Coroners Act, 1996
[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION INTO DEATH

Ref No: 29/14

I, Rosalinda Vincenza Clorinda Fogliani, State Coroner, having investigated the death of ***John Vincent KEARNEY*** *with an Inquest held at Perth Coroners Court, Court 51 Central Law Courts, 501 Hay Street Perth on 7 August 2014 and 11 to 13 August 2014 find that the identity of the deceased person was* ***John Vincent KEARNEY*** *and that death occurred on 30 March 2010 at 17 Errina Road, Alexander Heights, as a result of carbon monoxide toxicity in the following circumstances -*

Counsel Appearing :

Ms K Ellson assisted the State Coroner

Mr D Harwood appeared for the North Metropolitan Area Health Service and Sir Charles Gairdner Hospital

Ms B Burke appeared for Nurse Bright

Ms K Vernon appeared for Dr Momber

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INTRODUCTION

John Vincent KEARNEY (the deceased) was a 49-year-old male who died as a result of carbon monoxide toxicity at his home in Alexander Heights in Western Australia on 30 March 2010.

The deceased had been referred to the Emergency Department (ED) of Sir Charles Gairdner Hospital (SCGH) by his general practitioner on 26 March 2010, after he stated to him that he had suicidal thoughts. This was on a background of previous mental health problems. Straight after the referral the deceased was taken by his wife to the ED at SCGH and he had a psychiatric assessment. The deceased was admitted overnight in ED for observation and he was discharged the following day into the care of his brother. The mental health team at SCGH had assessed the deceased as not requiring admission as an inpatient.

As part of his discharge plan, the mental health team at SCGH scheduled a follow up review for the deceased with

the North Metropolitan Area Health Service Adult Mental Health Transition Program (the Transition Program) for additional community support following his discharge. Staff from the Transition Program visited the deceased at his brother's home two days after his discharge and it appeared that his mental state had continued to improve.

However, tragically on 30 March 2010 the deceased's wife returned to the matrimonial home and found the deceased unresponsive in his car, with the engine running in the carport and the roller door closed. The deceased had died of carbon monoxide toxicity.

The deceased's death was a "*reportable death*" within the meaning of section 3 of the *Coroners Act* 1996 (the Coroners Act) because it appeared to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from injury.

Under section 19(1) of the Coroners Act I have jurisdiction to investigate the deceased's death and under section 22(2) of the Coroners Act I held an inquest to investigate his death at Perth Coroners Court on dates between 7 and 13 August 2014.

The issues considered at the inquest were the nature and quality of the deceased's mental health assessment when he presented to the ED at SCGH and the circumstances

surrounding his discharge from the ED at SCGH the next day.

A further issue also concerned why the deceased and his family were told that there were no mental health beds available for him. I considered this issue within the context of whether, objectively, admission as a psychiatric patient was indicated.

The documentary evidence adduced at the inquest comprised the brief of evidence in one volume,[1] correspondence from Dr Bridgford of Joondalup Health Campus dated 9 June 2000,[2] correspondence from the Health Information Manager of Perth Clinic dated 28 July 2014,[3] correspondence from the North Metropolitan Area Health Service dated 23 July 2014,[4] statement of Kevin Richard Bright dated 5 August 2014,[5] Medical Board of Australia publication "Good Medical Practice: A Code of Conduct for Doctors in Australia",[6] Department of Health and Mental Health Commission publication "Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia" by Professor Bryant Stokes AM (the Stokes Report[7]), the Western Australian Government

[1] Exhibit 1, Tabs 1 to 26
[2] Exhibit 2
[3] Exhibit 3
[4] Exhibit 4
[5] Exhibit 5
[6] Exhibit 6
[7] Exhibit 7

Response[8] to the Stokes Report, and correspondence from Dr Mark McAndrew head of clinical service, psychiatry, SCGH dated 11 August 2014.[9]

A number of witnesses gave oral evidence at the inquest and they comprised, in order of evidence, Dr Chandra Panicker the deceased's general practitioner at the Mirrabooka Medical Centre, the deceased's wife Mrs Dianne Kearney, Senior Constable Thorp attached to the Coronial Investigation Unit, Martin Raymond psychiatric liaison nurse at SCGH, Sarah Lehmann senior social worker with the Transitions Program, Dr Adam Brett consultant psychiatrist, Dr Anne O'Sullivan psychiatry registrar in training at SCGH at the material time, Kevin Bright clinical nurse specialist in the mental health ward at SCGH and also acting clinical nurse specialist for the Transitions Program, Dr Salam Hussein consultant psychiatrist and Dr Antonia Momber psychiatry registrar at SCGH at the material time.

Dr Brett, referred to above, gave evidence at the inquest in his capacity as an independent expert witness, regarding the quality of the deceased's mental health assessment, his discharge and his post discharge assessment. Dr Brett has practiced as a consultant in psychiatry since 1999 and he currently consults for a range of mental health services. Part of his work involves providing reports for the courts.

[8] Exhibit 8
[9] Exhibit 9

His core work comprises treating patients with suicidal ideation. He has also had experience working in emergency departments as a general physician for approximately two years before doing his psychiatry training.

Dr Hussein, also referred to above, is acting head of clinical services at the Department of Psychiatry and Behavioural Neurosciences at SCGH. He gave evidence at the inquest about the structure of the psychiatry team and the admission and discharge procedures at SCGH in 2010. He was not one of the clinicians who treated the deceased at the material time.

Both Dr Brett and Dr Hussein had read the deceased's medical files and they gave their evidence on the basis of their consideration of the information on those files.

An issue that arose at the inquest concerned the further clarification of the discharge policy and procedures for mental health patients at SCGH at the time of the deceased's discharge, and at the present time.

Following the hearing the court through Ms Ellson obtained further materials relevant to those policies and procedures from Mr Harwood of the State Solicitor's Office. Copies of those materials were provided to counsel for Nurse Bright and Dr Momber and they were provided with an opportunity

to present any submissions in respect of them by 29 January 2015.

On 27 and 29 January respectively, counsel for Nurse Bright and Dr Momber advised they had no submissions to make in respect of the further materials.

THE DECEASED

The deceased was born on 21 June 1960. At the time of his death on 30 March 2010 he was 49 years of age, married, and he and his wife and had two teenaged children. He worked part time and he also worked night shift at a supermarket store.

The deceased and Mrs Kearney both worked, with the deceased working part time so that he could assist with the care of the children.[10] By working part time he was able to attend to the school drop offs and pick-ups and this was important to him.

The deceased and his wife were married in 1987 and he lived in a close and caring environment with his family. Throughout his marriage, the deceased's moods fluctuated and he had difficulty coping with change.

[10] T15 - 16

Mrs Kearney described the deceased as having a history of anxiety and depression for which he had sought previous medical assistance. There was an episode shortly after their marriage in 1987 where the deceased sought psychological assistance due to stress but this did not involve ongoing treatment. Mrs Kearney described the deceased after this initial episode as having peaks and troughs over the years and that on certain days she could see that he was blue, depressed and not coping well.[11]

Mrs Kearney gave evidence about her observations concerning an acute episode of the deceased's depression and/or anxiety in 2000.[12] On this occasion the deceased made a non-fatal attempt at suicide and then he rang Mrs Kearney to tell her of his plan. The deceased had prepared to take his life by carbon monoxide poisoning. This resulted in the deceased being hospitalised but upon being discharged, he took an overdose of medication and was returned to hospital then treated at a private clinic, with further participation in an outpatient program.

