Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: 43/19

I, Michael Andrew Gliddon Jenkin, Coroner, having investigated the death of ***Paul STRANGE*** *with an inquest held at the* ***Perth Coroner's Court, Court 85, CLC Building, 501 Hay Street, Perth*** *from* ***4 – 6 September 2019*** *find that the identity of the deceased person was* ***Paul STRANGE*** *and that death occurred on* ***9 December 2016*** *at* ***Joondalup Health Campus*** *as a result of* ***ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Ms A Barter assisted the Coroner.

Ms R Paljetak (State Solicitor's Office) appeared on behalf of East Metropolitan Health Service (EMHS) and North Metropolitan Health Service.

Mr S Denman (Denman Legal) appeared for Dr R Afroz.

Mr D Langman (Minter Ellison) appeared for Joondalup Hospital Pty Ltd.

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INTRODUCTION

1. Paul Strange (the deceased) died on 9 December 2016 at Joondalup Heath Campus (JHC), as a result of ligature compression of the neck (hanging). He was 30 years of age.

2. I held an inquest into the deceased's death on 4 – 6 September 2019. Members of the deceased's family and some of his friends attended the inquest. I was greatly assisted by a statement made to me by the deceased's mother, Mrs Irene Strange.

3. The following witnesses gave oral evidence at the inquest:

i. Senior Constable F Milham (investigating officer);
ii. Mr L Voight (mental health nurse);
iii. Dr A Tabasum, (resident medical officer);
iv. Dr S Febbo (consultant psychiatrist);
v. Dr G Smith (Office of Chief Psychiatrist);
vi. Dr A Brett (independent consultant psychiatrist);
vii. Dr A Torshizi (consultant psychiatrist);
viii. Dr R Afroz, (registrar);
ix. Mrs I Strange (the deceased's mother); and
x. Mr A Shah (a friend of the deceased).

4. The documentary evidence at the inquest included a report into the deceased's death prepared by Western Australia Police,[1] expert reports, the deceased's medical notes and a letter from the deceased's mother. Together, the Brief comprised three volumes.

5. The inquest focused on the deceased's treatment and care while he was an inpatient, his discharge arrangements and the circumstances of his death.

[1] Exhibit 1, Vol. 1, Tab 2, Report - First Class Constable S Follows

THE DECEASED

Background

6. The deceased was born in London on 8 February 1986 and was 30 years of age when he died on 9 December 2016. He had a twin brother and an older sister and his family came to Western Australia when he was about 4 years of age.[2,3]

7. The deceased left high school after completing year 11 and later went to college to qualify for entry to university to undertake a Bachelor of Sports Science at Edith Cowan University (ECU). He subsequently completed the degree and achieved distinctions and high distinctions in the units he studied.[4,5]

8. At the time of his death the deceased had been in a relationship for about three months, but had reportedly been upset by his partner's infidelity and the relationship was referred to by one of his friends as "*on again, off again*".[6,7]

9. The deceased enjoyed going to the gym as well as soccer and kick-boxing.[8] He was described by one of his friends as the most caring person she had ever known.[9,10]

10. The deceased had a very close relationship with his family and in a moving tribute, his mother described him in the following way:

> Paul was kind, caring and selfless. Always there for you when you needed him. He always had a smile on his face and stood up for the right thing. He made us want to do better and be better. He still has that effect on everyone. Paul was one of a kind, a true friend and no one will ever replace him.[11]

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[2] Exhibit 1, Vol. 1, Tab 1, P100
[3] Exhibit 1, Vol. 1, Tab 10, File note - Conversation with Mrs Strange (03.04.17)
[4] Exhibit 1, Vol. 1, Tab 10, File note - Conversation with Mrs Strange (03.04.17)
[5] ts 04.09.19 (Milham), p6
[6] Exhibit 1, Vol. 1, Tab 10, File note - Conversation with Mrs Strange (03.04.17)
[7] Exhibit 1, Vol. 1, Tab 12, File Note - Discussion with Ms K Wyse (18.07.17), p1
[8] Exhibit 1, Vol. 1, Tab 10, File note - Conversation with Mrs Strange (03.04.17)
[9] Exhibit 1, Vol. 1, Tab 11, File note - Conversation with Ms C Wyse (10.07.17)
[10] Exhibit 1, Vol. 1, Tab 12, File Note - Discussion with Ms K Wyse (18.07.17), p1
[11] Statement - Mrs Strange and see also ts 06.09.19 (Strange), p248

FEATURES OF THE DECEASED'S MENTAL ILLNESS

Diagnosis

11. The deceased's mental health condition was formulated in a number of ways by different clinicians but was primarily described in terms of chronic major depression with anxiety and personality vulnerabilities. Some of the formulations include:

> Mr Strange had a history consistent with major depression and anxiety. He was vulnerable to stress and at these times had suicidal ideation. He had a history of acting in a dangerous manner towards himself, specifically attempts to hang himself;[12]
>
> Paul was suffering from a chronic major depressive disorder complicated by severe anxiety and recurring suicidality over the years…Paul had a vulnerable personality structure with likely Cluster B and/or Cluster C traits which made him even more vulnerable at life cross roads or unfortunate experiences involving interpersonal relationships;[13] and
>
> Adjustment disorder with depressed mood and suicidal ideation, anxiety and Cluster B personality.[14]

Repeated suicide attempts

12. The deceased's clinical notes document repeated self-harm, usually involving the deceased placing ligatures over his neck and/or stabbing himself in the hand with plastic cutlery.[15] There was evidence of the deceased applying ligatures around his neck for progressively longer periods causing light-headedness.[16] For obvious reasons, several clinicians attempted to dissuade the deceased from using ligatures to self-harm.[17]

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[12] Exhibit 1, Vol. 1, Tab 22 Report - Dr Brett, p7
[13] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, paras 77-78
[14] Exhibit 1, Vol. 2, Tab 2, JHC ED notes (10.11.16: 11.30 am), p2
[15] For example, see: Exhibit 1, Vol. 1, Tab 20, Report - Dr Chester, p2
[16] For example, see: Exhibit 1, Vol. 1, Tab 21, Report - ECU Student Counselling Service, p2
[17] For example, see: Exhibit 1, Vol. 1, Tab 20, Report - Dr Chester, p2

13. One of the features of the deceased's interactions with mental health services was that the involvement tended to be episodic. That is, when there was a crisis of some kind he would see a mental health professional, but when the crisis had subsided, contact would conclude.[18]

The deceased's risk profile

14. According to Dr Torshizi, who reviewed the deceased's case: "*elements of ambivalence, impulsivity*" which were noted by a number of clinicians, were very likely to have led to significant fluctuations in the deceased's mental state and risk whilst he was in hospital and after his discharge.[19]

15. The deceased's fluctuating suicidality is charted in his Royal Perth Hospital (RPH) inpatient notes and was in evidence on 15 November 2016, when he attempted strangulation using a sheet or blanket.[20] When the deceased was first admitted to RPH, his nursing observations were completed every 15 minutes. As his mood improved, this interval was lengthened but at times, 15-minute observations were reinstated.[21]

16. A number of clinicians noted that because of his maladaptive coping strategies, the deceased was particularly vulnerable to external factors causing distress.[22]

17. The deceased's risk was particularly high at around the time of his presentation to JHC on 9 November 2016. At that time, it was noted that his mother and brother had been closely supervising him for several days, because of numerous incidents of self-harm.[23]

18. In terms of fluctuations in a patient's risk profile, Dr Torshizi noted that "*risk is fluid and can change over very short timeframes*". He also pointed out that some risk factors were long-term whereas others were more dynamic.[24]

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[18] ts 05.09.19, (Smith), p136
[19] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 81
[20] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (15.11.16)
[21] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, paras 82 and 86
[22] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 84 and ts 05.09.19, (Smith), p136
[23] Exhibit 1, Vol. 2, Tab 2, JHC Mental health assessment (9.11.16: 8.00 pm), p1
[24] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 112 and see also : ts 04.09.19, (Brett), p158

19. In cases such as the deceased's, Dr Torshizi said short-term factors were critical when:

> Considering the particular conditions and circumstances that place the individual at special risk and need to be given particular consideration in informing decisions about safety and care.[25]

20. Dr Smith referred to the deceased's increased long-term risk of suicide and observed:

> Patients like Mr Strange, who engage in repeated self-harm, have an underlying heightened baseline risk of suicide, which fluctuates in duration and intensity, and…can rapidly tip over into an episode of suicidal or self-harming behaviour when faced with stressful life events.[26]

21. As for the deceased's apparently calm presentation in the hours immediately prior to his death, Dr Torshizi noted:

> This is unfortunately a very common scenario when patients who present as stable one day/hour will be extremely suicidal the next when there is an underlying impulsivity, a documented fluctuation in mental state and underlying personality vulnerability.[27]

The "predictability" of suicide

22. As Dr Brett pointed out, suicide is extremely unpredictable. It is a rare event and it is impossible to predict rare events with any certainty. Instead, clinicians conduct risk assessments where they consider historical and dynamic risk factors. As noted, a person's suicidality can fluctuate, sometimes on relatively small time frames.[28,29]

23. In their respective reports, Dr Smith[30] and Dr Torshizi[31] referred to a 2017 Department of Health document titled: *Principles and Best Practice for the Care of People Who May Be Suicidal* (the Document).

