

76. I do not say this as a criticism. I understand that Dr Lee's reason for not providing this information is because the deceased did not consent to her doing so and she was restricted by patient confidentiality. However, it does indicate that the deceased was given into the care of Ms Johansen without Ms Johansen having any real knowledge about what had occurred, other than the information provided by the deceased that he had gone to the ED because he was feeling suicidal and he was now being released with some sort of plan for the future.

77. Ms Silk said she had wanted to have some sort of conversation with Ms Johansen face to face but unfortunately did not get the opportunity to do so. Unless the deceased had given his consent, she probably would not have

[101][101] Section 41
[102] T 21.
[103] T 20.
[104] T 19 – 21.
[105] T 19 – 21.

been able to give much information to Ms Johansen or elicit it, but she indicated that she also wanted to at least make some contact. It was agreed by both Dr Lee and Ms Silk that it was desirable to do so, but their hands were largely tied as to how much information they could provide.

78. It was also agreed that involving Ms Johansen more in the discharge planning and/or obtaining more collateral information from her, while desirable, may not have had an impact upon the final outcome. Ms Johansen herself acknowledged that. However, what it would have avoided is the situation that resulted, where Ms Johansen feels ongoing guilt for not staying awake and observing the deceased overnight to help to keep him safe, because she did not understand what he had previously planned and what were the possible risks that he might do it again.

79. After the deceased left with Ms Johansen and their son, the three of them went to the Mandurah Foreshore and had something to eat. They then returned home, collecting the deceased's car from the GP surgery on the way.[106]

80. During the evening Ms Johansen tried to speak to the deceased about what had occurred earlier as she had at least some understanding that he had been suicidal, which had prompted the hospital attendance. Ms Johansen told the deceased that she would still be there for him even if they separated and she reminded him that their sons needed their father in their lives. Ms Johansen last saw the deceased at 9.00 pm. He was wearing a t-shirt and underpants and appeared ready to go to bed. Ms Johansen went to another room and watched television until about 11.00 pm. She assumed the deceased had gone to bed by this time but did not see or hear the deceased again.[107]

DISCOVERY OF THE DECEASED IN THE WATER

81. The next morning, at about 6.15 am, Ms Johansen got up and could not locate the deceased. He would normally be up before her to help their sons to get ready for the day but he was not in his room and she could not find him in the house. Ms Johansen assumed he had gone for a walk so she got the children ready for school and then took them to meet the school bus. Ms Johansen then returned to the house and began to search for the deceased on their property as she had seen that his car was still in the garage.[108]

82. Their property backed directly on to the Murray River and they had a small jetty at the water's edge. Ms Johansen went down to the jetty, where she noticed a large limestone block that had not been there the day before. Ms Johansen then saw the deceased's mobile phone on a nearby seat and became concerned. She looked into the water but could not see anything.

[106] Exhibit 1, Tab 15.
[107] Exhibit 1, Tab 15.
[108] Exhibit 1, Tab 8.

Ms Johansen then contacted the police and told them of her concerns for the deceased's welfare.[109]

83. Local police officers attended. They went to the jetty and found the deceased's mobile phone and a padlock key on top of a pylon on the jetty and observed a large limestone block on the end of the jetty near the water. They looked into the water from the jetty and observed the deceased in approximately two metres of water at the bottom of the river.

84. The Water Police were notified and officers from the Water Police attended later in the morning. A police diver entered the water and found the deceased's fully clothed body submerged in the water with a heavy metal link chain wrapped around him and connected to a large limestone slab via a metal loop. The chain was securely fastened to the deceased with a padlock. The chain had to be cut with bolt cutters in order to release the deceased and bring him to the surface.[110] The limestone block was then also brought to land.

85. An examination of the limestone block indicated the block had been prepared with the insertion of metal eyelet bolts into both ends, through which the chain had been attached before the deceased fastened it to himself with the padlock.[111]

86. Police officers searched the deceased's property and did not find a suicide note.[112]

87. Ms Silk gave evidence that she saw the deceased's regular GP, Dr van der Walt, later in the week and he told her that the deceased had died. She recalled that Dr van der Walt expressed surprise that the deceased had apparently committed suicide. Ms Silk said that she was "surprised and really distraught"[113] to hear the news.[114] She was also very surprised to hear that he had used the same apparatus, as she had believed the deceased when he said that he had dismantled it and had no plans to go ahead with using it again.[115] Ms Silk genuinely believed the deceased was not suicidal at the time he left Peel Health Campus, and felt something must have happened to change his mind after he left.