From Mrs Kearney's observations, the episode in 2000 was related in part to stress that the deceased experienced from a work situation where he was required to make some changes to his job. She observed changes in his behaviours and routines that indicated that he was deeply troubled and not coping.

[11] T 18
[12] T 16 - 23

On the evidence before me I am satisfied that in 2000 the deceased experienced mental health problems which included suicidal ideation and an attempt at suicide, and that he was treated for that.

In 2010 shortly before his death, Mrs Kearney began to observe the deceased experiencing symptoms that were similar, but more severe than the ones she observed him experiencing just prior to his hospitalisation in 2000. These had recurred at a time when he again faced an impeding change to his work situation. There were also other stressors. The overt deterioration in the deceased's mental health developed over a period of approximately four weeks before his death.[13]

Whilst the deceased's 2010 episode appears to have been precipitated by an impending change to his work situation, it is clear that the deceased had experienced long term mental health problems of varying degrees over the years and some of these manifested themselves when he was faced with needing to cope with unexpected or unwelcome changes to his routines. On some occasions he had received treatment, but this was situational rather then ongoing.

[13] T 21

In the month prior to his death, Mrs Kearney observed that from a mental health perspective, the deceased appeared quite unwell.[14] She interceded when she observed his deterioration and at her insistence on 24 March 2010 the deceased had a consultation with his doctor at the Mirrabooka Medical Centre in order to obtain medical assistance for his stress, including in particular his inability to sleep. He was prescribed medication for that.[15] However, during the course of this consultation he was unable or unwilling to speak frankly about his previous suicide attempt.

Mrs Kearney counselled the deceased against returning to work and upon further inquiry of him and from her own observations, she formed the view that on 24 March 2010 the deceased's doctor had not had an adequate opportunity to assess the extent of the deterioration in his mental health because the deceased had not disclosed sufficient relevant details (in particular he had not disclosed his previous suicide attempt). Mrs Kearney had become increasingly concerned about the exacerbation of his symptoms and she considered it most important that he seek professional help.[16]

The next day on 25 March 2010, with Mrs Kearney's further encouragement, the deceased had a consultation with his

[14] T 22
[15] Exhibit 1 Tab 10
[16] T 23

GP, Dr Panicker, at the Mirrabooka Medical Centre and the deceased provided more information relevant to his mental state. This resulted in Dr Panicker deciding that arrangements needed to be made for a Mental Health Care Plan for the deceased and he was asked to return the next day to enable that to be done. Mrs Kearney then actively involved herself in ensuring that the deceased attended at this further medical appointment with Dr Panicker scheduled for 26 March 2010.

On 26 March 2010 and prior to this medical appointment, the deceased telephoned Mrs Kearney at work to tell her he was considering suicide but he also added that he was not serious about it. She monitored him by telephone calls over the day until she was able to see him and then she accompanied him to the Medical Centre.

At the medical appointment on 26 March 2010, with Mrs Kearney's counselling and encouragement, Dr Panicker was informed by the deceased that he was depressed and that he had suicidal thoughts.[17] Mrs Kearney was present for at least part of that consultation.

Dr Panicker took into account a range of relevant considerations including the deceased's suicidal ideation and past suicide attempt as described to him, and he formed the view that the deceased was at great risk of

[17] T 8 – 10 and T 24 – 25 and Exhibit 1, Tab 10

harming himself. As a consequence, he immediately referred the deceased to the ED of SCGH.[18]

Mrs Kearney drove the deceased to SCGH straight after Dr Panicker referred him there, arriving at the ED in the late afternoon of that same day, 26 March 2010.

THE DECEASED'S ASSESSMENT BY NURSE RAYMOND

The triage nursing record from the ED of SCGH discloses that the deceased was seen by the general nurse at the triage window at approximately 5.18pm on Friday 26 March 2010 and that he said that he had a plan to end his life.[19]

After triage, Nurse Raymond attended to the deceased in the ED. He was aware of the deceased having indicated at triage that he had a plan to end his life. This information led Nurse Raymond to prioritise the deceased's progression into the ED.[20]

Nurse Raymond's usual procedure was to make an assessment and then refer the mental health patient on to the psychiatry registrar, who was his first point of contact.[21]

[18] T 10 and Exhibit 1, Tab 10
[19] T 42 – 43 and Exhibit 1, Tab 20(I); The triage assessment records that the deceased had a plan to gas himself in a car.
[20] T 43
[21] T 44

At SCGH in 2010, the psychiatric team at the shift commencing 5.00pm comprised of a psychiatric liaison nurse, the psychiatry registrar and the on call consultant psychiatrist. In Nurse Raymond's experience, the consultant would be contacted where appropriate and it would depend on degree of risk and/or ambiguity of diagnosis. At that time the general rule at SCGH was that the psychiatry registrar saw all GP referrals.[22] The deceased had been referred by his GP.

A complicating factor is that on the evening of 26 March 2010, the availability of beds in the psychiatric ward at SCGH was compromised because there had been a severe hailstorm and the ward had been flooded. Consequently, the ward was evacuated. Nurse Raymond's understanding was that there were no beds available there.

With this knowledge, Nurse Raymond conducted a risk assessment in the form of a "rapid triage" of the deceased to assist him to get into the ED because he was concerned for his welfare. The ED medical notes for the deceased made by Nurse Raymond were written at 6.30pm on 26 March 2010.[23] The deceased told Nurse Raymond that he wanted help with his anxiety and cited a range of stressors. The ED medical notes disclose that the deceased believed that he was at "medium" risk of suicide (with which Nurse Raymond agreed), that he had no plan and no intent regarding

[22] T45 and 50
[23] T 49 and Exhibit 1, Tab 20(E)

suicide, but that 10 years ago he had made a non-fatal attempt at suicide. Nurse Raymond formed the view that the deceased's mind was oriented and that he had no formal thought disorder.

During the course of his assessment by Nurse Raymond, the deceased said he wanted a private hospital bed and provided his private funding details. Nurse Raymond discussed the deceased's case with Dr O'Sullivan, the rostered psychiatry registrar who agreed for Nurse Raymond to endeavour to source a private hospital bed for the deceased. As a result, Nurse Raymond contacted two private mental health services providers but he was unable to source a private hospital bed for the deceased and he advised Dr O'Sullivan of this.[24]

Nurse Raymond did not record nor recall Mrs Kearney being present during his assessment of the deceased. Mrs Kearney does recall being present when a person assessed the deceased in the ED that evening and she recalls being informed that there were no beds available at SCGH due to the closure of the psychiatric ward following the hailstorm. She also asked this person to source a private hospital bed for the deceased.

It is likely that Mrs Kearney was present during at least part of Nurse Raymond's assessment of the deceased and I am

[24] T 52 - 55

satisfied that she was informed by a member of staff at SCGH that there were no beds available for the deceased due to the closure of the psychiatric ward, whether that was Nurse Raymond or another staff member.

Mrs Kearney left the deceased at the ED, to go home to look after their children, at approximately 10.00pm on 26 March 2010. When she left she understood that the deceased was to be admitted to the observation ward at SCGH with a further decision concerning his admission to a psychiatric ward be made the following morning.[25] Nurse Raymond completed his shift at 11.30pm.

Dr Hussein gave evidence about relevant procedures at SCGH at the material time. He confirmed that the multidisciplinary approach to admission would involve a psychiatric liaison nurse (such as Nurse Raymond) conducting an initial assessment in order to fast track the patient from the ED triage, towards psychiatric assessment.[26]

I am satisfied that the deceased was progressed in a timely manner through triage and towards his psychiatric assessment.