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[25] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 112 and see also : ts 04.09.19, (Brett), p158
[26] Exhibit 1, Vol. 1, Tab 24, Report - Dr G Smith, pp3-4
[27] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 87
[28] ts 04.09.19, (Febbo), p118
[29] ts 04.09.19, (Brett), p158
[30] Exhibit 1, Vol. 1, Tab 24, Report - Dr G Smith, p2
[31] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 108

24. The Document contains useful observations and guidance for the care of suicidal patients, and I commend its contents to clinicians.

25. The Document points out that clinicians faced with the onerous task of assessing a person who is suicidal confront two issues. First, suicide is a rare event and second, there is no set of risk factors that can predict suicide accurately in an individual patient.[32]

26. Further, the Document points out that the use of risk assessment tools containing checklists of characteristics has been found to be ineffective.[33]

27. The deceased's RPH inpatient notes contain several examples of a risk assessment tool known as a K-10 (*HONOS Health of the Nation Outcome Scale*). Although the wording on the K-10 form suggests that it is the patient who completes it, in the deceased's case, the forms were completed by nursing staff on his admission to RPH and on the day of his discharge.[34]

28. The K-10 form requires the patient to indicate how often, in the previous three days, they have felt tired, nervous, restless, depressed and so on and to indicate how much of a problem, issues such as self-harm and depression have been. The K-10 form notes that ratings at the time of admission can only be made after comprehensive clinical assessment.[35,36] The ratings on the K-10 forms completed on the deceased's admission and discharge were essentially the same.[37]

29. Consistent with the views expressed in the Document as to the usefulness of checklist type assessment tools, Dr Febbo said he did not use the K-10 form because he had been trained to take a full history and conduct a mental state examination. He said he might read the K-10 form if he saw it on the patient's file, but that he would always conduct a full mental state examination.[38]

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[32] Exhibit 1, Vol. 1, Tab 25, Principles and Best Practice for the Care of People Who May Be Suicidal, pp2-3
[33] Exhibit 1, Vol. 1, Tab 25, Principles and Best Practice for the Care of People Who May Be Suicidal, pp2-3
[34] ts 06.09.19, (Torshizi) p185
[35] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes, K-10 forms (11.11.16) & (28.11.16)
[36] ts 04.09.19, (Voight) pp18-19
[37] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes, K-10 forms (11.11.16) & (28.11.16)
[38] ts 04.09.19, (Febbo) p92

30. According to guidelines published by the Royal Australian and New Zealand College of Psychiatrists:

> There are no widely accepted tools for clinically assessing a patient's risk of subsequent DSH (deliberate self-harm) or suicide. No empirical studies have demonstrated that categorising patients to be at low risk or high risk of future fatal or non-fatal self-harm can contribute to a reduction in overall rates of these adverse events…Despite this, many health service jurisdictions mandate regular risk categorisation of mental health clients in order to determine follow-up care.[39]

31. Given that there has been a move away from using checklist type tools to assess risk, and the fact that clinicians seem to have little regard to these tools, one has to ask why the K-10 form continues to be used.[40]

32. Indeed, it may be preferable for clinical staff to spend their time interacting with the patients in their care and recording their observations from those interactions in the patient's notes.

33. A related issue the Document deals with is the widespread community belief that suicide can be accurately predicted. The Document states that this belief:

> [H]as led to the assumption that suicide represents a failure of clinical care and that every death is potentially preventable if risk assessment and risk management were more rigorously applied. However the evidence is clear that, even with the best risk-assessment practices and care, it is not possible to foresee and prevent all deaths by suicide.[41]

[39] Exhibit 1, Vol. 2, Tab 27, RANZCP Clinical practice guidelines for the management of deliberate self-harm, p37
[40] Exhibit 1, Vol. 1, Tab 25, Principles and Best Practice for the Care of People Who May Be Suicidal, pp2-3
[41] Exhibit 1, Vol. 1, Tab 25, Principles and Best Practice for the Care of People Who May Be Suicidal, pp2-3

34. Two priorities for the care of people who may be suicidal are the promotion of recovery through enhancing individual autonomy and control and the minimisation of risk. Dr Torshizi said a recovery-based model necessitates a shift in the current approach where clinicians manage risk to an approach that promotes safety and recovery. As Dr Torshizi noted, this requires meaningful collaboration with the patient and their family and support persons.[42]

35. Dr Smith also emphasised the importance of involving the family of a person grappling with mental health issues. As he said:

> They [the family] know a lot more than we do…they're with the person day-to-day. They see their reactions to things…So families and carers…are a really important part of the assessment process.[43]

36. Mrs Strange eloquently put the perspective of family involvement in the following terms:

> Mental health professionals should listen and include family members in their mentally ill relative's treatment and care plan. A major strength is their intimate knowledge of the patient and what they have learned through the process of trial and error. The professionals have known the patient for maybe three weeks at the most. The family has known them all their life. The information given to a nurse, psychologist or psychiatrist should be treated as gold information. Listen to families and treat them as equal partners.[44]

Vulnerability after discharge

37. As Dr Brett pointed out, the period immediately following discharge is a high-risk period, which is presumably one of the reasons why the seven-day follow-up phone call after discharge was implemented.[45,46]

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[42] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, paras 109-111
[43] ts 05.09.19, (Smith), p137
[44] ts 06.09.19, (Strange), p250
[45] Exhibit 1, Vol. 1, Tab 22, Report - Dr A Brett, p7
[46] See also: Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 120

38. Dr Smith referred to a study which found that 17% of patient suicides occurred within 3 months of discharge, with the highest prevalence occurring in the first week. Dr Smith also noted that suicide had been found to be more prevalent where, as in the deceased's case, the patient was discharged from a non-local inpatient unit. In that context, the post-discharge period is a critical time and Dr Smith said that this was a matter which could be discussed with the deceased and his family, in a room together at the same time.[47,48]

39. Dr Brett agreed that even where a patient did not want their family involved in their care, at the time of discharge, the family should be told:

> [H]ere are the emergency numbers. Discharge is a vulnerable time. Be vigilant. These are the things to look out for.[49]

40. In terms of patient safety on discharge, the Document states:

> Safety following discharge from psychiatric inpatient units requires assertive and coordinated follow-up...Transfer of care information between service providers should take place before discharge and a clear understanding of the responsibilities of clinicians for follow-up should be documented in the Safety Plan. Follow-up should, where feasible, include discussion with the person's support person.[50]

41. As I will explain, none of this occurred in the deceased's case.

[47] Exhibit 1, Vol. 1, Tab 24, Report - Dr G Smith, p2
[48] ts 05.09.19, (Smith), p144
[49] ts 05.09.19, (Brett), p163
[50] Exhibit 1, Vol. 1, Tab 25, Principles and Best Practice for the Care of People Who May Be Suicidal, pp2-3

CONTACT WITH MENTAL HEALTH SERVICES

Contact as a child

42. In August 1995, when the deceased was 9 years of age, he was referred to what was then the Community Child and Adolescent Health Service (CCAHS), after his teacher had expressed concern about the deceased's response to verbal instructions. Despite the referral, Mrs Strange observed that the deceased's academic progress for 1995 had been satisfactory. The CCAHS assessment found the deceased had some issues with visual motor integration and auditory and visual sequencing and he was referred to various specialists.[51]

