Coroners Act 1996

[Section 26(1)]

Western  ***Australia***

RECORD OF INVESTIGATION OF DEATH

Ref No: 26/12

I, Barry Paul King, Coroner, having investigated the death of ***Robert Kenneth Scott*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***25 February 2014****, find that the identity of the deceased person was* ***Robert Kenneth Scott*** *and that death occurred on* ***22 May 2008*** *at* ***5A George Street, Midland,*** *from* ***ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Ms M. Smith assisting the Coroner
Mr N. Snare (Aboriginal Legal Service) appeared for the family of the deceased
MS C. Lakewood (State Solicitors Office) appeared for the North Metropolitan Area Health Service (NMAHS)
Mr E.A. Panetta (Panetta McGrath Lawyers) appeared for Dr A. Tavasoli.
Ms B. Burke (Australian Nursing Federation) appeared for Ms R. Stannard (nee Craig).

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INTRODUCTION

1. Robert Kenneth Scott (**the deceased**) died on 22 May 2008 after he had hanged himself after absconding from Graylands Hospital (**Graylands**).

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

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

4. An inquest to inquire into the death of the deceased was therefore mandatory.

5. Under s.25 (3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

6. The death of the deceased was investigated together with the deaths of nine other persons who had been persons held in care as involuntary patients at Graylands under the *Mental Health Act 1996* immediately before they died.

7. The joint inquest commenced before Coroner D.H. Mulligan in the Perth Coroner's Court on 27 August 2012. On 28 and 29 August 2012 evidence specific to the deceased was received. The inquest was then adjourned until it recommenced on 11 March 2013 when evidence relevant to the other deceased persons and general evidence about Graylands was provided to the Court. The hearings were completed on 22 April 2013.

8. Coroner Mulligan became unable to make findings under s.25 of the *Coroners Act 1996.* I have been directed by Acting State Coroner Evelyn Vicker to investigate the deaths.

9. To remove any doubt of my power to make findings under s.25, on 25 February 2014 I held another inquest into the death of the deceased and the other persons. The evidence adduced in that inquest was that which had been obtained by Coroner Mulligan, including exhibits, materials and transcripts of audio recordings of the inquests. Interested parties who were present at the inquests before Coroner Mulligan were invited to make fresh or further submissions. All of the parties indicated their agreement with the appropriateness of the procedure I had adopted.

10. I should note that there was a great deal of evidence adduced at the inquest that was related to general or systemic issues pertinent to Graylands. That evidence was adduced to investigate whether those issues had a bearing on any or some of the deaths and to allow the coroner to comment on the quality of supervision, treatment and care of the deceased patients. For example, evidence of the condition of the buildings at Graylands containing wards was provided in order to allow the Court to investigate whether the physical environment of the wards would have been more therapeutic had the buildings been refurbished.

11. That general evidence was useful in providing an overview of the context in which the deceased persons were treated for their mental illnesses; however, in my view many of the issues the subject of that evidence were not sufficiently connected with all the respective deaths for me to comment on those issues under s.25 (2) or (3) of the *Coroners Act 1996* generally as if they did.

12. I have therefore not addressed those general issues separately from a consideration of each death. Rather, where I have come to the view that the issues were connected with the death or were relevant to the quality of the supervision, treatment and care of the deceased, I have addressed them in the respective findings.

THE DECEASED'S MENTAL HEALTH

13. The deceased was born in Meekatharra on 6 April 1980.

14. As he grew up, the deceased was known as a quiet and obedient child. He attended school in Geraldton until year 11 but then left school to join a girlfriend.[1]

15. At some stage in their relationship the deceased's girlfriend left the deceased, causing him to become distressed enough that he threatened to kill himself. From about that time, he became withdrawn and began to use illicit drugs and to commit property crimes.[2]

16. In 1997 the deceased was on remand in Geraldton, having been charged with five counts of stealing and one count of aggravated burglary. He was reviewed by the Geraldton Mental Health Team who considered that he was suffering from cannabis-induced psychosis. He was transferred to the forensic unit at Graylands for his first admission there and was diagnosed with schizophreniform psychosis.[3]