[25] T 27 – 30 and T 55 - 56
[26] T 145

THE DECEASED'S PSYCHIATRIC ASSESSMENT BY DR O'SULLIVAN

At the material time, Dr O'Sullivan was a psychiatry registrar at SCGH and she was rostered from 5.00pm on 26 March 2010 until 8.30am on 27 March 2010. After Nurse Raymond's assessment, Dr O'Sullivan conducted a comprehensive psychiatric assessment of the deceased commencing at approximately 11.00pm on 26 March 2010 and she made detailed notes.[27] At the inquest she also had her own independent recollection of the deceased, describing him as having difficulty making some decisions, but quite settled and pleasant and very easy to engage with.

Dr O'Sullivan interviewed the deceased for approximately one hour and he was admitted overnight to the observation ward in the ED of SCGH. Afterwards she made her notes, which took approximately 30 to 40 minutes, and this provided her with the opportunity to further reflect on him. At about 2.00am on 27 March 2010, Dr O'Sullivan checked on the deceased as she had given him medication, and was advised by nursing staff that he was sleeping soundly.

Dr O'Sullivan's notes disclose that during her interview with the deceased she took his medical history, which included a history of a non-fatal attempt at suicide 10 years ago, and she was aware of the circumstances of that attempt. She

[27] T 105 – 107, Exhibit 1 Tab 20(G) and Exhibit 24

noted his increased anxiety due to his possible work transfer and she concluded that whilst he did have a fleeting thought of suicide, he exhibited no planning and no intent to die. The deceased told her he felt he needed an admission to have a break from things, but he also added that he would probably go to work on Monday. The deceased indicated to her that he did not feel like he did when he previously attempted suicide in 2000. As part of her assessment, Dr O'Sullivan was also aware that his GP had commenced him on an antidepressant the previous day.

Dr O'Sullivan concluded the deceased had no formal thought disorder and no psychosis and she noted his denial of suicidal ideation. In her opinion he had an acute stress reaction to work and her plan was to talk through the possibilities of admission to the psychiatric unit, HITH[28] and follow up treatment with his work psychologist and his GP. She discussed these alternatives with the deceased and he agreed to take his prescribed medication and to stay in the observation ward of the ED overnight, with the intention of considering these alternatives the next day in conjunction with the mental health team.

She had made the deceased aware that, save for the observation ward, there were no beds available in the public or private system at that time, especially given the

[28] Hospital in the Home, which Dr O'Sullivan equated with the Transitions Program. Nurse Bright's evidence was that they became two names for a similar service (T126)

temporary closure of the psychiatric ward at SCGH due to storm damage.

Throughout the interview with Dr O'Sullivan, the deceased made numerous references to his wife and he described how she was worried about him. Dr O'Sullivan took account of his domestic situation.

Towards the end of her interview with the deceased, which was shortly after midnight on 26 March 2010, Dr O'Sullivan asked the deceased if she could contact Mrs Kearney but he requested that she be called in the morning instead, to avoid waking her up at that hour.[29] I am satisfied that it was proper for Dr O'Sullivan to accede to the deceased's wish that his wife not be contacted at that point.

Dr O'Sullivan's evidence was that she had formed the view that the deceased was reliant on his wife's opinion of his care and she wanted to involve her in the decisions regarding the plan for his care, stressing however that the approval to that plan had to come from the deceased himself. Dr O'Sullivan concluded that, subject to being reassessed, the deceased could go home in the morning.[30]

From Dr O'Sullivan's perspective the purpose of the deceased's further assessment was to determine his suitability for the HITH program or a voluntary admission to

[29] T 104 and T113
[30] T 110 – 113 and Exhibit 1 Tabs 15 and 20(G)

hospital, to ensure his mental state was settled and stable if he was to be discharged to HITH and to ascertain whether Mrs Kearney agreed with the plan.[31]

Dr Brett gave independent expert evidence at the inquest about the quality of the deceased's psychiatric assessment by Dr O'Sullivan.

In Dr Brett's opinion, the deceased's initial assessment and management was appropriate, including the risk management. Further, in his opinion Dr O'Sullivan documented an extremely thorough assessment for the setting that the deceased was in and she made a crisis plan, which was to admit the deceased overnight into SCGH. Dr Brett described Dr O'Sullivan's assessment as probably more comprehensive than he would do in a similar situation.[32]

I am satisfied that the deceased's assessment by the mental health team at SCGH, and in particular his psychiatric assessment by Dr O'Sullivan, was properly conducted and comprehensive.

[31] Exhibit 1 Tab 15
[32] T 87 - 91

THE HANDOVER BY DR O'SULLIVAN TO DR MOMBER

On the morning of Saturday 27 March 2010 between approximately 8.30am and 9.00am, Dr O'Sullivan handed over all of the patients she had assessed in the ED overnight, and who were still to be assessed, to Dr Antonia Momber.

Dr Momber was a consultant liaison psychiatry registrar at SCGH at the material time. Her role was to see patients who required psychiatric review referred by medical and surgical teams throughout the hospital.[33] On 27 March 2010 at the commencement of her shift attending to patients in the ED of SCGH, she received a handover of the care of the deceased from Dr O'Sullivan.

Also participating in the handover of the care of Dr O'Sullivan's patients was Nurse Kevin Bright, clinical nurse specialist in the metal health ward at SCGH and also the acting clinical nurse specialist for the Transitions Program. He was present for at least part of the handover discussions between the two doctors concerning the deceased.

Dr O'Sullivan conducted a face-to-face handover with Dr Momber. Dr O'Sullivan had an independent and quite detailed recollection of the circumstances attending the

[33] Exhibit 1 Tab 25

deceased's handover, and in her evidence she was also assisted by her report.[34]

Dr Momber's evidence concerning the deceased's handover and discharge was based upon a subsequent review of the deceased's medical records and a consideration of her usual practice concerning the handover and discharge of mental health patients at the material time. There was no record of notes having been made by Dr Momber on the deceased's medical records. She did not have an independent recollection of the deceased.

Nurse Bright's evidence concerning the deceased's handover and discharge was based primarily upon his ED and Transition Program notes, though he did have some independent recollection of some of the material events concerning the deceased.

Dr O'Sullivan recalls that she discussed the deceased at length with Dr Momber during the handover. The discussion included Dr O'Sullivan's concerns that the deceased was minimising his situation and a consideration of the possibility of HITH or a voluntary admission.

Dr O'Sullivan formed the view that the deceased had a tendency to attribute his deteriorating mental health solely to the impending change to his work situation, whilst

[34] T 114 and Exhibit 1 Tab 15

minimising his other stressors and without demonstrating relevant insight into them.[35]

Dr O'Sullivan wanted Mrs Kearney to be contacted as it was considered she would be able to provide them with further collateral history.[36] Nurse Bright left the handover meeting discussions in order to review the deceased and to contact Mrs Kearney.

It is clear that one of the reasons for contacting Mrs Kearney was to sound her out on the plan to discharge the deceased into her care.

Nurse Bright reported back to the two psychiatry registrars that, in effect, that he had spoken with Mrs Kearney who was of the firm view that the deceased required admission. It appeared that Mrs Kearney was not willing to have him discharged into her care due to her concerns about his need for treatment. Mrs Kearney had become upset upon hearing about the plan to discharge the deceased and it was not at that point possible to continue to outline the discharge plan in any detail.

Nurse Bright also reported to the doctors at the handover meeting that the deceased was willing to stay with his brother over the weekend.