88. In that regard, Ms Johansen addressed the court at the end of the inquest and spoke of her dismay to hear the family home described as a 'supportive environment' into which he could be discharged.[116] Ms Johansen described the terrible problems the family were experiencing at the time of the deceased's death. She said they were "just at breaking point."[117] Ms Johansen felt that his actions had indicated a desire to escape his stressors and yet she unknowingly drove him home straight back into them.

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[109] Exhibit 1, Tab 15.
[110] Exhibit 1, Tab 2, p. 2 and Tab 3.
[111] Exhibit 1, Tab 2, p. 5.
[112] Exhibit 1, Tab 2, p. 3.
[113] T 44.
[114] T 44; Exhibit 1, Tab 18 [99].
[115] T 45.
[116] T 107.
[117] T 107.

Ms Johansen spoke of her guilt and regret that she didn't provide him with the safe environment that he needed as she had not been forewarned of what signs to look out for and what safeguards she might put in place.[118] She did not know about his plan to commit suicide with the block and chain so when she collected him from the car park she had no idea what he had been planning to do, so she could not guard against it happening again.

89. Ms Johansen's concerns emphasised the communication issues surrounding the deceased's risk assessment and discharge without speaking to her or other family or friends. Knowing the deceased as she did, Ms Johansen understood why the deceased would have been embarrassed to have been forced to seek help. She described him as a person who was usually always in charge and fully in control, mulling over every decision before it was made, so on an occasion such as this he would have been out of his depth.[119]

90. Ms Johansen also knew the deceased's significant family history of mental illness, a brother with paranoid schizophrenia who committed suicide, another brother with bipolar affective disorder and a father who was diagnosed with depression. In addition, there was a history of a bitter divorce between the deceased's parents, a tragic accidental death of a young brother and a strict upbringing including severe physical punishments.[120] All of this information would have been helpful to Ms Silk when completing the deceased's risk assessment, but the deceased had not been willing to consent to her accessing that information, for reasons of embarrassment or concern about the impact on his custody issues or both.

91. Unfortunately, the information the deceased withheld was generally agreed to be very relevant to the assessment of his risk and was likely to have changed the pathway that Dr Lee and Ms Silk followed.

CAUSE AND MANNER OF DEATH

92. On 31 October 2014 a forensic pathologist, Dr Jodi White, conducted a post-mortem examination on the body of the deceased. There were no evident injuries and the only significant natural disease noted was focal mild coronary artery disease.[121]

93. Toxicology analysis showed the prescribed medication amitriptyline at a non-toxic level and no evidence of alcohol or other common drugs.[122]

94. The deceased showed frothy fluid in his airways and extruding from his mouth and nose. His lungs were heavy and fluid-laden. Dr White formed the opinion the cause of death was consistent with drowning.[123]

[118] T 108 – 109.
[119] T 108 - 109.
[120] T 107 – 108.
[121] Exhibit 1, Tab 9.
[122] Exhibit 1, Tab 9 and Tab 10.
[123] Exhibit 1, Tab 9.

95. I accept the conclusion of Dr White and, taking into account the other known circumstances surrounding the death, I find the cause of death was drowning.

96. There was no dispute at the inquest that the deceased had an intention to take his life at the time he entered the water. Indeed, the evidence indicated he had formulated a methodical plan and put that into effect. Accordingly, I find that the manner of death was suicide.

COMMENTS ON PUBLIC HEALTH MATTERS CONNECTED TO THE DEATH

97. Under s 25(2) of the *Coroners Act 1996* (WA), a coroner may comment on any matter of public health sufficiently connected with the death.

98. As noted at the beginning of this finding, concerns were raised by the deceased's brother, Dr Johanson, about the deceased's psychiatric care. Dr Johanson also detailed a specific concern that appears to arise from his own experiences, that Emergency Doctors routinely ignore the advice of General Practitioners who recommend psychiatric admissions. Given the deceased was referred to the hospital by a GP and then released, Dr Johanson expressed concern that his experience may have been replicated in the case of his brother.