17. Over the next two years or so, the deceased returned to Graylands six times as an involuntary patient. His psychiatric condition did not change until he was administered clozapine in 1999. In January 2000 during the last of those admissions, his sister committed suicide in Geraldton during a time when the deceased was absent without leave (AWOL) from an

[1] ts 25
[2] ts 25
[3] Exhibit 1 Volume 1 Tab 18 p.1

open ward. The deceased appeared to cope with the news of her death. He was discharged on a community treatment order and remained on clozapine.[4] His diagnosis at this time was schizophrenia (disorganised type).

18. The deceased was not admitted to Graylands again until March 2007 when he was referred from Geraldton Hospital following a relapse of schizophrenia because of his poor compliance with medications. He was again prescribed clozapine and placed in an open ward where he was treated until being discharged on a community treatment order into his brother's care.[5]

19. In January 2008 the deceased was referred to Graylands by the Community Emergency Response Team for assessment after acting aggressively toward his family. He was diagnosed with another relapse of schizophrenia and treated with depot risperidone consta. He improved gradually and on 13 February 2008 was discharged under a community treatment order to his mother's home.[6]

20. On 5 April 2008 the deceased was admitted to Graylands for the last time after again being referred from Geraldton Hospital. He had been responding to voices and was non-compliant with medication. He was made an involuntary patient on the basis of his schizophrenia, inappropriate behaviour and risk to himself and others when agitated. He denied suicidal or homicidal thoughts.[7]

21. The deceased's treating doctors and psychiatrists assessed his risk of self-harm to be low although he was considered to be at risk of non-compliance with his medication and at risk of aggression toward others. He was placed in a secure ward on 22 April 2008 and his

[4] Exhibit 1 Volume 1 Tab 18 p.3
[5] Exhibit 1 Volume 1 Tab 18 p.3
[6] Exhibit 1 Volume 1 Tab 18 p.3
[7] Exhibit 1 Volume 1 Tab 18 p.4

involuntary status was continued for a further three months.[8]

22. The deceased's condition began to improve after about three weeks on the secure ward. He went on an escorted hospital grounds access without any problems and became settled on the ward. He continued to deny any self-harm ideation. A plan was made to treat the deceased with clozapine again because of his successful treatment in the past.[9]

23. On 1 May 2008 the deceased was transferred to Hutchison Ward, an open ward where patients could come and go at will during open hours.[10] He was on 60 minute observations, meaning that staff were required to check for his presence every 60 minutes to guard against him absconding from the hospital.[11]

24. On 5 May 2008 the deceased was given depot risperidone consta while waiting for registration for clozapine. For unknown reasons, but possibly from alcohol or solvent use, or from overstimulation from being on the open ward, his behaviour changed and he became more paranoid.[12]

25. Because of the risk of the deceased setting back his treatment, he was transferred back to a secure ward.[13] The results of diagnostic tests and examinations of the deceased done as part of the preparation for the administration of clozapine were all in the normal range.[14]

26. Over the next few days the deceased's mental state deteriorated.[15] He was then recommenced on clozapine on 10 May 2008 and he began to settle. He was taken on escorted walks in the grounds without problems and

[8] Exhibit 1 Volume 1 Tab 18 p.4
[9] Exhibit 1 Volume 1 Tab 18 p.5
[10] ts 34
[11] Exhibit 1 Volume 1 Tab 18 p.5
[12] Exhibit 1 Volume 1 Tab 18 p.5
[13] Exhibit 1 Volume 1 Tab 18 p.6
[14] Exhibit 1 Volume 1 Tab 18 p.6
[15] ts 35

was initiating reasonable conversations. He was still considered to be at risk of aggression, substance abuse and absconding, but was not considered to be at risk of self-harm.