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[35] T 116
[36] T 119

The tenor of the communication from Mrs Kearney precipitated a further discussion between Dr O'Sullivan, Dr Momber and Nurse Bright of some 30–45 minutes. As a result of the outcome of Nurse Bright's discussion with Mrs Kearney, Dr O'Sullivan recommended a further psychiatric review of the deceased, despite him indicating his willingness to be discharged into the care of his brother. Dr O'Sullivan's view was that he should not be discharged unless it was to a safe place in the care of a responsible adult, and only if his mental state was stable for discharge and he was willing to engage with HITH.[37]

Dr O'Sullivan left her shift at about 10.00am on 27 March 2010 and did not have any further duties in respect of the deceased. At the time she left, she believed the deceased would be for further psychiatric review in accordance with her recommendation.[38]

I am satisfied that the quality of the handover of the deceased's care from Dr O'Sullivan to Dr Momber was appropriate in the circumstances, with Dr O'Sullivan having clearly articulated the conditions that needed to be met in order for the deceased to be discharged.

[37] T 114 – 115 and Exhibit 1 Tab 15
[38] T 114 – 115 and Exhibit 1 Tab 15

THE DECEASED'S DISCHARGE FROM SCGH ED

The deceased was discharged from SCGH ED into the care of his brother on the morning of 27 March 2010. At the time of his discharge, the deceased was in the care of Dr Momber, who made the decision that it was appropriate to discharge him.

Given the concerns expressed by the deceased's family relating to his discharge, I have given particular consideration to the roles of Nurse Bright and Dr Momber in connection with his discharge, and this is addressed in more detail below.

The role of Nurse Bright

During the course of the handover from Dr O'Sullivan to Dr Momber, and in the period afterwards, the deceased was reviewed and assessed by Nurse Bright, the clinical nurse specialist for the mental health ward at SCGH (CNS) and acting clinical nurse specialist for the Transitions Program (CNS Transitions). Nurse Bright is an experienced mental health nurse, having first qualified in 1988. As a nurse, he has always worked in the mental health area.

Nurse Bright's substantive role as CNS had involved the assessment of patients in the mental health ward of SCGH for level of suicide risk. He explained that at the material

time, the mental health Risk Assessment form was still in development and that he applied his clinical judgement in respect of his risk assessments, and he kept written notes.

However, when Nurse Bright assessed the deceased on the morning of 27 March 2010, it was for his suitability for the Transitions Program.

Nurse Bright explained that his CNS Transitions role was set up specifically during the period of the storm crisis. In this capacity his role was to attend at ED and assist the psychiatry registrar with the assessment of patients for suitability for the Transitions Program and the coordination of the referrals to that program. The actual decision regarding the patient's suitability was to be made by the psychiatry registrar. Nurse Bright was assigned to this role for a period of approximately three weeks.[39]

In order to be assessed as suitable for the Transitions Program, from Nurse Bright's perspective a patient needed to meet certain criteria. First, that the patient wanted outpatient care and to be linked into a community service (in the present case it was with Swan Adult Mental Health Centre, near to where he would be staying); secondly, that their level of risk was considered acceptable and thirdly that they were not assessed as requiring "100%" a hospital bed.[40]

[39] T 125
[40] T 126

Nurse Bright did not have an independent recollection of his assessment of the deceased and was assisted by the notes he made at the material time. The assessment was conducted by Nurse Bright over a period of approximately 45 minutes and during that time he had telephone conversations with Mrs Kearney and, separately, the deceased's brother, Mr Philip Kearney.[41]

From Nurse Bright's two sets of ED continuation notes made at approximately 9.30am and then at 10.15am on 27 March 2010[42] it is recorded that the deceased stated to him that he was willing to go home with his brother, who was going to come in and collect him at 10.00am that day. The ED continuation notes also reflect that Mrs Kearney returned Nurse Bright's first telephone call and she was adamant that the deceased should be treated in hospital.

The first set of ED continuation notes finish with an entry to the effect that Nurse Bright would be seeking further input from the psychiatry registrar. The second set of ED continuation notes reflect Nurse Bright's arrangements regarding the deceased's referral to the Transitions Program linked in with the Swan Adult Mental Health Centre and they finish with an entry to the effect that the deceased can be discharged into the care of his brother, with particular medications being prescribed. There is also reference to the provision of medical certificates to the deceased for use for

[41] Exhibit 5
[42] Exhibit 1, Tab 20(G)

time off work. This second set of ED continuation notes is consistent with a psychiatry registrar having made a discharge decision with respect to the deceased. Nurse Bright would not have been able to grant or change a medical certificate, make the decision to discharge the deceased of his own accord, nor would he have been able to prescribe those particular medications.[43]

After Nurse Bright completed the relevant entries in the ED continuation notes, he made an entry in the Transition Program notes[44] and they represent a more detailed outline of what he recorded in the ED continuation notes, and are consistent with the ED continuation notes.

At the inquest, Nurse Bright was questioned about his telephone discussion with Mrs Kearney where he sought to talk to her about the plan to discharge the deceased. By that stage discussion had already taken place regarding the deceased's suitability for the Transitions Program. I am satisfied however that no discharge decision had been made by a doctor prior to Nurse Bright's contact with Mrs Kearney. Rather, she was being contacted as part of a conferral process because there was a plan to discharge the deceased into her care.

It is clear that at one point during this telephone conversation, Mrs Kearney made Nurse Bright aware that

[43] Exhibit 5 and T 121, 135 and 139
[44] Exhibit 1, Tab 21(K)

the deceased was exhibiting symptoms similar to those 10 years ago when he attempted suicide. She also provided him with information to the effect that she was unable to cope with having the deceased discharged into her care. Nurse Bright was not able to independently recall the specific contents of the telephone conversation, relying on his notes instead. However, he was able to recall that Mrs Kearney was very upset, that the conversation was extremely heated and that from his perspective Mrs Kearney was very definite in what she was willing to accept regarding the deceased's treatment.[45]

Mrs Kearney recalls that during this telephone conversation she was told by Nurse Bright that there were no beds available anywhere. She refused to have the deceased discharged into her care. She wanted the deceased treated in hospital. Consistent with Nurse Bright's recollection, Mrs Kearney also recalled it being a difficult telephone conversation.[46]

Mrs Kearney did not recall having a discussion with the deceased himself about whether he wished to be admitted or not.[47]

Nurse Bright agreed that it would have been important to discuss Mrs Kearney's views with the psychiatry registrar

[45] T 136 - 137
[46] T 31 - 33
[47] T 32 - 33

but he did not have an independent memory of specifically doing that. It is however clear that he did have discussion with Dr O'Sullivan about Mrs Kearney's views to the extent at least that Dr O'Sullivan was aware that Nurse Bright had had a very detailed and intense conversation with Mrs Kearney, and she was not willing to accept him home and wanted him admitted.[48]

Nurse Bright waited with the deceased until the deceased's brother arrived to collect him. He advised the deceased's brother to contact the mental health response line, SCGH or someone from the Transitions Program if the deceased became worse or if he became worried about the deceased.[49]

Nurse Bright believes he rang Mrs Kearney back to let her know the deceased was being discharged into his brother's care but he was not certain about it. There is a note of Mrs Kearney's telephone number in Nurse Bright's Transitions Notes.

Mrs Kearney did recall that about one hour after the first telephone call on 27 March 2010, she received a second telephone call from SCGH advising that the deceased's brother had come to collect him. That was left by way of a recorded message. I am satisfied that it was Nurse Bright who made that second telephone call and left that message for her, or that call was made at his instruction.