43. Although the deceased's clinical records contain several references to him reporting being bullied at school, this issue is not referred to in the CCAHS assessment report. Mrs Strange is recorded as saying that the bullying of the deceased was "*quite bad*" although this was not disclosed to her or her husband at the time.[52]

Contact in 2011-2012

44. The deceased was seen at the ECU Student Counselling Service (the ECU Service) on 8 April 2011. He said he was not managing stress well and was having trouble eating and sleeping. He discussed past suicidal ideation relating to the breakdown of a three year relationship and his discharge from the Australian Army. He denied any current suicidal ideation and cancelled a follow-up appointment on 29 April 2011.[53]

45. On 15 August 2011, the deceased's GP prepared a mental health care plan and referred him to the Joondalup Psychology Centre. The presenting problem was said to be "*depression and low mood with suicidal thoughts*". The plan noted that the deceased had a supportive family but had difficulty discussing his moods. It is not clear whether the deceased received psychological support under the plan.[54]

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[51] Exhibit 1, Vol. 3, Tab 2, GP notes: CCAHS assessment report (08.08.95), pp2-3
[52] Exhibit 1, Vol. 2, Tab 2, JHC Inpatient notes (01.09.14)
[53] Exhibit 1, Vol. 1, Tab 21, Report - Edith Cowan University Student Counselling Service, p1
[54] Exhibit 1, Vol. 3, Tab 2, GP notes: Mental health care plan (15.08.11)

46. The deceased was seen by the ECU Service on 9 November 2012. He disclosed a family history of suicide and said he was having difficulty with sleeping, eating and physical activity. He disclosed some suicidal ideation but denied intent, saying he would not be able to put his family through the distress that other suicides in his family had caused. He did not attend a follow-up appointment on 23 November 2011.[55]

Contact in 2014

47. The deceased was seen in the emergency department at JHC on 8 August 2014. He was referred there by his GP following a suicide attempt that day involving a rope. He was reviewed in the presence of Mrs Strange and reported weight loss, poor sleep and poor concentration. He declined an offer of voluntary admission and was referred back to his GP with a recommendation that he be referred to the '*Joondalup Mental Health Clinic*'.[56]

48. The deceased attended the ECU Service with Mrs Strange on 18 August 2014 and she expressed concern about the deceased's recent suicide attempt. The deceased disclosed being bullied at school and said that this had led to anxiety and feelings of low self-worth. The deceased expressed a close relationship with his mother and said that failing a unit in his university course had reinforced his sense of worthlessness and had led to his suicide attempt. The deceased was assessed as high-risk and was offered an appointment the following day. When the deceased didn't attend the appointment, the ECU Service contacted the deceased and later Mrs Strange, and a further appointment was booked.[57]

49. When seen by the ECU Service on 27 August 2014, the deceased disclosed daily suicide attempts by strangulation since his last appointment. He agreed to be referred to hospital for psychiatric evaluation and subsequently withdrew from the only unit he was scheduled to study in 2015. He was not seen again by the ECU Service until August 2016.[58]

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[55] Exhibit 1, Vol. 1, Tab 21, Report - Edith Cowan University Student Counselling Service, p1
[56] Exhibit 1, Vol. 2, Tab 2, JHC ED discharge summary (08.08.14)
[57] Exhibit 1, Vol. 1, Tab 21, Report - ECU Student Counselling Service, p1
[58] Exhibit 1, Vol. 1, Tab 21, Report - ECU Student Counselling Service, p1

Admission to JHC - 27 August 2014

50. The deceased was admitted to JHC on 27 August 2014 after disclosing suicide attempts with an electrical cord and a belt. On admission, he said he had been feeling depressed for months with worsening suicidal ideation over the previous 11 weeks.[59] His diagnosis was major depressive disorder with anxiety.[60]

51. It was thought that the deceased's presentation may have been related to difficulties he was having with his university studies. In addition, the breakdown of the deceased's relationship several years previously, seemed to be a major source of his depression.[61]

52. The deceased underwent a head CT scan and an MRI of his brain. These tests found cortical and subcortical gliosis (non-specific reactive change in the glial cells in response to damage to the central nervous system) that was thought likely to be due to a previous ischaemic injury (relating to restriction of blood supply).[62] The deceased's mood and behaviour were said to have improved during his admission "*utilising a combination of therapies*". He was seen by a hospital psychologist and he attended group therapy sessions.[63] During the deceased's admission, two family meetings were held with the deceased, Mrs Strange and members of the treating team.[64]

53. The deceased was discharged on 15 September 2014 to be followed up by his GP, a community psychologist and the ECU Service. His diagnosis was major depressive disorder with anxiety.[65]

54. In a letter dated 16 September 2014, the deceased's GP referred him to a psychologist for further management. The letter noted that the deceased had a supportive family and that despite high achievements in his university exams, the deceased had very negative self-thoughts.[66]

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[59] Exhibit 1, Vol. 2, Tab 2, JHC Nursing discharge summary (15.09.14)
[60] Exhibit 1, Vol. 2, Tab 2, JHC Discharge summary (15.09.14)
[61] Exhibit 1, Vol. 2, Tab 2, JHC Inpatient notes (28.08.14)
[62] Exhibit 1, Vol. 2, Tab 2, JHC Discharge summary (15.09.14), pp1-2
[63] Exhibit 1, Vol. 2, Tab 2, JHC Nursing discharge summary (15.09.14)
[64] Exhibit 1, Vol. 2, Tab 2, JHC Inpatient notes (01.09.14) & (09.09.14)
[65] Exhibit 1, Vol. 2, Tab 2, JHC Discharge summary (15.09.14)
[66] Exhibit 1, Vol. 3, Tab 2, GP notes, Letter (16.09.14)

Admission to JHC - 22 September 2014

55. The deceased was admitted to JHC on 22 September 2014 after presenting to the emergency department with Mrs Strange. He said he had wrapped a computer cord around his neck and had contemplated using a rope to hang himself from a pergola at the family home.[67]

56. On admission, he was found to be agitated, evasive and anxious. The deceased was also preoccupied with feelings of worthlessness which had resurfaced, along with suicidal ideation, the day after his previous discharge. The deceased's mental state gradually improved during his admission and he received psychoeducation, and input from a psychologist and a social worker.[68]

57. A family meeting attended by the deceased, his parents and members of his treating team was held on 7 October 2014. The purpose of the meeting was to discuss the deceased's discharge plan and to: "*decrease family anxiety*".[69]

58. The deceased's diagnosis was major depression with cluster C personality traits. He was discharged into the care of his parents on 9 October 2014 with a plan for follow-up by his GP, the Wellbeing Centre and the 'Joondalup community clinic'.[70]

59. In a letter dated 27 October 2014, the deceased's GP referred him to a psychologist for further management. The mental health care plan that accompanied that letter noted the presenting issue was depression and stated that the deceased's family were supportive.[71]

60. In a letter dated 10 December 2014, the deceased's GP referred him to his psychologist for a further four sessions under an updated mental health care plan.[72]

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[67] Exhibit 1, Vol. 2, Tab 2, JHC Discharge summary (09.10.14), p1
[68] Exhibit 1, Vol. 2, Tab 2, JHC Discharge summary (09.10.14), pp1-2
[69] Exhibit 1, Vol. 2, Tab 2, JHC Inpatient notes (07.10.14) & (08.10.14)
[70] Exhibit 1, Vol. 2, Tab 2, JHC Discharge summary (09.10.14), pp1-2
[71] Exhibit 1, Vol. 3, Tab 2, GP notes, Letter (27.10.14)
[72] Exhibit 1, Vol. 3, Tab 2, GP notes, Letter (27.10.14)

Contact in 2015

61. The deceased's mental health care plan was again renewed on 16 January 2015 and at that time, he was said to be: "*making good progress with his depression*".[73] On 23 April 2015, the deceased's GP wrote to the deceased's university to support the deceased's withdrawal from two units of his Bachelor of Sports Science degree, due to "*overwhelming anxiety*" relating to his study load.[74]

62. The deceased was seen twice by psychiatrist, Dr Chester at Bracaragh Psychiatry. His GP had referred him there, asking for advice in managing the deceased's ongoing depression. Dr Chester first saw the deceased on 5 May 2015. He told her he had been bullied "a bit" at school and that he had held a number of jobs after leaving school, including joining the Australian Army. He told Dr Chester he was completing a Bachelor of Sport Science and that his perfectionist tendencies led to panic and stress.[75]