27. On 11 May 2008 the deceased was transferred to Ellis Ward, a locked mixed gender rehabilitation ward, where he continued to improve.[16]

28. By 15 May 2008 he was allowed unescorted ground access and was assessed as low self-harm risk.[17] He was then transferred back to Hutchison Ward on 30 minute monitoring for absconding.[18]

29. Over the next two days the deceased kept a low profile and was self-reporting every 30 minutes. He had no aggressive episodes in the open ward.

30. On 19 May 2008, the deceased asked his psychiatrist, Dr Robert Serich, when he was likely to be discharged. Dr Serich informed him that he would be discharged in one or two weeks depending on when the medical officer, Dr Fazli, could make arrangements.[19]

31. The deceased then informed Dr Fazli that he had his accommodation arranged and the he was keen to be discharged. He said that he had been on clozapine before and that he would be compliant and would have the blood tests. His family were happy to support him in any way that was necessary.

32. On 20 May 2008 the deceased again kept a low profile on the ward and was observed every 30 minutes for the morning, although that requirement was reduced to every 60 minutes. [20]

[16] ts 36
[17] ts 36
[18] ts 37
[19] ts 41
[20] ts 77 Exhibit 1 Volume 1 Tab 29

21 MAY 2008

33. During the day on 21 May 2008 the deceased wandered around the ward, keeping a low profile. He was monitored every 30 minutes without incident until 11.00am when the requirement was changed to 60 minute observations.[21] The observations continued to be done without incident up until 4.00pm when Registered Nurse Rhiannon Craig, the nurse responsible to conduct visual observations of patients, saw the deceased apparently asleep in his bed.[22]

34. At 5.00pm Nurse Craig could not sight the deceased, so she notified the ward co-ordinator, Registered Mental Health Nurse Ashley Skett.[23] Nurse Skett informed her that he had seen the deceased at about 4.30pm that day in the upstairs part of the ward.[24] She continued the 5.00pm observations of other patients without sighting the deceased and returned to Nurse Skett to tell him that she could not find the deceased.

35. Nurse Craig and Nurse Skett waited to see if the deceased attended dinner, which was usually served between 5.20pm and 5.25pm.[25] When he did not attend, together they searched all of Hutchison Ward including outside of the ward, and they also searched nearby Plaistowe Ward.[26]

36. They looked in the deceased's room and noticed that all his personal belongings were gone, but that did not concern Nurse Skett a great deal because it was not unusual for patients to take all their belongings with them when they left the ward even for a short time. Nonetheless, he contacted the nurse manager to seek clarification as to what steps he should take next. The

[21] ts 42 Exhibit 1 Volume 1 Tab 29
[22] Exhibit 1 Volume 1 Tab 16 p.1
[23] Exhibit 1 Volume 1 Tab 16 p.1
[24] ts 82
[25] ts 82
[26] Exhibit 1 Volume 1 Tab 16 p.1

nurse manager advised him to contact the duty medical officer, Dr Amir Tavasoli, so he did.[27]

37. Nurse Skett informed Dr Tavasoli of the risks recorded in the deceased's medical notes including absconding, aggression and substance abuse. He said that the deceased was not a high risk for self-harm.[28]

38. Dr Tavasoli told Nurse Skett that if the deceased did not return to the ward at 10.00pm when it was locked for the night, that he should declare the deceased to be AWOL. Nurse Skett considered that instruction to be reasonable given the deceased's risk profile.[29]

39. At about 6.30pm, security staff at Graylands conducted a search of the grounds but were unable to find the deceased.[30]

40. Nurse Skett attempted to contact the deceased's mother at about 7.00pm without success.[31]

41. When the deceased had not returned by 10.00pm, Nurse Skett declared the deceased AWOL and rang the nurse manager to notify him of this development. The nurse manager contacted the police at about 10.15pm to report the deceased as an absconded mental patient.