[48] T 114, Exhibit 1, Tab 15
[49] Exhibit 5

The role of Dr Momber

Dr Momber's decision making on 27 March 2010 needs to be considered within the context of Dr O'Sullivan's prior psychiatric assessment of the deceased the night before and Dr O'Sullivan's recommendations regarding the conditions upon which he could be discharged after she was apprised of Mrs Kearney's conversation with Nurse Bright on 27 March 2010.

Relying on her usual practice, Dr Momber's evidence at the inquest was that when considering discharging mental health patients from an overnight stay in the ED, she would take into account any preceding psychiatric assessment. If there had already been a sound and reliable psychiatric assessment, and there were no major changes to somebody's mental state, or no new symptoms or levels of distress arising she would discuss the proposed discharge with the relevant mental health clinician who would see the patient. On the other hand, if a psychiatric assessment had not been fulfilled, then Dr Momber would see the patient herself in order to do that, prior to making a decision to discharge the patient.[50]

Dr Momber's evidence was that her practice was to always consider whether or not a patient's mental state was stable before discharging that patient. Depending on the

[50] T 165 - 166

circumstances outlined above, that consideration would occur as a result of her seeing the patient herself, or otherwise as a result of her discussing the review of the patient by another mental health clinician. If a patient's discharge plan involved follow up with community programs such as Transitions Program or HITH, she would ascertain whether a patient was willing to engage with such programs.[51]

In the case of the deceased's discharge, Dr Momber's view was to the effect that she could properly have relied on Nurse Bright's risk assessment of the deceased's condition. That would have included a review of the patient's risk and mental state.[52]

Dr Momber's usual practice was to make an entry in the ED Notes if she saw a patient herself. She could not recall seeing the deceased herself, though it is possible that she did. She confirmed there was no entry by her in the deceased's ED Continuation Notes and she offered possible explanations for that, ranging from the removal of the deceased's patient records by administrative staff before there was a chance for her to make a final entry, that another patient may have required her immediate attention that delayed the making of an entry, or that the deceased's file could not be located before the end of her shift.[53]

[51] T 164 - 166
[52] T 164
[53] Exhibit 1 Tab 25

Dr Momber had previously encountered these problems and she subsequently made arrangements with nursing staff for files to be made available to her in similar circumstances.[54] The fact of there being no entry in the ED Continuation Notes may indicate that Dr Momber did not see the deceased herself.

Whist Dr Momber had no independent recollection of her being involved in the deceased's discharge, she accepted that it was she who must have approved the deceased's discharge, having regard to a number of factors, including the staffing on that shift and her standard practice of being responsible for the final decision on a patient's discharge from ED during her shift.[55]

Whilst she had no specific recollection of them, Dr Momber was able to confirm that she signed the four medical certificates for the deceased on 27 March 2010 giving separate date ranges for time off work, which were for the purpose of affording flexibility.[56] Dr Momber confirmed that she only ever provided medical certificates for an ED patient as part of their discharge. Further, those medical certificates indicate to Dr Momber that she must have had an understanding of the deceased's current assessment when she wrote them, that she was satisfied his needs

[54] Exhibit 1 Tab 25
[55] T 168 and Exhibit 1, Tab 25
[56] T 167 – 168 and Exhibit 1, Tab 20(A) and (B)

required flexibility and that she was involved in the decision to discharge him.[57]

Taking into account these factors, and the prescription of medications associated with the deceased's discharge, I am satisfied that the decision to discharge the deceased was made by a doctor, and that was Dr Momber.

The reasonableness of the deceased's discharge

Dr Hussein explained that in 2010, in most cases at SCGH the psychiatry registrar made the decision about admission to hospital and if the case was complex, the consultant psychiatrist could be contacted. As a matter of practice the psychiatry registrar based his or her decision upon a holistic assessment, which included the clinical assessment of the patient, the collateral history and consultation with the psychiatric liaison nurse.[58]

Dr Hussein had read the deceased's medical records and in his opinion, he did not consider there was any indication for a consultant psychiatrist to be involved in the deceased's discharge. He took into account the deceased's willingness to engage with the community programs as part of the

[57] Exhibit 1, Tab 25
[58] T 142

discharge plan and his willingness to be discharged into the care of his brother and go to his house.[59]

Dr Brett's independent expert evidence was that in the mental health area, assessments are done by teams and reliance is placed upon colleagues. The vast majority of assessments are done by clinicians, nurses, social workers and occupational therapists and the psychiatrist's role is to listen, ask questions and oversee the plan.[60] In his opinion, presupposing that Nurse Bright liaised with Dr Momber about his assessment of the deceased, it would have been appropriate for Dr Momber to make the decision to discharge the deceased without her seeing him.[61] Dr Hussein confirmed that practice.[62]

Dr Brett opined that the clinicians who were involved in the deceased's care in the morning made appropriate assessments and put an appropriate plan in place, commenting also that in the public system, it would have been very unlikely that the deceased would have stayed any longer in a hospital bed given his risks as they were known and assessed.[63]

Dr Brett would have considered the deceased was a low priority for a hospital bed because it was not clear whether

[59] T 149
[60] T 96
[61] T 100
[62] T 142 – 143 and T 153
[63] T 91 – T 92

he had a mental illness, he had been treated by his GP for depression, with medications that could be taken in an outpatient setting, and he had organised to see his work psychologist.[64]

The consistent opinion of the clinicians who gave the relevant evidence and the expert opinion of Dr Brett was to the effect that the deceased did not require an urgent review by the consultant psychiatrist.

Having regard to the multidisciplinary team approach, (which all of the health clinicians referred to or touched on in evidence at the inquest) Dr Brett considered that clinical judgement was used in relation to the deceased's risk assessment and that the clinicians devised a plan for the deceased's discharge from SCGH ED which was safe, noting also that the deceased was seen by the Transition Program staff in the community following that assessment.[65]

In addition to the plan for interim follow up by the Transition Program, the deceased's discharge plan had made provision for ongoing treatment by the Swan Adult Mental Health Centre.[66]

[64] T 99 - 100
[65] T 90
[66] Exhibit 1 Tab 18

From her subsequent review of the deceased's medical files, Dr O'Sullivan was of the view that the three conditions for the deceased's discharge that she articulated at the handover on 27 March 2010 were addressed. Dr Brett's opinion was to a similar effect.[67]

Dr Brett gave the following reasons for the deceased's discharge plan being safe and sensible:

> *"His brother was willing to take him home. Mr Kearney requested that he go home. And it should be remembered that Mr Kearney is the – is the client, if you like, in these negotiations. So it's him who really is the key person. If he says this is the plan that he wants it would be an unusual clinician to say that, well, we're disagreeing with your plan. So it sounded like a safe plan, and he agreed to have follow up further Transitions Program in the community. So it – it seems as a safe plan for them to go through with."*[68]

Dr Hussein also referred to the importance of working with the patient's willingness, in circumstances where he was not an involuntary patient within the meaning of the *Mental Health Act* 1996 nor were there any indications for admitting him to the psychiatric ward at SCGH (had it been open) as the only option for treatment. Further, he had regard to the fact that the deceased had requested private admission.[69]

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[67] T 122 and Exhibit 1 Tab 24
[68] T 89
[69] T 155 and Exhibits 13 and 18

Dr Hussein confirmed that in 2010, all patients being discharged from SCGH were required to have a discharge plan, and that there have been further developments regarding the recording of that plan since the Stokes Report. However, he emphasised that the application of clinical judgement has remained a consistent requirement.[70]

At the time of the deceased's discharge in 2010, there was no specific written policy regarding the discharge of psychiatric patients and/or the recording of the discharge plan. The relevant doctor, exercising his or her clinical judgement, made the decision to discharge by considering each case on its own merits. There was a general practice of completing a standard ED discharge summary form, with a note being made on the patient's medical record. It was not a mandatory requirement at that time.