63. The deceased spoke about his admission to JHC in 2014 and said that the antidepressant he had been prescribed at that time (desvenlafaxine) was ineffective and made him worse. He told Dr Chester that his GP had changed his medication to duloxetine which he was tolerating well.[76]

64. The deceased disclosed daily suicidal thoughts but said he "*wouldn't do it*", and that he stabbed himself in the hand with a plastic fork when he was feeling "*stressed out*". He also disclosed tying ligatures around his neck once or twice per week since his discharge from JHC in 2014 and although he had never lost consciousness by doing so, he had felt light-headed at times.[77]

65. Dr Chester talked to the deceased about the "*high potential for lethality*" of ligatures and he agreed to stop using them to self-harm. Instead, he agreed to reduce his distress with prescribed "calming medication" (i.e.: quetiapine) and to stab himself in the hand with a plastic fork if he felt unable to resist the urge to self-harm altogether.[78]

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[73] Exhibit 1, Vol. 3, Tab 2, GP notes, Letter (16.01.15)
[74] Exhibit 1, Vol. 3, Tab 2, GP notes, Letter (23.04.15)
[75] Exhibit 1, Vol. 1, Tab 20, Report - Dr Chester, pp1-2
[76] Exhibit 1, Vol. 1, Tab 20, Report - Dr Chester, p2
[77] Exhibit 1, Vol. 1, Tab 20, Report - Dr Chester, p2
[78] Exhibit 1, Vol. 1, Tab 20, Report - Dr Chester, p2

66. The deceased cited his mother as a protective factor for not wanting to die and Dr Chester discussed options for accessing emergency care including contacting her rooms, seeing his GP and going to a hospital emergency department.[79]

67. When reviewed on 5 June 2015, the deceased told Dr Chester he was "*going well*". His dose of duloxetine had been increased and he had only used quetiapine once, and felt "*quite relaxed*" after taking it. He denied any self-harm episodes in the previous month and was using techniques his psychologist had discussed with him. He said he was seeing his GP and his psychologist fortnightly. Dr Chester asked the deceased to see her in six weeks, but he did not make a further appointment.[80]

Contact in 2016

68. The deceased attended the ECU Service on 18 August 2016 and disclosed relationship issues that had led to thoughts of self-harm. He said he had been seeing a clinical psychologist regularly over the previous two years.[81]

69. A follow-up appointment had to be cancelled due to a counsellor being unavailable, but he was seen on 1 September 2016. He told the counsellor his relationship had ended the night before. He said he hadn't collected his recently prescribed medication because of the cost and was offered ongoing counselling support in between his appointments with his clinical psychologist.[82]

70. When seen at the ECU Service on 13 October 2016, the deceased said he had recommenced his medication. He also disclosed his urges to self-harm by strangulation, which he said he had not discussed with his clinical psychologist. He said he wanted to defer his university exams and the counsellor discussed alternatives to self-harm as well as the impact on his family, if he was to die.[83]

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[79] Exhibit 1, Vol. 1, Tab 20, Report - Dr Chester, p2
[80] Exhibit 1, Vol. 1, Tab 20, Report - Dr Chester, pp2-3
[81] Exhibit 1, Vol. 1, Tab 21, Report - ECU Student Counselling Service, p2
[82] Exhibit 1, Vol. 1, Tab 21, Report - ECU Student Counselling Service, p2
[83] Exhibit 1, Vol. 1, Tab 21, Report - ECU Student Counselling Service, p2

71. The deceased was last seen by the ECU Service on 3 November 2016. He discussed ongoing urges to self-harm by strangulation, with progressively longer episodes of choking that had led to him feeling faint. He said he had disclosed these urges to his clinical psychologist and was seeing her on a weekly basis. An appointment that was booked on 1 December 2016 was cancelled as the deceased was, by then, an inpatient at RPH.[84]

[84] Exhibit 1, Vol. 1, Tab 21, Report - ECU Student Counselling Service, p2

ADMISSION TO JOONDALUP HEALTH CAMPUS 2016

Presentation - 9 November 2016

72. The deceased was referred to his GP by his psychologist on 9 November 2016. On the same day, the deceased's GP referred the deceased to JHC and stated the reason for the referral in the following terms:

> [M]ultiple self-harm and suicide attempts over the past few days (by strangulation and other) and believes he has the capability of further attempts. He was commenced on duloxetine 30 mg three weeks ago and has previously tried multiple other antidepressants. His exacerbation in his depression appears to be triggered by a recent breakup and stress over university exams.[85]

73. The deceased presented to JHC with his mother on 9 November 2016 at 6.31 pm. His JHC notes record a suicide attempt the day before when the deceased tied a jumper around his neck and secured it to a door.[86]

74. The deceased's family history of suicides[87] was noted and his current stressors were identified as his upcoming university exams and the recent breakdown of his relationship. The deceased's mother confirmed that she and the deceased's brother had been supervising him closely over the previous few days because the deceased had been placing ligatures around his neck. His admissions to JHC in 2014 were noted and he was assessed as "*high risk*".[88]

Diagnosis

75. A psychiatric registrar reviewed the deceased and the impression recorded in the deceased's JHC notes was:

> *Adjustment disorder, depressed mood and suicidal ideation, anxiety and cluster B personality*.[89]

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[85] Exhibit 1, Vol. 2, Tab 2, JHC ED Notes, Letter GP (09.11.16)
[86] Exhibit 1, Vol. 2, Tab 2, JHC ED Medical assessment (09.11.16)
[87] The deceased's maternal uncle and cousin were both reported to have taken their lives
[88] Exhibit 1, Vol. 2, Tab 2, JHC ED Mental health assessment (09.11.16)
[89] Exhibit 1, Vol. 2, Tab 2, JHC Inpatient notes (10.11.16)

Bed situation and transfer

76. In normal circumstances, the deceased would almost certainly have been admitted to JHC. However, on 9 November 2016, there was extreme pressure on the psychiatric beds at JHC with seven patients in the emergency department waiting for a bed and a further six patients in the community and nine across the State all waiting for a bed – a total of 22 patients.[90]

77. In these circumstances, a centralised placement system locates the next most appropriate available bed and the patient is transferred to that facility.[91] Dr Brett said he was aware of repeated examples of metropolitan hospitals being unable to accept further admissions and that there had been cases where metropolitan patients had been transferred to hospitals as far away as Bunbury.[92]

78. The deceased was referred to several hospitals for possible transfer, including Bentley Hospital and RPH. The option of the deceased waiting at home with supervision from his family was also discussed, but his parents stated that this was "*not possible*" at that stage.[93] The deceased was ultimately transferred to Ward 2K at RPH on the evening of 10 November 2016 when a bed became available there.

79. The fact that the deceased could not be offered a bed at JHC had unfortunate consequences. The first was that the deceased was transferred to a facility with which he and his family were unfamiliar and where staff were unfamiliar with him.[94] The second, perhaps more compelling consequence, was that RPH was not in the catchment for the Joondalup Community Mental Health Service (JCMHS), where the deceased was to have been referred on discharge.