42. The response of the police was to put out a general broadcast across the police radio that the deceased had absconded and that officers should be on the lookout for him.[32]

43. According to police inquiries after the deceased's death, the deceased went directly from Graylands to the home of his uncle, Donald Scott (**Mr Scott**), in Midland where he stayed the night. He appeared to be in good spirits and gave Mr Scott no indication that he intended to

[27] ts 82; 83
[28] ts 83
[29] ts 83
[30] ts 83; 85
[31] ts 86
[32] ts 8

harm himself.[33] However, Mr Scott was aware that the deceased was an absconding patient from Graylands.

22 MAY 2008

44. At about 8.50am on 22 May 2008 Mr Scott called police to complain that the deceased was at his house causing problems.[34] He told police that he wanted the deceased removed.[35] It appears that he did so in order to have the deceased returned to Graylands where the deceased would be given his medication.

45. Some 25 minutes later, two police officers attended Mr Scott's home, but Mr Scott advised them that the deceased had already left with two other men, probably in the direction of the Midland train station.[36]

46. Mr Scott then left for work.

47. The officers searched around the house and then conducted a search of the general area without success. They then 'closed the job', presumably because the deceased was no longer at Mr Scott's home to cause problems.[37]

48. At about 3.15pm that afternoon, Mr Scott returned home to find the deceased hanging by his neck with a garden hose from a pergola at the back of the house.[38] Mr Scott attempted to resuscitate the deceased until police arrived and took over. Ambulance paramedics then arrived and continued CPR for approximately 40 minutes but to no avail.[39]

[33] Exhibit 1 Volume 1 Tab 5 p.9
[34] ts 13
[35] ts 12
[36] ts 13
[37] ts 14
[38] ts 14
[39] ts 15

49. Police examined the scene and determined that there was no sign of a struggle or any other evidence indicating the involvement of another person.

50. A post mortem examination was carried out by Chief Forensic Pathologist Dr C.T Cooke on 26 May 2008. Dr Cooke concluded that the cause of death was ligature compression of the neck (hanging).[40]

DELAY IN DECLARING THE DECEASED AWOL

51. The deceased was last seen at Graylands at 4.30pm and was not present at the 5.00pm check, at dinner or at any of the subsequent hourly checks. His clothing was gone from his bedroom, and he was considered a risk of absconding and of aggressive behaviour. Despite these circumstances, he was not declared AWOL and police were not notified until 10.00pm that he had absconded. Should he have been declared AWOL earlier?

52. Nurse Skett said that he was comfortable with Dr Tavasoli's instruction to wait until 10.00pm before declaring the deceased AWOL. He said that many patients go missing and generally come back at 10.00pm because they know that it is lockup time and that there will be consequences.[41] He said that the fact that the deceased's belongings were gone only indicated that the deceased had gone out, and that he had few belongings.

53. Nurse Skett said that, based on the deceased's risks and on the fact that other patients are given the opportunity to return by 10.00pm, it was reasonable to wait till then in relation to the deceased. However, when pressed, Nurse Skett agreed that if the deceased was at risk of absconding and he had absconded, then it was important to act promptly. [42]

[40] Exhibit 1 Volume 1 Tab 7 p.1, p. 5
[41] ts 91
[42] ts 94

54. After the deceased's death Dr Tavasoli was not approached to provide a statement. He remained unaware of the death for some time. Dr Tavasoli had no independent recollection of the events of the evening of 21 May 2008, so his evidence in relation to them was necessarily a description of what he considered he was likely to have done or have thought based on his usual practice. He accepted that the integrated progress notes for the deceased were accurate. He provided the following reasons for his decision not to have the deceased declared AWOL earlier:

a) he was quite familiar with the deceased because he had treated him at his previous admission;[43]

b) he would have obtained information about the deceased's risk from Nurse Skett;[44]

c) when a patient's risks are high, his practice was to document in the patient's notes that the patient be declared AWOL straightaway;[45]

d) the deceased's transfer to an open ward indicated that he had responded to medication;[46]

e) the deceased had responded to medication on his previous admission;[47]

f) where Dr Tavasoli's assessment of a patient was that he or she was at low risk of self harm, his practice was to place the patient on daily leave rather than reporting their absence to police.[48] If he considered the patient to be at moderate risk of harm to self and others, he would generally wait until 10.00pm before declaring the patient AWOL because patients often wandered off for several