In the case of the deceased's discharge, there is no record of an ED discharge summary form. The notes in the deceased's medical records relevant to discharge on 27 March 2010 were made by Nurse Bright.

On the evidence before me I am satisfied that the deceased's discharge occurred as a result of the exercise of clinical judgement on the part of Dr Momber (who addressed Dr O'Sullivan's recommendations and took into account Nurse

[70] T 143

Bright's assessment) and that the exercise of that judgement was reasonable in the circumstances.

Subsequent changes to discharge procedures

The requirements regarding the documentation of clinical decisions have changed since the deceased's death. Since April 2014 all public adult Mental Health Services have been required to implement the State-wide Standardised Clinical Documentation suite, which includes a written Treatment, Support and Discharge Plan Form and a Case Transfer Summary Form, amongst others.

These forms must be completed by mental health clinicians caring for a patient, as part of the comprehensive mental health assessment process, from triage to discharge.[71] The suite of documents was in response to recommendations in the Stokes Report.[72] They represent a minimum standard and are a recognition that mental health care is especially dependent on good clinical documentation. They facilitate the recording of the salient features of a patient's medical care and assist in ensuring that vital information is imparted at the time of handover and/or discharge. They also promote transparency and accountability.

[71] '*Triage to Discharge*' Mental Health Framework for State-wide Standardised Clinical Documentation, Government of Western Australia, Department of Health.
[72] Exhibit 7. See recommendations 1.1.3, 2.2, 4.5 and 7.3

The overriding obligation remains the exercise of proper clinical judgement and the suite of documents assists in that process.

THE ENGAGEMENT WITH MRS KEARNEY

Mrs Kearney has expressed her concern about not having been sufficiently consulted in respect of the deceased's discharge from the ED of SCGH and his follow up treatment in the community. She had brought the deceased into the ED the day before his discharge.

Through information gleaned from both the deceased and separately from Mrs Kearney at different stages, the mental health team at SCGH was aware that she was very concerned about the deceased. They knew that Mrs Kearney was adamant that he be admitted to SCGH for treatment for his mental health problems. They were also aware that she was having difficulty coping with the manifestations of his symptoms at home.

On 27 March 2010, Mrs Kearney became upset upon hearing there was a plan to discharge him into her care. After her telephone conversation with Nurse Bright she decided to take a step back from decision making regarding the deceased's treatment. By that stage she had made her views clear to SCGH, namely that the deceased needed to be

admitted and treated, and she provided her reasons for that to Nurse Bright.

Later that day Mrs Kearney received a message to the effect that the deceased was going to be discharged into the care of his brother. Mrs Kearney then ceased her engagement with SCGH for all practical purposes.

With the deceased's agreement, the mental health team then began to liaise with the deceased's brother in respect of his discharge plan and, separately, Mrs Kearney also spoke with his brother shortly after his discharge.

Mrs Kearney was at all times motivated by her desire to ensure that the deceased received the medical treatment that she believed he needed at the material time.

Dr O'Sullivan did not become aware of the specific fact that Mrs Kearney was particularly concerned about the deceased because she had observed him demonstrating symptoms which were similar, but more severe than those he had exhibited at around the time he had made a previous suicide attempt, in 2000.

At the inquest, Dr O'Sullivan's evidence was to the effect that had she known this, she would have sat down with them both and explored this information. However, as to whether it would have changed the decision not to admit the

deceased, in Dr O'Sullivan's view this was a matter of speculation.[73]

Dr Brett's evidence was that ideally Mrs Kearney should have been involved in the discharge plan, because she had useful information and she was concerned about what had happened regarding the deceased's suicide attempt 10 years previously. However, in Dr Brett's experience, it would be very difficult to draw any correlations from 10 years ago. This is particularly as a person's risk of suicide is a dynamic thing that varies, even over short periods of time.[74]

Dr Brett proffered the view that a holistic mental health service would have helped Mrs Kearney understand the discharge plan and in that way, helped her as well. However, Dr Brett's opinion was that he would be surprised if that information would have changed the discharge plan, which he described as a safe and sensible plan.[75]

Dr Hussein's evidence was of a similar tenor.[76]

The need to communicate with carers of mental health patients is well known. Carers are in a position of being able to provide relevant and important information about a patient, they can make valuable contributions to the

[73] T 117
[74] T 98
[75] T 89 and T 95
[76] T 150

consideration of a discharge plan and they are impacted upon at the time of discharge.[77]

Senior counsel assisting submits to me that it is open for me to find that there was room for improvement in the way communication occurred as between SCGH and Mrs Kearney.

Communications, by their very nature, can often be improved upon. Where there is a disagreement regarding care of a patient there always exists scope for adding to explanations, seeking further conferral and for extending empathy and compassion. The degree of engagement becomes a matter for individual consideration.

In light of the desirability of taking into account the deceased's express wishes of wanting to give his wife a rest and his willingness to go home with his brother, the degree of engagement by the mental health team with Mrs Kearney became a finely balanced matter. Certainly it was important that all reasonable efforts be made to engage with her, and to continue to engage with her after it was known that she disagreed with the discharge plan.

On the evidence before me I am satisfied that there was a genuine desire on the part of the mental health team at SCGH to engage with Mrs Kearney and that this did need to

[77] This is addressed in the Stokes Report and 'Triage to Discharge' Framework

be balanced with taking account of the deceased's wish that she be given a rest.

In the circumstances, I make no criticism of the mental health team's efforts to engage with Mrs Kearney, taken as a whole. I also accept that it would be difficult, at the clinical level, to draw correlations from events that occurred 10 years previously, having regard to the variables involved.

Since April 2014, the mandatory State-wide Clinical Documentation suite provides a process for recording the identification of the primary carer and liaison details, information about family relationships and other supports, and support person signature to the Treatment Support and Discharge Plan.[78]

This more structured approach assists in bringing into sharper focus the importance of the role of carers and support persons.

THE DECEASED'S ASSESSMENT BY THE TRANSITIONS PROGRAM

Shortly after his discharge the deceased was assessed by a psychiatry registrar and a social worker at his brother's home, where he was staying.

[78] Consistent with recommendations 3.1 and 3.2 of the Stokes Report

Ms Sarah Lehman gave evidence at the inquest about this assessment. Ms Lehman is a social worker and in 2010 she was a member of the Transitions Program. One of its functions was to support people who were discharged from hospital, once they went home into the community. The team ran programs, tailored to the individual, around areas including stress management and relapse prevention.

In 2010 the Transitions Program would get referrals from the ward staff at SCGH, primarily those attached to the psychiatry team, identifying patients who they thought would be suitable for the program. The Transitions Program was a structured program offering both one on one and group support to clients.

Under usual circumstances, the team comprised a social worker, nursing staff, occupational therapists and occupational assistants working in the mental health area. However, in around March 2010, due to the flooding of the psychiatric ward at SCGH, and the consequential need to relocate patients, the Transitions Program had more access to staff, including access to a doctor.[79]

Ms Lehman had some independent recollection of the deceased. She recalled that Nurse Bright had indicated to her that that the deceased needed follow up to see how he

[79] T 62 - 65

was after discharge. She would have had access to the deceased's hospital file at the time of the referral.[80]

Ms Lehman met with the deceased during a home visit on the afternoon of 29 March 2010, after having spoken with him over the telephone earlier that day, when he was back at work. A psychiatry registrar that had been allocated to the Transitions Program attended with her as well that afternoon. They both interviewed the deceased.