80. For the sake of completeness, I note that a further complication was that the psychiatric ward at JHC had been closed to new admissions from 2 – 7 November 2016 as a result of an outbreak of Norovirus (a contagious virus that causes vomiting and diarrhoea).[95]

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[90] ts 06.09.19 (Langman), p267
[91] ts 06.09.19 (Langman), pp267-8
[92] ts 05.09.19 (Brett), p176
[93] Exhibit 1, Vol. 2, Tab 2, JHC Inpatient notes (10.11.16)
[94] ts 05.09.19 (Smith), p134
[95] ts 06.09.19 (Langman), p268

ADMISSION TO ROYAL PERTH HOSPITAL

Admission - 10 November 2016

81. The deceased was admitted to Ward 2K at RPH at 11.15 pm on 10 November 2016. At the time, Ward 2K was a 20-bed voluntary inpatient ward treating patients with mental health issues. Patients were allocated to one of two teams (red and blue), each of which had a consultant psychiatrist, a registrar and a resident medical officer (RMO).[96]

82. The deceased was admitted under Dr Febbo, the consultant for the red team, who was working half-time in this capacity and half-time in private practice. Dr Febbo was readily available by phone to members of his team when they had concerns about any of the patients under his care. Although treatment was based on a team model, Dr Febbo was ultimately responsible for the decisions made about the treatment of patients admitted under his care.[97]

83. The deceased's JHC discharge summary and emergency department notes (which appear to have been faxed to RPH at 9.20 pm on 10 November 2016) assessed the deceased's risk as "*high*". On admission to RPH, staff noted the deceased's strong family history of suicide and his impulsivity. As a precaution, the deceased was placed on 15 minute nursing observations.[98]

Diagnosis

84. The deceased was reviewed by Dr Febbo on 11 November 2016 and was found to have low self-esteem, motivation and mood, with his symptoms worse in the morning. The treatment plan was for the deceased to be seen by a clinical psychologist and for the dose of his antidepressant medication (duloxetine), which had recently been increased to 60 mg, to be maintained.[99] Dr Febbo's impression of the deceased was that he had depression and dependant personality disorder.[100]

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[96] Exhibit 1, Vol. 1, Tab 34, Statement - Dr Febbo, paras 5 & 8-9
[97] Exhibit 1, Vol. 1, Tab 34, Statement - Dr Febbo, paras 6-11
[98] Exhibit 1, Vol. 2, Tab 1, RPH Inpatient notes (10.11.16) & (11.11.16)
[99] Exhibit 1, Vol. 2, Tab 1,RPH Inpatient notes (11.11.16)
[100] Exhibit 1, Vol. 2, Tab 1,RPH Inpatient notes (11.11.16)

85. In light of concerns about the deceased's risk profile, Dr Febbo instructed that if the deceased attempted to discharge himself against medical advice, then consideration would be given to making him an involuntary patient under the *Mental Health Act 2014 (WA)* (MHA).[101,102]

Safety plan

86. At the time of the deceased's admission, RPH policy required a safety plan (setting out such matters as likely triggers and steps to take in a crisis) for patients who were assessed as being at risk of suicide.[103] On the basis of Dr Febbo's assessment, this requirement clearly applied to the deceased.

87. Dr Febbo's evidence was that a safety plan was in place for the deceased during his admission at RPH but that the plan was not documented in the deceased's RPH inpatient notes.[104] Dr Febbo agreed that it is best practice for a patient's safety plan to be documented to ensure that all staff are aware of the patient's triggers and treatment strategies.[105]

88. Regrettably, given that the details of the deceased's safety plan were not documented, the quality of that plan cannot now be assessed.

Family involvement in the deceased's care

89. As I have observed, meaningful collaboration with a person's family and support persons is, wherever possible, essential in the care and assessment of those who may be suicidal.[106] In this case, the evidence establishes that the deceased had a very close relationship with his family. He is variously recorded as having said that his family and/or his mother were protective factors with respect to his self-harm behaviour.[107]

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[101] Exhibit 1, Vol. 2, Tab 1,RPH Inpatient notes (11.11.16)
[102] Exhibit 1, Vol. 1, Tab 34, Statement - Dr Febbo, para 21
[103] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 113
[104] ts 04.09.19 (Febbo), p78
[105] ts 04.09.19 (Febbo), p78
[106] Exhibit 1, Vol. 1, Tab 25, Principles and Best Practice for the Care of People Who May Be Suicidal, p5
[107] For example, see: Exhibit 1, Vol. 3, GP notes, Mental health care plan, (15.08.11)

90. For the sake of completeness, I note that there are also entries in the deceased's notes to the effect that the deceased felt pressured to achieve what other members of his family had achieved and that he viewed his achievements in a negative way when compared to those of other family members.[108]

91. During the deceased's admissions to JHC in 2014, the evidence establishes that the deceased's family, and Mrs Strange in particular, were involved in his care and attended family meetings with the deceased's treating team.[109]

92. It is therefore surprising that during his admission to RPH in 2016, the deceased is reported to have indicated that he did not want his family involved his care. Unfortunately, the deceased's instructions in this regard were not documented in his RPH inpatient notes[110] and I was obliged to have regard to the recollections of members of his treating team.

93. In a statement in the Brief, Dr Febbo, said that:

> As far as I understand, it was not the case that Paul did not want his family involved at all in his treatment; it was more that doctors should not talk to his family, but whether or not Paul would talk to his family was a matter for him. I also recall that Paul did not want a family meeting.[111]

94. In his evidence at the inquest, Dr Febbo put it this way:

> [T]he family were visiting. So you know, at that level they were involved. But I mean…I think there was probably two parts to this. One was a part where probably Paul wanted to sort of keep some things private and the other part was probably the fact that he didn't want his family to be perhaps burdened by, you know, information in relation to, or the involvement that would occur.[112]

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[108] For example, see: Exhibit 1, Vol. 2, Tab 2, JHC Inpatient notes, (29.08.14)
[109] Exhibit 1, Vol. 2, Tab 2, JHC Discharge summary (09.10.14), pp1-2 & JHC Inpatient notes (08.10.14)
[110] Exhibit 1, Vol. 2, Tab 1, RPH Inpatient notes
[111] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, para 34 and ts 04.09.19 (Febbo), p83
[112] ts 04.09.19 (Febbo), p84

95. Dr Afroz (Dr Febbo's registrar at the relevant time) went further and said that as far as she could recall, the deceased was: "*reluctant to involve his family in his treatment plan*".[113]

96. One of the inevitable results of the treating team's failure to document the deceased's instructions about his family in his RPH inpatient notes is that the nature and basis of the deceased's instructions are now the subject of conjecture. As I have just demonstrated, Dr Febbo and Dr Afroz each had different recollections about the deceased's instructions regarding the involvement of his family.

97. In terms of the rationale for the deceased's decision, (which was respected on the basis that the deceased was not psychotic), Dr Febbo explained:

> Based on my review of Paul's notes, he did not want to cause his family concern or distress, and he wanted to be seen as a success not as a failure. It may be the case that Paul wanted to keep his family separate from his mental health issues as he was embarrassed by them.[114,115]

98. Given that the deceased's family were visiting him regularly, taking him out of RPH on day leave and that the deceased was to be discharged into the care of his parents, the failure to document the deceased's instructions about what discussions his treating team could have with his family is a significant omission.

99. Mrs Strange says she requested a family meeting to discuss the deceased's care and discharge plan on four separate occasions and that these requests were ignored.[116] There is only one example of her request being documented.[117] On 17 November 2016, the deceased's notes record the multidisciplinary team's decision to refer the deceased to a service called "Partners in Recovery" and the notation "*organise a family meeting*" appears.[118]

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[113] Exhibit 1, Vol. 1, Tab 35, Statement - Dr R Afroz, para 24 and ts 06.09.19 (Afroz), p207
[114] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, paras 35 & 36 and ts 04.09.19 (Febbo), p83 & p84
[115] See also: Exhibit 1, Vol. 1, Tab 35, Statement - Dr R Afroz, para 24 and ts 06.09.19 (Afroz), p206
[116] ts 05.09.19 (Strange), p198
[117] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (16.11.16: 8.30 pm)
[118] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (17.11.16: 1.50 pm)

100. There is no evidence that Mrs Strange's requests for a family meeting were ever discussed with the deceased or progressed in any way by his treating team.

101. I accept that an important part of trying to build a therapeutic relationship with the deceased was to gain his trust. I also accept that the deceased was a voluntary patient and issues of patient autonomy and confidentiality cannot be completely discounted. If the deceased's reported request that his treating team not discuss his care with his family was in fact his position, then his treating team were placed in a difficult position.[119]

102. However, as Dr Febbo agreed, even in those circumstances, it would have been appropriate (and indeed in line with best practice) for the deceased's instructions (whatever they were) to be documented. Importantly, the deceased's instructions should also have been revisited periodically with a view to changing his mind. All of these discussions should obviously have been documented in the deceased's RPH inpatient notes.[120,121]

103. There are at least two reasons why the deceased's instructions about the involvement of his family should have been revisited during his admission. First, and most obviously, just as the deceased's mood fluctuated during his admission, so too could his desire to have his family involved in his care. Secondly, revisiting the issue regularly would allow the deceased's perceptions to be therapeutically challenged. In this case, at least part of the deceased's apparent motivation for not wanting his family informed about his care was to avoid causing them distress (including financial stress).[122]

104. Had there been ongoing discussions with the deceased about this issue, it could have been explained to him that excluding his family in this way would in fact cause them greater distress. As noted, there is no evidence that this issue was ever raised with the deceased, despite the active and demonstrated involvement of his family in his care.