99. In this case, Dr Lee and Ms Silk both acknowledged that the deceased was referred by a GP to the ED, but noted that it was not his regular GP so it was not someone who would have a lot of additional information about the deceased's background. Further, Dr Mohansunder's evidence was that she was recommending assessment and a management plan, but not necessarily admission. Nevertheless, Dr Lee and Ms Silk's evidence was that they took into account the fact that the deceased's presentation came from a GP referral and, indeed, as a result of this referral Ms Silk was required to confer with a consultant psychiatrist. This was indicated in the Psychiatric Assessment Care & Evaluation Plan form used by Ms Silk, which prompted discussion with a Consultant Psychiatrist if the patient had been referred by a medical practitioner for admission.[124]

100. It was explained at the inquest that this requirement came out of recommendations from coronial inquests and general reviews and was a clear recommendation that if a medical practitioner refers someone to an ED, that is an indication that the ED staff need to give greater consideration to that presentation, which then indicates a consultant needs to be involved in the decision-making.[125] In this case, the referral of the deceased by Dr Mohansunder meant that there was a requirement for Ms Silk to discuss the case with a consultant psychiatrist, without any prescriptive requirement as to the extent of that conversation.[126] Ms Silk did discuss the

[124] Exhibit 1, Tab 17.
[125] T 99.
[126] T 99.

case briefly with Dr Vecchio, who also briefly met the deceased face to face, which complied with this requirement.

101. The existence of this required procedure hopefully satisfies Dr Johanson's suggestion that there "needs to be a clear protocol that a general practitioner's referral to an ED regarding suicide risk is regarded as a 'red flag'.[127]

102. Dr Johanson also raised a concern about the failure to consider the deceased's family history of mental illness and suicide and the significance of the date of his presentation. As previously identified, Dr Lee and Ms Silk were not aware that the date was significant and were unaware of any the deceased's relevant family medical history.

103. Dr Lee had directly questioned the deceased about whether there was any mental health history in his family as she indicated that was a factor that can change the evaluation of the patient. The deceased had denied any family history of mental illness or suicide. Dr Lee did not find out until after the deceased's death that one of the deceased's brothers had committed suicide and that the deceased had presented to the ED on the same day as this brother's birthday.

104. Dr Lee explained that a family history of suicide made the deceased an increased risk of suicide himself and the significance of the anniversary meant he would potentially be in an acute phase of risk.[128] For this reason, Dr Lee indicated that if she had been told that his brother had committed suicide, she would have been uncomfortable about the deceased being discharged without a face-to-face psychiatric review. Further, if the deceased had told her of the significance of the particular date, Dr Lee stated that she would have insisted that he be reviewed by a consultant psychiatrist before he was discharged.[129]

105. Ms Silk agreed that, looking back, the main factor that would have made her change her decision was the missing information about the deceased's family history. She believed if she had known about his brother's suicide and the fact that it was his birthday, she would have tried to arrange a voluntary admission for him.[130] However, as for Dr Lee, the deceased was not forthcoming about his family history even when directly questioned by Ms Silk.

106. The omission of this information by the deceased raises the question why he did not share that information, given he had previously disclosed some of it to his regular GP in the past? It also raises the question of whether there should have been an attempt to obtain a collateral history from other sources, such as Ms Johansen, other family members, the deceased's GP or counsellor.

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[127] Letter from Dr Johanson to WA Coroner dated November 2014.
[128] T 20.
[129] T 17; Exhibit 1, ab 20 [61] – [65].
[130] T 44.

107. I have already noted above the reasons given by Dr Lee and Ms Silk for not contacting Dr Mohansunder and not questioning Ms Johansen. The first related to an understanding the doctor would be unable to provide much more information and would be difficult to contact, the latter because of the deceased's express refusal to allow Ms Johansen to be informed and questioned. I now propose to explore further what options were available and whether the present situation has altered that position, in the context of a general review of the care given the deceased.