Ms Lehman's notes on the Initial Assessment Form dated 29 March 2010[81] made after the home visit disclose that the deceased indicated that he had no planning or intent to self-harm. The notes reflect that she and the psychiatry registrar were aware of the nature of the deceased's suicide attempt 10 years previously. Ms Lehman made detailed notes in respect of the deceased's stressors, citing work related and other aspects, though noting the deceased considered his work situation was "sorted". The types of matters noted as relevant by Ms Lehman were similar in theme to those noted by Dr O'Sullivan during her psychiatric assessment of the deceased. The conclusion reached by the psychiatry registrar and Ms Lehman was that the deceased was at low risk of attempting suicide.[82]

[80] T 68
[81] Exhibit 1 Tab 21(J)
[82] T 70 and T 77

The management plan implemented by the Transition Program was based upon an awareness that the deceased had been prescribed an anti-depressant and medications to assist with his sleep, that the SCGH ED had referred him to Swan Adult Mental Health Centre, that he had a GP, and that he had access to counselling in various forms, including through his workplace. Ms Lehman made a note to the effect that the deceased's thoughts of suicide were fleeting ones.[83]

Ms Lehman and the psychiatry registrar discussed the management plan with the deceased during the home visit on 29 March 2010, and Ms Lehman recalled the deceased said that much of the stress that he had reported had resolved and that he would follow up with counselling through his workplace, independently. The deceased agreed to stay in touch with them so that they could confirm that he did link in with those services.[84]

Ms Lehman also made contemporaneous entries in the Integrated Progress Notes for the Transition Program.[85] They are consistent with her Initial Assessment notes, and in addition they also record events that took place after 29 March 2010. The Integrated Progress Notes also reflect that the deceased had been contacted by telephone the day before, by a Transition Program nursing staff member.

[83] Exhibit 1, Tab 21(J)
[84] T 71
[85] Exhibit 1, Tab 21(K)

After the home visit by Ms Lehman and the psychiatry registrar on 29 March 2010, Ms Lehman made two unsuccessful attempts to contact the deceased by telephone on 30 and 31 March 2010, noting she was unable to leave a message. On the latter date she also sent out a letter to the deceased and that is her usual practice if she has been unable to contact a client. Tragically, by this latter date, the deceased had died.

Ms Lehman did not contact Mrs Kearney during that period due to the deceased advising her that he was staying at his brother's house to give his wife a rest from the stress he believed she was experiencing as a result of his mental state.[86]

Independent expert Dr Brett reviewed the assessment of the deceased in the community after discharge, noting it was undertaken by a senior social worker and a psychiatry registrar who both felt the deceased was safe and manageable in the community. Dr Brett had no criticism of the Transition Program's interaction with the deceased and he referred to factors that supported their assessment of the deceased, as follows:

> "*….their role was to ensure that he transitioned safely from the emergency department to an ongoing plan, and their assessment was that his risk had reduced. He*

[86] T 72

made – he – he had made plans for the future, and he had made plans to see a psychologist through his work to address his issues related to stress with changing work."[87]

On his own review, Dr Hussein was unable to detect any lack of engagement with the Transitions Program on the part of the deceased as at the time of the home visit.[88]

I am satisfied that the deceased's assessment by the Transitions Program team, including the timing of that assessment, was reasonable in the circumstances.

THE RELEVANCE OF WHETHER A BED WAS AVAILABLE

Evidence was given at the inquest regarding the state-wide bed co-ordination system for mental health patients and whether it ought to have been engaged by the clinicians attending to the deceased.

Dr O'Sullivan explained that at the commencement of her shift she was informed that, due to the closure of the psychiatric ward at SCGH as a result of the flooding, there was stress placed upon the mental health system, and that included the availability of beds. Relevantly, she was also told and she understood, that there was no pressure to discharge any patients from SCGH ED and if necessary, patients could be kept in ED overnight, for further review the next morning when more beds may become available

[87] T 94
[88] T 151

(including through the efforts of the state-wide bed coordinator). Dr O'Sullivan was also informed that as a result of the ward closure, contingency plans had been put in place including the HITH/Transition Program.[89]

Dr Hussein confirmed that in his experience, if a patient wants to be admitted and they need a bed they may stay in ED up to a week or two pending the availability of a bed.[90] Dr Hussein's evidence was that in his experience, the bed availability is not a determinant factor and if the mental health team thought strongly that an admission was indicated for the deceased, they would not have let him leave the ED.[91]

Dr O'Sullivan recorded that the deceased understood that there were no beds available in the public or private system at that point, due to the closure of the psychiatric ward at SCGH. However, she also assured the deceased that the closure would not influence decision making if he needed admission and that they could keep him in the ED observation ward until a voluntary bed was available. By morning the deceased's status may have changed and the question of whether a voluntary bed was to be sourced for him would be dependent upon the deceased's risk assessment at that point. As a result of her assessment of the deceased, Dr O'Sullivan decided it was appropriate to

[89] T 111 – 112 and Exhibit 15
[90] T 146
[91] T 148 and T 155

admit him into the ED for observation overnight, pending further review the next morning.[92]

On all of the evidence given at the inquest, I am satisfied that the lack of available beds was not determinative of the decision to discharge the deceased. The discharge plan was reasonable and appropriate in the circumstances.

For that reason, I explored the manner of discussing the lack of bed availability with the deceased, given that he would not have been denied a bed if he was assessed as requiring one.

Nurse Raymond assessed the deceased following his triage on the evening of 26 March 2010. As part of his normal practice he would have discussed bed availability with the deceased. This was in the context of the deceased being a voluntary patient, whose GP recommended an admission and who was seeking a private bed. He also had an awareness of Mrs Kearney's strong wish to have the deceased admitted. At that stage, the deceased had not had his psychiatric assessment by the psychiatry registrar.[93]

Nurse Bright's assessment on the morning of 27 March 2010 occurred after the deceased's psychiatric assessment by the psychiatry registrar. Nurse Bright formed the view that the deceased did not especially wish to be admitted.

[92] T 122 – 123 and Exhibit 15
[93] T 61

His practice is to discuss bed availability with patients as part of the interview. In his experience, the lack of bed availability influences the amount of work that needs to be done at the level of risk assessment, community visits and outpatient follow-up.[94]

Dr Hussein explained that in the context of the deceased seeking a private admission and there being no private beds, it was appropriate to discuss the lack of bed availability in the public system, not on a clinical ground, but to in effect, explore alternatives.[95]

I am satisfied that Dr O'Sullivan was very clear in her assurances to the deceased that, in effect, the lack of bed availability would not affect his outcome. It was important that the deceased received that assurance. Otherwise it might run the risk of a patient in his position being inclined to demonstrate acquiesce to a discharge.

Dr Brett, who is a very experienced clinician, made comment at the inquest about the pressures on the availability of beds in Western Australia. The inquest did not explore the situation regarding bed availability in Western Australia, given that the evidence of the treating clinicians and the independent expert was to the effect that, in the particular circumstances of the deceased, his discharge from the ED of SCGH was appropriate.

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[94] T 132
[95] T 159

THE INTRODUCTION OF THE MENTAL HEALTH OBSERVATION AREA

There have been changes made to the manner in which mental health patients are assessed upon their presentation to the ED of SCGH since the time of the deceased's death.