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[119] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, para 36
[120] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 91 and ts 06.09.19 (Torshizi), p180
[121] ts 04.09.19 (Febbo), p82
[122] Exhibit 1, Vol. 1, Tab 35, Statement - Dr R Afroz, para 24

105. The fact that on 15 November 2016, the deceased is recorded as having given consent for collateral history to be obtained from his parents, casts doubt on whether he really intended to exclude his family from his care.[123]

106. In any event, a further benefit of having a family meeting in the deceased's case would have been that some of his perceptions about his place in the family and his interactions with significant family members could have been addressed.[124] This was especially important given that the deceased was being discharged into the care of his parents. As noted, these family meetings were never held in the deceased's case, despite repeated requests by Mrs Strange.

107. In passing, I note that Division 3 of Part 13 of the MHA deals with the treatment, support and the preparation of discharge plans with respect to involuntary patients. Section 188 of the MHA requires the patient and their nominated person, carer or close family member (as appropriate) to be involved in the preparation of the discharge plan.

108. Of course, the deceased was not an involuntary patient and so those provisions of the MHA did not apply to him. Nevertheless, those provisions provide a useful guide to the way in which a patient's family and support persons can be appropriately involved in discharge planning. In the deceased's case, there was close and obvious support from his family and a greater effort should clearly have been made to involve them.

109. Given that the families of mental health consumers are, in most cases, "experts" in the care and treatment of their loved ones, the exclusion of families from care and discharge planning is clearly inappropriate, except in very clear cases where family involvement is contraindicated.

110. At the risk of repeating myself, in those exceptional cases, the patient's wishes need to be clearly documented and periodically revisited. Neither of those things occurred in the deceased's case.

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[123] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (16.11.16: 2.45 pm) & ts 06.09.19 (Torshizi), p180
[124] ts 06.09.19 (Torshizi), pp195-196 and p197

Mental state 11 – 15 November 2016

111. On 11 November 2016, the deceased's mood was flat and he minimised the extent of his suicidal behaviour. His request to go home was refused and he spoke with nursing staff about his relationship breakup and expressed concern about his upcoming university exams.[125]

112. The deceased's mood and affect remained flat over the period 12 – 13 November 2016. He told staff that as soon as he woke up he began thinking about his former girlfriend's reported infidelity. He reported that suicidal thoughts were present although he denied any plan or intent.[126]

Self-harm attempt - 15 November 2016

113. When reviewed by Dr Afroz at 11.35 am on 15 November 2016, the deceased reported low mood although he said he was ready to sit his upcoming exam. He denied any suicidal thoughts, intentions or plan and he was assessed as being at low risk of self-harm.[127]

114. When assessed by nursing staff at 2.00 pm, the deceased reported he was having a "*bad one*" and that his mood was quite low, with fleeting suicidal ideation but no plan or intent. He was given Lorazepam and appeared to settle.[128] The deceased's low mood persisted and at 9.35 pm, he approached a nurse to advise that he wanted more Lorazepam because he had just tried to asphyxiate himself by wrapping a blanket around his neck whilst in bed.

115. The relevant entry in the deceased's notes states:

> It [the ligature] was not attached to any fixed point and there was no LOC (loss of consciousness) or ligature marks on inspection of his neck. He expressed remorse for his actions and stated he would comply with directions to stay on the ward. 15/60 (15 minute) visual observations commenced and pt (patient) aware. He denied any further intent to act on DSHI (deliberate self-harm ideation)".[129]

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[125] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (11.11.16: 12.40 pm) & (11.11.16: 8.50 pm)
[126] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (12.11.16) & (13.11.16)
[127] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (15.11.16: 11.35 am)
[128] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (15.11.16: 2.00 pm)
[129] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (15.11.16: 9.35 pm)

116. A notation at 8.35 pm on 15 November 2016 (which perhaps should be 9.35 pm) states: "*Pt's* (patient's) *property checked and any potential ligatures removed, x 2 razors removed*".[130]

117. Despite the deceased's well-known history of self-harm using ligatures, he was not promptly reviewed by a medical officer following his disclosure, when he should have been.[131] Instead, he remained in bed, apparently asleep. In her oral evidence, Dr Afroz noted that although there was no overnight doctor on Ward 2K, a registrar from the emergency department would have been available had ward staff requested assistance.[132]

118. It seems clear that the deceased should have been the subject of a risk assessment following his disclosure of self-harm. The lack of a documented safety plan may have meant that nursing staff did not appreciate the significance of the deceased's actions in terms of being an indicator of heightened distress.

119. Apart from anything else, given the self-harm incident, consideration needed to be given to whether the deceased's status as a voluntary patient was still appropriate. As Dr Febbo noted, had the deceased been made an involuntary patient, he could not have remained on Ward 2K. When the deceased was reviewed, it was felt that making him an involuntary patient and transferring him to an "*approved hospital*" as an involuntary patient would probably have been counterproductive.[133]

120. Dr Afroz gave evidence at the inquest that she conducted a risk assessment when she reviewed the deceased the next day (i.e.: 16 November 2016).[134] Dr Afroz made the following entry in the deceased's notes:

> Denied thought, intention or plan of self-harm or harm to others. Last night tried attempt to strangle himself with bed cover. Paul feels safe here in hospital.[135]

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[130] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (15.11.16: 8.35 pm)
[131] ts 06.09.19 (Torshizi), pp193-194
[132] ts 06.09.19 (Afroz), p218
[133] See: ts 04.09.19 (Febbo), p126
[134] ts 06.09.19 (Afroz), pp218-219
[135] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (15.11.16: 2.45 pm)

121. As Dr Afroz properly acknowledged, the record of her risk assessment should have been more comprehensive.[136] Her plan following her review of the deceased, was to increase the dose of his antidepressant medication (duloxetine) from 60 mg to 90 mg. She also obtained the deceased's permission to obtain collateral history from his parents.[137]

122. That collateral history was obtained from Mrs Strange by way of a telephone call on 17 November 2016 whilst she was at work.[138] As Mrs Strange pointed out, it would have been more appropriate for collateral information to have been gathered at a mutually convenient time, when Mrs Strange was not at work.[139]

123. In any event, there is a dispute as to whether or not Dr Afroz told Mrs Strange about the deceased's self-harm attempt during their conversation on 17 November 2016.

124. Unfortunately, there is no contemporaneous record of this conversation. Dr Tabasum, an RMO on Ward 2K, was sitting next to Dr Afroz during the call to Mrs Strange, but could not recall whether or not the self-harm incident had been mentioned.[140]

125. In a late entry in the deceased's RPH inpatient notes on 9 February 2107, Dr Afroz referred to the telephone conversation she had with Mrs Strange.[141] That entry came about because after the deceased's death, Dr Afroz and Dr Febbo were reviewing the deceased's notes and they had been asked whether there had been any contact with the deceased's family. Dr Afroz says she recalled her phone call to Mrs Strange and asked Dr Febbo if she could make a late entry about the matter. Dr Afroz says Dr Febbo agreed. Although he said he could not recall having done so, Dr Febbo said he might have told Dr Afroz it was important to document the conversation.[142,143,144]

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[136] ts 06.09.19 (Afroz), p219 and see also: ts 06.09.19 (Torshizi), pp194-195
[137] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (15.11.16: 2.45 pm)
[138] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes - Late entry: (09.02.17: 3.00 pm)
[139] ts 06.09.19 (Strange), p250
[140] ts 04.09.19 (Tabasum), p58
[141] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes - Late entry: (09.02.17: 3.00 pm)
[142] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes - Late entry: (09.02.17: 3.00 pm)
[143] Exhibit 1, Vol. 1, Tab 35, Statement - Dr R Afroz, paras 30-31 & para 33
[144] See: ts 04.09.19 (Febbo), p104 & p120

126. The late entry by Dr Afroz, was based solely on her memory. In it, Dr Afroz sets out some family history she obtained from Mrs Strange. The entry also refers to Mrs Strange expressing the view that it was really important for the deceased to sit his university exam, but accepting that this would not be permitted.[145]