[43] ts 108
[44] ts 108
[45] ts 108
[46] ts 110
[47] ts 110
[48] ts 112

reasons, including to drink alcohol or smoke cigarettes;[49]

g) most patients who wander off come back by the time the doors are locked;

h) he would have considered the deceased to be at low to moderate risk;[50]

i) an important thing about the risk of absconding was not just the risk of harm to self or others, but was the risk of the patient jeopardising his or her treatment;[51] and

j) he was unaware at the time of the contents of a hospital policy for absconding patients (in relation to documenting a risk assessment).[52]

55. Dr Tavasoli's evidence contained a number of other relevant points:

a) there was no way of containing patients on open wards who wanted to leave the grounds of the hospital;

b) there was no way of knowing which patients would return and which would not;

c) the process of declaring a patient AWOL was a time-consuming process which requires a person, usually a nurse, to spend a long time speaking to police by telephone;

d) police at that time did not actively search for an AWOL patient. Usually a patient was found when the hospital was informed by one of the patient's family or friends and the hospital then contacted the police who picked up the patient to bring him or

[49] ts 112
[50] ts 112
[51] ts 114
[52] ts 114

her back to the hospital. Therefore, there was not much benefit in calling the police unless the patient's whereabouts were known;

e) to the extent that the deceased had a high risk of aggression to others, there were two possible causes: a mental illness or a chronic risk based on his personality. The hospital could not change the second cause;

f) at the time the deceased absconded, he had a high chronic risk of violence to others but this was related to his personality and not something that could be changed with psychiatric interventions[53]; and

g) by the time of the deceased's absconding, Dr Tavasoli had sought police intervention for absconding patients at least 20 times.

56. In my view, Dr Tavasoli's decision to delay declaring the deceased to be AWOL was reasonable both having regard to what was known to him and from an objective perspective. In particular, the fact that notifying police of the deceased's absconding would not, at that time, have resulted in a police search for the deceased meant that there was little immediate benefit to be gained by declaring him AWOL.

57. It is also worth noting Dr Serich's evidence that the deceased had never talked of self-harm, that his only documented instance of attempted self-harm was when he was an adolescent following a breakup of a relationship, and that he was settled and looking forward to getting home within about two weeks.[54] There was no indication that the deceased was at a high risk of self-harm.

[53] ts121
[54] ts 43

GRAYLANDS POLICY FOR ABSCONDING PATIENTS

58. As indicated above, there was a policy in place at Graylands for absconding patients.[55] When a patient was noted to be missing, the Ward Coordinator/Clinical Nurse Supervisor was to be informed. The ward and environment was then to be searched by nursing staff and the Ward Coordinator was to notify security officers to search the campus and local areas.

59. If the patient could not be found, the Ward Coordinator was to notify the patient's doctor or the duty doctor who, in consultation with nursing staff was to undertake an immediate risk assessment and advise nursing staff how to proceed. The nursing staff was to document in the patient's integrated progress notes the time the patient was last seen, the decision by the doctor as to how to proceed and the time that occurred, the actions taken and the times they were taken, and the name of persons notified and when.

60. The policy required the doctor to document the risk assessment and management as soon as possible. If the doctor considered the patient to be at risk to himself or herself or others, security was to so be notified in order to undertake a full grid search of the hospital grounds and local surrounds. Ward staff were required to complete a clinical incident form.

61. For involuntary non-forensic patients, the policy required the nurse manager to inform the police and to contact the Mental Health Emergency Response Line. The Ward Coordinator was to inform the next of kin/meaningful person and write the details in the clinical record. The decision to place a patient to AWOL was to be determined by the Team/Duty Medical Officer after consultation with nursing staff. If the risk was significant, the Team/Duty Medical Officer was to alert the Team/Duty Consultant Psychiatrist.