The Mental Health Observation Area (MHOA) commenced clinical services at SCGH in early 2014. It is a six bed, two-chair area that accommodates mental health patients who present to the SCGH ED for assessment. The MHOA admits patients with psychiatric or psychological issues who are mildly agitated and at mild to moderate risk. The MHOA is in close proximity to the ED, but it provides a dedicated place for patients away from the busyness and noise of the ED. The assessments are generally performed by the psychiatry registrars and it operates with a maximum length stay of 48 hours. Staff from HITH attend to assess whether patients are suitable for admission into HITH.[96]

Dr Hussein has been actively involved in the development of the MHOA and explained that it is used in a manner similar to what was done for the deceased. Save that it is re designed into a less stimulating environment and more orientated towards a mental health environment. It allows for the patient to be kept for assessment and planning for

[96] Exhibit 9

up to two days, and together with changes in the staffing configuration, it permits a more thorough observation.

Dr Hussein described it as a very dignifying place for an overnight or longer stay.[97] This is as would be expected where a process of continual improvement is adopted.

EVENTS LEADING TO DEATH

When the deceased was discharged from the ED of SCGH into his brother's care on 27 March 2010, he went to stay at his brother's home.

On the morning of 29 March 2010 the deceased went into his usual daytime workplace and he also attended to his night shift work. His manager at the night shift work place ascertained that the deceased was not medically cleared to return to work and he rang the deceased's brother about that. The deceased's brother heard him come home after his shift work at about 10.30pm on 29 March 2010.[98]

In between those two events, on the afternoon of 29 March 2010 the deceased received a home visit by the Transitions Program staff, who interviewed him and assessed him to be at low risk of suicide.

[97] T 146 - 147
[98] Exhibit 1 Tab 7

At approximately 8.00am on the morning of 30 March 2010 the deceased's brother (having earlier left the house for work) spoke to him by telephone about the requirement to obtain a medical clearance to return to work and in the course of that conversation the deceased appeared to be fine. When the deceased's brother returned home from work, he found a note written by the deceased recording tasks that he needed to attend to.[99]

On the afternoon of 30 March 2010 Mrs Kearney returned to the matrimonial home after having collected her children from school. On getting out of her parked car she heard the sound of a car engine running in the car port behind the closed roller door. She ran to the carport and found the deceased, unresponsive, in his car. She saw fumes around and in his car and she called for an ambulance.[100] Ambulance paramedics arrived promptly, but the deceased showed no signs of life. One of the paramedics completed a Life Extinct Form at 4.15pm on 30 March 2010.[101]

[99] Exhibit 1 Tabs 7 and 8
[100] Exhibit 1 Tab 6
[101] Exhibit 1 Tab 2

CAUSE AND MANNER OF DEATH

On 1 April 2010 Chief Forensic Pathologist Dr C.T. Cooke and pathologist Dr M. Hardie made a post mortem examination of the deceased at the State Mortuary. The examination showed colouration of the skin, blood and body organs consistent with carbon monoxide effect. There was also congestion of the lungs, a non-specific change which may be seen with inhalation of toxic fumes. There was some evidence of left ventricular hypertrophy and coronary arteriosclerosis.

Further examinations were undertaken as part of the post mortem examination. The microscopic examination confirmed the above changes, showing no further significant abnormalities in the major body tissues. Toxicology analysis showed a very high level of carbon monoxide, well above the fatal level, together with some alcohol and prescription medications at non-toxic levels.

On 29 April 2010 the Chief Forensic Pathologist formed the opinion that the cause of death was carbon monoxide toxicity.

The St John Ambulance Patient Care Record and related material discloses that a hose was affixed from the exhaust pipe to the passenger cabin of the car where the deceased was found unresponsive, that the engine was still running

and that there was a strong smell of exhaust fumes. The same records disclose that the deceased had already died when he was found.[102] This is consistent with Mrs Kearney's observations when she arrived home that day.

I find that the deceased undertook the actions of affixing the hose from the exhaust pipe to the passenger cabin, turning on the engine and sitting in the car, that he did that with the intention of taking his life and that as a result, he died on 30 March 2010. The cause of death is carbon monoxide toxicity.

I find that the manner of death was suicide.

CONCLUSION

The deceased was a 49 year old man who was married with two teenaged children. He had a history of depression and anxiety which included a non-fatal attempt at suicide approximately 10 years prior to his death. His depression and anxiety were intermittent. He worked part time during the day and also worked a night shift.

Approximately four weeks prior to his death the deceased began to manifest signs of deterioration in his mental health. These signs emerged at the time that the deceased's

[102] Exhibit 1, Tabs 2 and 14

work situation was due to change, which created a level of anxiety in the deceased. His mental health was already fragile and there were other stressors.

The deceased's wife noticed these signs and she actively counselled and encouraged him to seek medical assistance. The deceased was initially reluctant to seek medical assistance, but his wife noted an escalation in his symptoms and she persisted with her counselling and encouragement.

Through his wife's intercession, on 26 March 2010 the deceased eventually told his GP that he was having suicidal thoughts and his GP referred him to the ED of SCGH. His wife took him there immediately.

Upon presentation to the ED in the late afternoon on 26 March 2010, the deceased was triaged by the general nurse and then by the psychiatric liaison nurse, the latter assessing him to be at medium risk of suicide.

Following that the deceased underwent a comprehensive psychiatric assessment by the psychiatry registrar, who decided to admit him overnight into the ED for observation, with the intention of having him re assessed the next morning, for consideration for discharge or a voluntary admission. The psychiatry registrar concluded the deceased had no formal thought disorder, no psychosis and that he

denied suicidal ideation. Rather, she concluded that the deceased had an acute stress reaction to work and she identified underlying contributing issues.

The next morning the psychiatry registrar on the overnight shift handed the care of the deceased over to the psychiatry registrar on the morning shift, conducting a comprehensive handover which also involved the clinical nurse specialist.

The deceased was reassessed, and in consultation with him a discharge plan was developed by the mental health clinicians. He was prescribed medications, provided with medical certificates and discharged by the psychiatry registrar who took handover of him, into the care of his brother on the morning of 27 March 2010. The deceased's wife had wanted him admitted and treated in hospital. The deceased was willing to go home with his brother and he wanted to give his wife a rest.

The deceased's mental health assessment, review and discharge were conducted within appropriate parameters and his discharge plan, including the follow up care, was safe and sensible.

The deceased's discharge plan included provision for interim and immediate follow up by the Transitions Program, provision for ongoing treatment by the Swan Adult Mental

Health Centre and follow up with psychological counselling through the deceased's work.

Two days later on 29 March 2010 the Transitions Program staff (one of whom was a psychiatry registrar) conducted a home visit and assessed the deceased as being at low risk of attempting suicide. The deceased was staying at his brother's home. He had been to work earlier that day.

On 30 March 2010 the deceased spoke with his brother over the telephone in the early morning and he later made a list of matters that he needed to attend to.

On the afternoon of 30 March 2010, the deceased's wife, upon returning to the family home tragically found the deceased, unresponsive, in the family car. The deceased had died from carbon monoxide toxicity.

In the period prior to his death, the deceased's wife had been tireless in her efforts to encourage the deceased to seek assistance and she also sought to arrange that assistance for him. At every stage she endeavoured to act in his interests.

After his discharge the deceased's mental state appeared to continue to improve and he appeared to be future oriented. Whilst the assessment of the risk of suicide is regularly undertaken by mental health clinicians, it is not possible to

predict suicide. Given what is known of the deceased's overt improvement and his future oriented behaviour, his suicide may have been an impulsive act rather than a premeditated one, but this would be speculation. The considerations giving rise to his final actions are complex. His death was unexpected and tragic.

R V C FOGLIANI
STATE CORONER

26 February 2015