108. Dr Victoria Pascu, a Consultant Forensic Psychiatrist with extensive experience within the Western Australian mental health system, was asked to prepare a psychiatric opinion in relation to the mental health care provided to the deceased prior to his death. Dr Pascu is currently the Director of Clinical Services for North Metro Mental Health Public Health Ambulatory Care and was formerly the Head of Clinical Services at Graylands Hospital, but she provided this report in her private capacity as a forensic psychiatrist.[131]

109. In her report Dr Pascu outlined the deceased's main risk factors were his age and gender and that he had displayed active suicidal intent. The deceased specifically denied any family history of suicide, so that was not raised as a risk factor at the time of his presentation, although in hindsight it was obviously relevant.[132] Dr Pascu expanded further in her oral evidence to identify the deceased's history of depressive symptoms and anxiety symptoms since 2013 related to life stressors, which indicated he had been having difficulty coping for a long time and was probably becoming increasingly depressed as his stressors escalated as his marriage came to an end and he had to sell the family home.[133] Dr Pascu considered the deceased's history of depressive illness was important as it would have affected the way he dealt with the particular situational crisis he faced.[134]

110. Dr Pascu noted that there was no documentation regarding any collateral information obtained from Ms Johansen or the deceased's GP or counsellor, and no involvement of either Ms Johansen or the GP in his discharge planning.[135] She also saw the note that the case was discussed with the Consultant Psychiatrist, but no documentation about how or when this occurred. I have set out previously in this finding the additional evidence that explains why no collateral information was sought, the consultation with Dr Vecchio and the details of the discharge planning, but none of that information was available to Dr Pascu at the time she prepared her report. It demonstrates the importance of comprehensive documentation, so that an expert is able to fully understand the reasoning behind decision making when reviewing medical records.

111. For example, Dr Pascu raised concerns about the failure to consider increasing the deceased's antidepressant medication to a dose consistent

[131] T 66; Exhibit 1, Tab 16.
[132] Exhibit 1, Tab 20 [36] – [39].
[133] T 96.
[134] T 97.
[135] Exhibit 1, Tab 16 [27], [44].

with it working as an antidepressant, not only for its sedative effects.[136] Ms Silk indicated that she had recommended the deceased to see his regular GP the next day to do exactly that, but this was not recorded in her notes. Dr Pascu also queried whether psychological intervention could have been better explored, as it was not apparent in the notes that Ms Silk had confirmed the deceased had an upcoming appointment with his psychologist that he was intending to keep.

112. With the additional information about the plan for the deceased to attend his GP to increase his antidepressant dose and to continue with psychological counselling, Dr Pascu accepted that it was a reasonable plan based on the information known to Ms Silk at that time.[137]

113. Based upon her review of the records, Dr Pascu believed that at the time of his referral to Peel Health Service on 28 October 2014 the deceased's "acute risk was significant, given the multiple psychosocial stressors in his life, his sense of hopelessness, helplessness, possibly feelings of inadequacy as a father, husband and recurrence of possible unresolved grief related to the suicide of his eldest brother whose birthday was on the 28 October."[138] Dr Pascu acknowledged that the missing information about his brother's suicide was a significant gap in the knowledge available to Dr Lee and Ms Silk.

114. In Dr Pascu's opinion, the deceased remained an ongoing risk to harm himself given his limited coping and problem solving skills, noting the precipitating factors remained unresolved on his discharge from the ED.[139] Based upon what was known to the mental health clinician at the time, Dr Pascu expressed the opinion that, given his active risk factors, the deceased's risk to himself would have been significant.[140] Dr Pascu also emphasised that "risk to self and others is dynamic and requires repeated assessment in order for a better understanding of the actual risk."[141]

115. Dr Pascu acknowledged that it is easier to determine risk in hindsight, but still maintained that in this case there were sufficient concerns to warrant a referral for psychiatric assessment and likely a brief voluntary mental health admission to a mental health unit to at least be offered.[142] Dr Pascu observed that a voluntary admission to hospital may have been beneficial in providing short term containment for the deceased, away from the environment which contributed to his emotional distress and to allow further assessment and the formulation of a more comprehensive management plan.[143] Dr Pascu also believed it may have allowed a better opportunity to gather collateral information, which was particularly important in a case such as the deceased's where there were no previous medical records.[144]

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[136] Exhibit 1, Tab 16 [54].
[137] T 90.
[138] Exhibit 1, Tab 16 [40].
[139] Exhibit 1, Tab 16 [40].
[140] Exhibit 1, Tab 16 [47].
[141] Exhibit 1, Tab 16 [51].
[142] Exhibit 1, Tab 16 [50], [56].
[143] Exhibit 1, Tab 16 [53].
[144] T 68.