[55] Exhibit 1 Volume 1 Tab 23 Att 3 p.1-5

62. There was no evidence to suggest that any part of the policy was unreasonable, and it does not appear to be so from a common sense perspective.

63. It is clear that Dr Tavasoli failed to comply with the requirement of recording his risk assessment but in my view that failure was more a failure of his training than a failure by him. He said in evidence that he had received no training. In any event, any such failure was of no consequence to the deceased's absconding or to his death and it did not subvert the application of the policy on the night the deceased absconded.

64. Nevertheless, after the death of the deceased, the policy with respect to absconding patients was changed to require involuntary patients who were considered to be at risk of harm to themselves or others to be declared AWOL if a search of the grounds and local surrounds does not locate them quickly.[56] More recently, a procedure has apparently been adopted whereby absconding patients are declared AWOL immediately unless it is documented in their management plan that there is reason to delay the AWOL process.[57]

65. Nurse Skett said that there was a new process of disseminating changes to policies by placing them in a '14 day file' on each ward. Staff are required to read the updated policies and sign a sheet to show that they have done so.[58] It therefore seems that steps have been taken at Graylands to rectify any shortcoming in the training of staff with regards to new policies.

66. In addition, on-going training has been introduced at Graylands to target high-priority areas, which include the management of absconding patients.[59]

[56] Ex 1, Vol 1, Tab 6, Attachment 5
[57] ts 31 on 24/5/13
[58] ts 90
[59] General Evidence Ex 1, Vol 7, Tab 7, p 9

POLICE ROLE IN SEARCH

67. As mentioned, a significant consideration is that Graylands staff declaring the deceased to be AWOL and so notifying the police would not have led to an active search by the police if the deceased's whereabouts were not already known. Apart from giving the process of having police pick up absconding patients some formality, it is difficult to see a tangible benefit from such a declaration at the time.

68. Senior Constable Stephen Morgan, who was involved in the investigation of the death of the deceased, gave evidence at the inquest before Coroner Mulligan.[60] He confirmed Dr Tavasoli's evidence that police would keep a lookout for absconding patients and not actively search for them, but he said that about three months before he gave evidence, a different process was put in place.

69. By way of a fundamental change to policy procedures, a greater priority was then given to absconding patients by police. Instead of merely keeping a lookout for an absconded mental patient, police would allocate the matter to a general duties unit in the relevant district who would search for the person and, if initially unsuccessful, will handover the responsibility to find the person to officers in the next shift. The search would continue until the patient is found.

70. However, as I understand the evidence of police policies provided later, absconding patients are deemed to be 'Persons At Risk' and are automatically assessed as high risk. However, unless Graylands provides an address at which the patient is believed to be, police officers would be directed only to keep a look out for the patient.[61] The new policy has apparently been rescinded.

[60] ts 9-10
[61] General Evidence Ex 1, Vol 6, Tab 3.2

NO-SMOKING POLICY

71. The evidence at this inquest indicated that on 1 January 2008 a policy under which the smoking of cigarettes was not allowed was implemented at Graylands.[62]

72. Counsel for the deceased's family, Mr Snare, stated that the deceased's mother had said to him that one of the biggest issues the deceased had while at Graylands was that he could not smoke while he was there.[63] Dr Serich provided oral evidence about the policy in answers to Mr Snare's questions.

73. Dr Serich agreed that the policy is one reason why patients have been known to abscond, but he noted that most people who are on an open ward can smoke outside the ward. Dr Serich noted that, prior to the policy commencing, getting a history out of patients was easier because patients would tend to be more relaxed and cooperative while they were smoking.[64]

74. Dr Serich said that the hospital provides nicotine replacement, but he thought that it was probably not the same for patients as smoking cigarettes. He noted that smoking may be something that patients do to give them pleasure in a context where the physical environment has deteriorated over the years.[65]

75. The Council of Official Visitors provided submissions together with a copy of the Council's Annual report for 2011-2012.[66] The Council submitted that there is little doubt that the no smoking policy has contributed to the despair felt by some of the patients locked up in hospital. The introduction of partial exemptions to the ban on smoking had been announced but not implemented by December 2012.