127. Although the deceased's self-harm attempt on 15 November 2016 is referred to in the late entry it is not clear from the context of the notation whether this was actually discussed with Mrs Strange.[146,147] Dr Afroz could not recall whether she had mentioned the self-harm incident to Mrs Strange during their telephone conversation, but based on the wording of her late entry, thought she would have.[148]

128. However, Dr Afroz agreed that it was possible that in discussing why the deceased was not permitted to sit his university exam, she may have spoken to Mrs Strange about his elevated risk in general terms, and not specifically mentioned the self-harm attempt.[149]

129. For her part, Mrs Strange said she had no recollection of the deceased's self-harm attempt having been mentioned to her by Dr Afroz.[150] In a letter to the Court, (received on 30 March 2017), Mrs Strange refers to the deceased's top bedsheet being missing and says when she told the deceased she would ask for a replacement, he told her not to worry and that he would raise the matter. Mrs Strange goes on to say:

> Then every night the sheet was still missing and he said not to worry. I later found out, when Paul was discharged from the hospital, he told me that he had attempted suicide by hanging. No one advised me of this even though there was a release of information on his file.[151]

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[145] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes - Late entry: (09.02.17: 3.00 pm)
[146] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes - Late entry: (09.02.17: 3.00 pm)
[147] Exhibit 1, Vol. 1, Tab 35, Statement - Dr R Afroz, para 32
[148] ts 06.09.19 (Afroz), p221
[149] ts 06.09.19 (Afroz), p222
[150] ts 06.09.19 (Strange), pp245-246
[151] Exhibit 1, Vol. 1, Tab 15. Letter - Mrs Strange to the Court, received 30.03.17, p2

130. There is no evidence that Mrs Strange ever raised the deceased's self-harm incident with any member of his treating team during his admission. Given her close relationship with the deceased, I would have expected her to have done so, had she been told about the self-harm incident.

131. In my view, if Mrs Strange had been told about the deceased's self-harm incident when Dr Afroz called her on 17 November 2016, it is inconceivable that she (Mrs Strange) would have forgotten about the incident by the time she wrote her letter to the Court in March 2017.

132. Having considered all of the available evidence, I have concluded that Mrs Strange was not told about the deceased's self-harm (on 15 November 2016) when Dr Afroz called her on 17 November 2016. Given the significance of this event, it is my view that the deceased should have been asked whether he consented to his family being advised about the matter.

133. Had the deceased's family been advised about this incident, they would almost certainly have expressed a more strident view about the appropriateness of his discharge on 28 November 2016, regardless of whether a family meeting to discuss the deceased's discharge was going to be held or not.

Medication change

134. Given that the deceased's mood had not shown the improvements that had been hoped for, Dr Febbo decided to switch the deceased's antidepressant from Duloxetine, which he had been taking since admission, to the more potent Effexor.[152] The new medication was introduced on 21 November 2016 and the dose was increased on 24 November 2016.[153]

[152] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, para 22 and ts 04.09.19 (Febbo), p119
[153] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (21.11.16: 10.00 am) & (24.11.16: 11.00 am)

135. Dr Febbo said that the deceased's behaviour after the medication change was consistent with the view that he was improving.[154] It is true that the deceased's mood is generally reported as having improved in the few days after he started on Effexor. For example, on 24 November 2016, the deceased reported no longer experiencing suicidal thoughts and said that his mood was "*good*".[155]

136. However, over the next two days (25 - 26 November 2016), the deceased's mood was reported as low and he was noted to be feeling anxious.[156] In addition, his suicidal ideation was variously described as "*persisting*"[157] and "*fleeting without any plan and intention*".[158]

137. Dr Febbo was asked whether it was appropriate to have discharged the deceased on 28 November 2016, so soon after his medication had been changed and the dose increased. Dr Febbo said that much depended on the assessment of the patient and their suitability for discharge. In the deceased's case, Dr Febbo noted:

> What was being monitored was Paul's mental state and the improvement or not of his mental state. I mean, as I said, you know, that has to be, sort of, balanced with the fact that Paul had – I think he had an 18 day admission which is sort of, you know, very long compared to other admissions at – on ward 2K because we're under quite considerable pressure to discharge people early.[159]

138. On the question of discharge after a medication change, Dr Torshizi noted that:

> Usually it is recommended that no medication is changed in the week prior to discharge due to the risks associated with medication change, side effects etc.[160]

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[154] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, para 22 and ts 04.09.19 (Febbo), p74
[155] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (24.11.16: 11.00 am)
[156] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (25.11.16 – 26.11.16)
[157] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (25.11.16: 9.25 pm)
[158] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (25.11.16: 5.15 pm)
[159] ts 04.09.19 (Febbo), p121
[160] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, p120

139. In the deceased's case, on 27 November 2016, he was reported to be catastrophising and ruminating on perceived future difficulties. He was also said to be experiencing fleeting suicidal thoughts but denied any plan or intent.[161] In contrast, when reviewed by Dr Afroz on 28 November 2016, the deceased denied any suicidal thoughts.[162]

140. As Dr Torshizi pointed out:

> In Paul's case, the fact that the dose increase was so close to discharge, as well as the fact that Paul said he was suicidal the night before his discharge, should have made it incumbent on the treating team to follow-up the patient more aggressively, like making sure a referral was made and received by the Acute Treatment Team of the Joondalup Community Mental Health Clinic.[163,164]

Pre-discharge assessment - 28 November2016

141. The deceased was discharged from RPH at 6.00 pm on 28 November 2016.[165] Although it was acknowledged that it is best practice for patients to be reviewed by their consultant before discharge, it was acknowledged that this frequently did not occur in practice and patients were often reviewed by registrars instead.[166]

142. In Dr Febbo's absence, Dr Afroz reviewed the deceased at 12.50 pm on 28 November 2016. The deceased reported his mood was "OK" and said he felt more confident and motivated. The deceased said his weekend leave with his family had gone well and that after a discussion with his mother, he was happy to be discharged.[167,168] In terms of the deceased's risk assessment, the notation made in his notes by Dr Afroz was:

> Low acute risk of self-harm at present. However, chronic risk of self-harm in the context of previous self-harm behaviour.[169]

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[161] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (27.11.16: 12.50 pm)
[162] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (28.11.16: : 12.50 pm)
[163] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 120
[164] See also: Exhibit 1, Vol. 1, Tab 24, Report - Dr G Smith, pp2-3 and ts 05.09.19 (Smith), pp153-154
[165] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (28.11.16: : 7.40 pm)
[166] ts 04.09.19, (Febbo), p91; ts 06.09.19, (Afroz), p231 and ts 06.09.19 (Torshizi), pp183-184
[167] Exhibit 1, Vol. 1, Tab 35, Statement - Dr R Afroz, para 40
[168] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (28.11.16: : 12.50 pm)
[169] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (28.11.16: : 12.50 pm)

143. Dr Afroz says that she rang Dr Febbo to discuss her assessment of the deceased and that Dr Febbo was happy for the deceased to be discharged.[170,171] Although he couldn't recall this conversation, Dr Febbo agreed this sounded right.[172]

Discharge planning

144. In accordance with best practice, planning for a patient's discharge should begin as soon as the patient is admitted.[173] This is sensible because discharge arrangements may take some time to finalise and a patient's clinical journey cannot always be predicted at the start of their admission.