116. Dr Pascu also commented that, if the plan was for the deceased to return home, then involving Ms Johansen in the discharge planning was important, given his planned return to the same environment that had contributed to the deterioration in his mental state.[145]

117. It was not apparent in the records reviewed by Dr Pascu, but Ms Silk indicated in her statement that she did in fact ask the deceased whether he would like a voluntary admission, and he indicated that he did not. He expressed embarrassment about being in the ED and wanted to go home. The deceased's reluctance to be admitted could perhaps have been reduced by counselling by Ms Silk, but the evidence of Ms Silk and Dr Lee was that they were reassured by his presentation and did not consider a voluntary admission was required.

118. Based upon everything that she had read, Dr Pascu's comment was that "it wasn't clear about what is really going on with this man."[146] The little information that was available on the day suggested that he had been depressed for some time due to things happening in his life but there was not enough information to assess his situation and it was later found there was significant missing information about his family history and the anniversary of his brother's birthday. Dr Pascu suggested a voluntary admission in a contained environment may have allowed him to talk about his issues and allow an opportunity to obtain the missing collateral information.[147] This was all in the context of the deceased admitting he had prepared everything to commit suicide only a few days before. Therefore, in Dr Pascu's opinion offering a voluntary admission was warranted, although she agreed there was insufficient information to justify an involuntary admission if he refused.[148] If, as is clear now from the evidence, the deceased declined a voluntary admission, Dr Pascu considered it was an appropriate case to discuss with a consultant psychiatrist. Again, there is evidence now to say this was done, although not in detail.

119. There was evidence given at the inquest about the general lack of availability of beds, if the deceased had agreed to a voluntary admission, but in this case Dr Lee and Ms Silk's evidence was that it was not a relevant consideration on their part. Dr Lee's evidence was that even if there were mental health beds readily available, she would not have sought to admit the deceased without the additional knowledge of his significant family history of suicide. Dr Lee noted that he was a man who was working and had future plans and protective factors and there was nothing to suggest he required admission at that time.[149]

120. Ms Silk maintained that at the time of her assessment the deceased's risk did not come across as significant. He did not want to be admitted and in her opinion he did not appear to need either voluntary or involuntary

[145] Exhibit 1, Tab 16 [49].
[146] T 76.
[147] T 76 – 77.
[148] T 77.
[149] T 23 – 24.

admission.[150] Therefore, the issue of whether or not a mental health bed was available did not directly arise.

121. In the face of that evidence, while the lack of mental health beds in the Peel, Rockingham and Kwinana region is a matter of concern, there is no direct connection with the deceased's death so I do not propose to take the matter further in terms of a recommendation. However, I do note that evidence was given by Dr Gordon Shymko that was of some interest in a more general sense.

122. Dr Shymko is the Mental Health Service Medical Co-Director of the South Metropolitan Health Service, which includes the PaRK mental health service that assists the Peel Health Campus. Dr Shymko has performed that role since 2007. In addition to clinical duties, Dr Shymko is involved in the oversight of the operational and clinical work within the service, which includes developing and implementing policies for the South Metro Health Service.[151] Dr Shymko was not involved in the deceased's care but reviewed his medical records and relevant witness statements, as well as the report of Dr Pascu, so that he could provide his own expert opinion on the care provided and whether it complied with the relevant policies in place at the time.

123. Dr Shymko acknowledged that there is a relative lack of inpatient facilities in the PaRK area compared to other areas.[152] Dr Shymko explained that the inpatient unit at Rockingham Hospital was designed to accommodate an increase of beds and was even planned so that it could be closed off and maintain functionality while the building process occurred.[153] There are currently 20 adult beds and 10 older adult beds but the plan was to expand the adult beds to 30 and the older adult beds to 20 beds. However, there is now a greater emphasis on community-based services that has removed some of the impetus to completing that expansion. All of the planning was done in anticipation of the unit expanding in keeping with the population expanding, but that has now been put on hold. The result is the current lack of inpatient facilities in the PaRK area, although it could be resolved in the way suggested in the future should resources allow. While I do not make a recommendation or any form of adverse comment in this regard, given the lack of direct connection with the death of the deceased given the evidence I have heard, I can say that I am reassured by Dr Shymko's evidence that there are opportunities to expand the Rockingham mental health facility and improve mental health care in the PaRK region if and when the Mental Health Commission or other relevant body considers it appropriate to do so.