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[62] ts 52
[63] ts 52
[64] ts 52
[65] ts 52-53
[66] General Evidence Ex 1, Vol 1, Tab 5

76. The Director General of the Department of Health issued an operational directive dated 18 January 2013 entitled Smoke Free WA Health System Policy.[67] That directive continues the previous policy proscribing smoking on all departmental premises, but it allows adult involuntary mental health patients an exemption from the proscription in circumstances detailed in a list of guidelines. The guidelines allow for smoking by nicotine-dependent patients outdoors in designated areas provided that alternatives to smoking are provided and considered.

77. The negative psychological effect of the no-smoking policy has therefore been addressed in a way calculated to reduce the many physical health hazards associated with smoking.

QUALITY OF SUPERVISION TREATMENT AND CARE

78. The evidence establishes that the deceased received a significant amount of treatment and care at Graylands over several years. He was, no doubt, a difficult patient due to his propensity to become aggressive and to behave inappropriately to female staff as a result of his chronic schizophrenia.

79. Each admission to Graylands bar the last one resulted in the deceased being discharged following successful treatment.

80. He was to be discharged within a short time from his last admission pending arrangements being made for his accommodation in the community when he absconded. Again his treatment appears to have been appropriate.

81. As to supervision, the question arises as to whether giving the deceased's unescorted ground access was appropriate. Common sense suggests that involuntary

[67] General Evidence Ex 1, Vol 7, Tab 1

patients who are close to the point of being discharged to the community would be encouraged to regain responsibility for themselves by being allowed some freedom of movement. Dr Nathan Gibson, Chief Psychiatrist of Western Australia, provided a report in which he addressed the issue this way:

> A common risk factor for completed suicide is a sense of hopelessness and loss of control over important aspects of one's life. Autonomy is temporarily lost to a significant degree during involuntary care. In the context of mental illness, the challenge is to provide a safe environment but facilitate a sense of hope and self-agency. How this is achieved is different for each individual, but the open wards must represent an environment that facilitates transition back to the community and in most cases regaining of personal autonomy.
>
> The process for moving from a secure ward often involves transition through Escorted Ground Access first, then Unescorted Ground Access before transition to open ward care. These steps are not formally required in every situation and depend upon the mental state progress, needs and risk management for each individual patient.[68]

82. The evidence shows that the deceased was progressing through that process as he neared being discharged. He was on an open ward when he absconded.

83. While it is tempting to conclude that the fact of deceased's absconding showed that the process was flawed in his case, it is clear to me that decisions relating to supervision made at the various stages of a mental patient's treatment must involve a considerable amount of professional judgement based on the

[68] General Evidence, Ex 1, Vol 1, Tab 6, p5

decision-maker's experience and expertise having regard to the patient's history and presentation. In such circumstances, it is not possible to assess the appropriateness of an otherwise apparently reasonable level of supervision by reference to the fact that the patient absconded. In particular, it is not possible for me to criticise the decision to place the deceased in an open ward. The evidence of the deceased's mental state progress, his needs and his risk management suggest to me that the decision was reasonable.

84. Finally, there was no evidence to suggest that any act or omission of a staff member in any way contributed to the death of the deceased.

85. In these circumstances, I am satisfied that the quality of the supervision, treatment and care of the deceased was appropriate.

CAUSE AND MANNER OF DEATH

86. Dr Cooke's post mortem report makes clear, and I find, that the cause of the death was ligature compression of the neck.

87. It is likewise clear that the deceased hanged himself with a garden hose with the intention of taking his life.

88. Consequently, I find that the manner of death was suicide.

B P King
Coroner
11 April 2014