124. The other aspect of the lack of a mental health facility at Peel Health Campus related to the issue of staffing. Dr Lee noted that they have good community teams and hardworking PLNs in the Peel region but suggested they could do with more support, in particular through more PLNs so that

[150] Exhibit 1, Tab 18 [119] – [123].
[151] T 97 - 98.
[152] T 103.
[153] T 103.

24-hour cover of the Peel Health Campus ED could be provided and also access to more on-site consultant psychiatrists.[154]

125. Ms Silk agreed with Dr Lee that there is a real lack of support and they need more access to psychiatrists, or even a psychiatric registrar, who can actually be present in the ED and see a patient face to face. At the time of the deceased's death they at least had Dr Vecchio there Monday to Friday, but she is now only there three days a week and other consultant psychiatrists fill the gap as required.[155] Dr Vecchio was finishing her shift at the time Ms Silk finished with the deceased, so if Ms Silk had wanted Dr Vecchio to formally review him she would have had to ask him to stay the night and have him reviewed the next day.[156] However, Ms Silk clarified that she had been reassured by the deceased's presentation and did not consider further assessment by a psychiatrist was required.[157]

126. Dr Sturdy had high praise for the PLNs who work in the Peel Health Campus ED and Dr Pascu agreed that most PLNs are fairly senior mental health practitioners with valuable experience. However, Dr Pascu observed that it is still important for them to have oversight from a consultant psychiatrist.[158]

127. Dr Shymko identified that Peel ED is the only metropolitan ED that doesn't have 24 hour PLN cover and he acknowledged it does have more limited medical cover than other ED settings. Dr Shymko described it as "the reality of funding models,"[159] and explained that in order to address this issue South Metro Health Service has put in place processes to address that as best they can, with escalation processes whereby Peel ED can access other resources off-site to support them. Dr Shymko commented that "a general theme in mental health is we don't have enough,"[160] both in the way of community services and services in hospitals, but they do the best they can to make things work. Nevertheless, Dr Shymko acknowledged that "Peel has less than everyone else, and there's no question about that"[161] but observed there is a finite amount of money and high level decisions are made about where those resources go.[162]

128. In this case, despite the various comments by witnesses noted above, I am satisfied that Mr Johansen was assessed by an experienced PLN and she had an opportunity to briefly discuss his case with a consultant psychiatrist, which is all she considered necessary at that time. Asked to reflect upon her decision making, Ms Silk did not consider that with the benefit of hindsight she felt there was evidence before her at the time she assessed Mr Johansen to have made a different decision in terms of a plan forward, such as keeping him in hospital until a consultant psychiatrist could review him. Therefore, while there was evidence before me about a relative lack of access to PLNs and 'face to face' consultant psychiatrist consultations compared to other

[154] T 22 – 23.
[155] T 41.
[156] T 38.
[157] T 40.
[158] T 72.
[159] T 101.
[160] T 101.
[161] T 101.
[162] T 101.

hospitals, I do not consider that these issues are properly connected to the death of the deceased in a way that would prompt me to comment further or make any recommendation in that regard.

129. However, one aspect of the mental health services at Peel Health Campus that arose in relation to the deceased's care was the fact that the deceased had to be assessed in the middle of a busy ED. Ms Silk gave evidence she usually tries to assess patients in a small room off the ED, as it is more private and confidential, but on this day there was already someone in there so she spoke to him by the bedside with the curtains around. Ms Silk did not get the impression that he was worried about the lack of privacy and felt he was being forthcoming despite the environment,[163] but the fact that we now know he withheld crucial information about his family history suggests that this may have not been the case.

130. Dr Pascu said that the most important thing is to do the most comprehensive assessment and management plan for the person that presents with suicidal intent to a mental health practitioner. In that regard, Dr Pascu advised that positive steps have occurred recently in changes to Department of Health policy in terms of managing people who present with suicidal ideation. The policy accepts that the focus on predicting and preventing suicide is flawed and the focus should be more on providing comprehensive assessments of people and then preparing comprehensive management plans to provide a better outcome for the patient.[164] Dr Pascu observed that it is very difficult to perform comprehensive psychiatric assessments, including risk assessments, in the busy environment of an ED.[165]

131. Ms Silk agreed and suggested that in an ideal world she would like to have a separate area for mental health patients to be in the ED because it's a highly stimulating environment and she did not consider it suitable for people who have mental health issues. However, Ms Silk noted they don't have that area at Peel Health Campus because there is not enough space or room for everyone as it is as it is a very busy ED. To have a designated area would also require extra staff.[166] Dr Lee also agreed that the ED environment is a chaotic environment, which is not a therapeutic environment for such patients to spend their time waiting.[167]

132. Dr Sturdy indicated that such a separate space for mental health patients is not possible in their current building structure. Dr Study suggested that if Peel Health Campus were to build a new ED, it would have very clear streaming of patients, or example with the aim of keeping children away from trauma and mental health patients in a quieter, less hectic environment where the lights could be turned down.[168] Such a new building is not currently planned, as it is in the hands of the State government rather than Ramsay Health Care.[169]

[163] T 47.
[164] T 71 - 72.
[165] T 68.
[166] T 47.
[167] T 22.
[168] T 58.
[169] T 58.

133. The building of a new ED is obviously a large undertaking and not a matter upon which I received any detailed evidence at this inquest. Therefore, whilst I can see the benefits, given its limited connection to the death of the deceased and the lack of information before me on what it would involve, I do not take the matter further.

134. One other matter Dr Pascu mentioned was the program available in the North Metro Health Service of 'Hospital in the Home.'[170] It allows for people with mental health issues that do not require in-patient admission to return home but be visited by psychiatrists and other mental health professionals in their home setting. It is apparently not available in the South Metro Health Service at present. Dr Pascu was positive about her experience with the Hospital in the Home service and felt it may have been something that could have benefited the deceased in the long-term. However, the sad reality is that the deceased died overnight, before any such visit could have occurred, even if the service had been available. Therefore, I do not consider it is directly relevant to the death of the deceased and I do not take that matter further.

135. Although she was not required to, Dr Sturdy voluntarily attended the entirety of the inquest in order to apprise herself of any concerns regarding the care that the deceased received at Peel Health Campus and to ascertain whether there were areas of potential improvement in Peel Health Campus' processes that might be implemented by Ramsay Health Care. With the benefit of having heard all the evidence, Dr Sturdy identified the following aspects of Peel Health Campus' practice and patient management that she believed warranted review:

- contemporaneous and comprehensive clinical documentation;
- discharging procedures; and
- how staff communicate to their mental health patients that they want them to remain in the ED for assessment.[171]

136. These matters were referred to the internal Emergency Department Government Committee and the Psychiatry Liaison Committee that is a line of communication with Rockingham Hospital.

137. Of particular interest to me is the change to the discharging procedures, which arose out of Ms Silk's evidence that her request to be notified when the deceased was discharged was not followed and she missed any opportunity to speak to Ms Johansen. It was agreed that the best way to ensure such a request is fulfilled is for the PLN to record this wish in the nursing documentation as a discharging nurse will review the relevant form prior to the patient leaving the ED. An electronic note in the ED patient tracking system can also be flagged by an ED staff member at the request of the PLN, and this is also encouraged. I am advised the relevant staff have been spoken to about these procedures and a memorandum has been circulated to all nursing staff.

[170] T 77, 79.
[171] Letter from Dr Sturdy to Counsel Assisting dated 16 May 2018.

138. Another area of concern was the evidence in relation to the deceased being told he might be "put on forms" if he tried to leave the ED before he was assessed. Dr Pascu had assumed that Dr Lee had made the reference to putting the deceased on forms because she believed he was a significant risk of suicide or self-harm. Dr Lee's evidence was, in fact that she had made the note as a way of ensuring he was assessed by the PLN rather than firmly believing he was at significant risk of self-harm at that time. Dr Pascu expressed some concern as to whether this was good clinical practice and considered it was not one of the criteria for invoking the *Mental Health Act.*[172]

139. Ms Johansen also indicated that, based upon her knowledge of the deceased, and his desire to be in control, he would have felt concerned by any suggestion of putting him on forms as he would not have wanted to lose control over his decision-making.[173]

140. Dr Sturdy acknowledged that, as a general proposition, being told they might be "put on forms" could prompt some patients to mask their symptoms and presentation and hide their true intent. Therefore, the two committees decided that it would be beneficial to adopt some scripted wording for encouraging a patient to stay in the ED for assessment that, whilst firm, should avoid any risk of patients becoming more guarded or less willing to disclose the extent of their symptoms. A memorandum to that effect was circulated to all ED Doctors at the Peel Health Campus on 16 May 2018.[174]

141. Dr Sturdy advised that the response to these various initiatives by ED medical staff and PLNs has been very positive.[175]

142. I am satisfied that the individual staff members involved, and Ramsay Health Care and the South Metro Health Service have all given significant thought to the events surrounding the death of the deceased, as well as participating fully in the inquest, and have since taken steps to try to identify ways their service can be improved arising out of this incident.

143. Whilst issues in relation to mental health resources in the Peel region were raised at the inquest that are of general public interest, as I have noted above I do not consider them sufficiently connected to the death of the deceased to take those matters further in this investigation.

[172] T 88 - 89.
[173] T 108 - 109.
[174] Letter from Dr Sturdy to Counsel Assisting dated 16 May 2018.
[175] Letter from Dr Sturdy to Counsel Assisting dated 16 May 2018.

CONCLUSION

144. The deceased was a 50 year old man who had experienced difficult family issues both as a child and as an adult and had been treated for anxiety and depression. However, despite a history of depression, he had no previous history of self-harming behaviour or suicidal thoughts.

145. On 28 October 2014 the deceased presented to his GP practice in crisis and admitted to having suicidal thoughts and a plan. Due to concerns for his safety he was appropriately transferred by ambulance to Peel Health Campus for psychiatric assessment. He was reviewed by an ED doctor and then referred to a PLN for more in-depth risk assessment. After consultation with the deceased, a diagnosis was made that he was experiencing a situational crisis, which had resolved. It was felt that there was no clear reason to admit him under the *Mental Health Act*. The deceased denied any current thoughts of suicide and appeared satisfied with a proposed management plan that involved actions he could take in the community. He had indicated that he was not seeking a voluntary admission and it was not felt at the time that this was required.

146. It was not disclosed to the health professionals who assessed the deceased that he had a family history of mental illness and suicide. He had also declined to allow the staff to speak to his family or other sources to gain more information about his background. This left the staff missing key pieces of information in their risk assessment that may have changed the pathway they followed. It also meant that when the deceased left the hospital and returned to his wife and family they did not have a full picture of the crisis he was undergoing.

147. The most disturbing aspect of this case is that the deceased described a very detailed plan to commit suicide, which had led him to be medically assessed and cleared, then put that plan into effect less than 24 hours after being discharged from hospital. However, a statistic was given in the inquest that, at least in the United Kingdom, 60% of patients who actually commit suicide were considered low risk prior to the event.[176] This shows the difficulty with assessing risk of suicide at any moment, and was emphasised by the experts who gave evidence before me.

148. The deceased was offered a voluntary admission, which could have been a good option to allow him more time to establish rapport with staff and time for collateral information to be obtained from other sources, as well as to keep him out of an environment that was causing him stress. However, it was his right to choose to decline given there was nothing at that stage to indicate he required involuntary admission.

149. I am satisfied that the PLN and doctor who assessed the deceased had appreciated that there was an increased risk that the deceased might harm himself, given his admitted plan and the fact that he was seeking help. However, they were reassured by the deceased's behaviour and demeanour in the ED and the responses that he gave, which made them consider his

[176] T 94.

risk was no longer acute. It is entirely possible that at the time his responses were genuine and his situation changed upon his return home. However, this also underscores the difficult situation in which the deceased's wife and family were placed, who could be told little about what had occurred.

150. These are not easy issues to solve when it is acknowledged that the rights of the patient must be respected. No one has suggested a simple solution and I have not identified one. All that can be said is that the more opportunity there is for comprehensive psychiatric assessment of patients, with as much detailed information as possible, the better the outcome is likely to be for those patients and their families.

S H Linton
Coroner
10 September 2018