145. The policy that covered discharge planning at the time of the deceased's admission to RPH (the Discharge Policy)[174] provided that:

> Discharge planning will commence at the point of admission to the mental health unit occurring parallel with care, not as a serial event, which happens only after the decision has been made to discharge the patient.[175]

146. When the deceased was reviewed by Dr Febbo the day after his admission to RPH (11 November 2016), the notation: "*EDD 1 1/2 weeks*" appears in his notes. This means that, at that time, the deceased's treating team expected he would be discharged in about 10 days.[176]

147. Dr Febbo recalled having a number of conversations with the deceased about discharge. Unfortunately, none of these conversations were recorded in the deceased's RPH inpatient notes and Dr Febbo could not remember the "*precise nature of those conversations*".[177]

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[170] Exhibit 1, Vol. 1, Tab 35, Statement - Dr R Afroz, paras 41-42
[171] ts 06.09.19, (Afroz), p231
[172] ts 04.09.19, (Febbo), p91
[173] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, para 13
[174] Although this was a South Metropolitan Health Service policy, it had been adopted by EMHS
[175] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, Att. 4: Discharge Planning in Mental health Services, p2
[176] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (11.11.16)
[177] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, para 24

148. Dr Febbo outlined his usual practice with respect to discussing discharge with his patients. He said that on admission, he discussed the likely length of the patient's admission and whether any accommodation or work issues need attending to. During the middle of the patient's admission, Dr Febbo said he would discuss follow-up arrangements including where the patient was being referred to and how contact with the referral agency would occur. Dr Febbo said that he would also discuss what to do in a crisis situation.[178]

149. After examining the deceased's notes, Dr Febbo said he could: "*see no reason why my conversations with him* (the deceased) *would not be in keeping with my usual practice*". Be that as it may, it is clearly unsatisfactory that not one of the conversations Dr Febbo recalls having with the deceased about discharge was documented.[179]

150. Dr Afroz also recalled that she and other members of the deceased's treating team had discussions with the deceased about his discharge. She did not discuss the deceased's discharge plan with his family, even though he was being discharged into their care, because: "*Paul was reluctant to involve his family during the hospital admission*".[180] Again, none of these conversations were documented.

151. At a multidisciplinary team meeting on 23 November 2016, it was decided that the deceased's provisional discharge date would be 30 November 2016.[181]

152. The plan in the deceased's discharge summary was:

> In terms of follow-up:
>
> 1) Paul is to continue taking venlafaxine and quetiapine in the community
>
> 2) Psychotherapy in the community
>
> 3) D/C (discharge) today under Joondalup Community Health Clinic.[182,183]

[178] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, para 25
[179] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, para 26
[180] Exhibit 1, Vol. 1, Tab 35, Statement - Dr R Afroz, paras 37-38
[181] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes, Multidisciplinary meeting notes (23.11.16)
[182] Exhibit 1, Vol. 2, Tab 1, RPH Discharge summary (28.11.16), p2
[183] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, para 27

153. All of the experts who reviewed the deceased's case were of the opinion that his discharge planning was suboptimal[184,185,186] and Counsel for the EMHS properly conceded that this was so.[187] I agree with these assessments and will make some further comments about the deficiencies in the deceased's discharge planning process later in this Finding.

Referral to GP and community mental health service

154. The deceased's discharge plan makes no mention of any referral to his GP. Nevertheless, Dr Afroz[188] recalled telling the deceased to make an appointment with his GP within one week of discharge. Although Dr Febbo says he would have discussed this with the deceased, he agreed that this conversation was not documented in the deceased's inpatient notes.[189]

155. Dr Afroz also recalled telling the deceased that he had been referred to the JCMHS for follow-up. As with so many important details about the deceased's care, there is no mention of this conversation in the deceased's RPH inpatient notes. The only referral for which there is documentation is the referral to the Centre for Clinical Intervention (CCI).[190] This was faxed to CCI by Mr Voight on 24 November 2016 and there is a notation to that effect in the deceased's RPH inpatient notes.[191]

156. As it happens, by letter dated 2 December 2016, CCI wrote to Dr Afroz to advise that it was unable to accept the deceased's referral because its courses for 2016 were fully subscribed. CCI placed the deceased on a wait list for its February 2017 course.[192] It is unclear when the CCI letter arrived at RPH, but Dr Afroz said that by the time the letter was referred to her and could be actioned, the deceased had died.[193]

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[184] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 114
[185] Exhibit 1, Vol. 1, Tab 24, Report - Dr G Smith, p2
[186] Exhibit 1, Vol. 1, Tab 22 Report - Dr Brett, pp7-8
[187] ts 06.09.19 (Paljetak), pp261-262
[188] Exhibit 1, Vol. 1, Tab 35, Statement - Dr R Afroz, paras 42 and ts 06.09.19, (Afroz), p227
[189] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, paras 28-29
[190] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes, Fax to CCI (24.11.16)
[191] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes (24.11.16:111.20 am)
[192] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes, CCI Letter to Dr Afroz (2.12.16)
[193] ts 06.09.19, (Afroz), p229

157. There is no evidence that a referral was made to the community mental health services *360* (as noted in the deceased's mental health care transfer summary)[194] or *Partners in Recovery* (as mentioned in his RPH inpatient notes).[195] There is also no evidence that any referral was ever made to JCMHS. Dr Febbo said he did not have any contact with JCMHS because this was the role of the Registrar or RMO.[196] Dr Afroz says that she did not send the referral to JCMHS because:

> As Dr Lynott (the RMO) was the author of the discharge summary, she would have sent the discharge summary through NaCS (the electronic system that generates the discharge summary) and needed to ask the ward clerk or nursing staff to fax it to Joondalup.[197]

158. Dr Lynott's first day on Ward 2K was 28 November 2016, the day of the deceased's discharge. She was a relieving RMO and prepared the discharge summary by reviewing the deceased's notes. Dr Lynott did not recall ever having met the deceased.[198]

159. Dr Lynott recalled printing off hard copies of the discharge summary and leaving them with the ward clerk to be posted to the deceased's GP.[199] With respect to the referral to JCMHS, Dr Lynott said:

> The Registrar was to arrange Mr Strange's referral to Joondalup. I do not know if the Registrar or the ward clerk sent the Discharge Summary to Joondalup with the Mental Health Care Transfer Summary.[200]

160. In passing, I note that there is no evidence that either Dr Afroz, Dr Lynott or Dr Tabasum were ever given any training about discharge procedures, or indeed an orientation when they started working on Ward 2K. Dr Afroz says she was unaware of the contents of the Discharge Policy at the time of the deceased's discharge.[201]

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[194] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes, Mental health care transfer summary (28.11.16)
[195] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes, (17.11.16)
[196] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, para 32 and ts 04.09.19, (Febbo), p95
[197] Exhibit 1, Vol. 1, Tab 35, Statement - Dr R Afroz, para 46
[198] Exhibit 1, Vol. 1, Tab 31, Statement - Dr F Lynott, paras 5-9
[199] Exhibit 1, Vol. 1, Tab 31, Statement - Dr F Lynott, paras 5-9
[200] Exhibit 1, Vol. 1, Tab 31, Statement - Dr F Lynott, paras 11
[201] ts 06.09.19, (Afroz), pp225-226

161. In the deceased's case it was crucial that referrals to external agencies were made before discharge. As Dr Smith noted:

> [I]n Paul's case, where he had just been in hospital for a period of time with depression, he had been suicidal, he was taking antidepressants, and those antidepressants had been changed. I would have expected him to get a fairly early appointment at the Joondalup Health Centre.[202]

Standard of notes

162. As counsel for the EMHS properly conceded, the overall standard of the deceased's RPH inpatient notes was inadequate and suboptimal.[203] Although there are examples of well-formulated and timely entries, too often critically important information is either inadequately recorded or not recorded at all. Examples of the deficiencies in the deceased's RPH inpatient notes include:

i. The deceased's safety plan was not documented;
ii. There is no reference to the deceased's reported instructions about what information could be shared with his family or alternatively that he did not want them involved in his treatment;
iii. There is no reference to the conversations that Dr Febbo, Dr Afroz and other members of the deceased's treating team said they had with him about his discharge;
iv. There is no contemporaneous record of the discussion Dr Afroz had with Mrs Strange on 17 November 2016;
v. The risk assessment conducted on 16 November 2016, the day after the deceased's self-harm incident, is inadequate;
vi. Reports about the success or otherwise of the deceased's various periods of leave from the ward are either missing, or if present, are inadequate; and
vii. There is no evidence of any systematic or comprehensive planning with respect to the deceased's discharge.

[202] ts 05.09.19, (Smith), p140
[203] ts 06.09.19, (Paljetak), p261

163. Dr Febbo accepted that as leader of the deceased's clinical team, he was ultimately responsible for the standard of the deceased's notes and had a role in mentoring and guiding his subordinates in this regard.[204]

164. Whilst I accept that concession, in my view the problems identified with the deceased's notes are part of a broader systemic issue that has been referred to in a number of other inquests.

165. Part of the problem, is the enormous workload that is shouldered by registrars and RMO's in the context of increased patient loads.[205]

166. Dr Torshizi mentioned that the Royal Perth Bentley Group is currently looking at adopting an electronic records system.[206] Assuming the system to be used is chosen wisely, this may reduce the burden on staff.

167. I accept that members of the treating team have limited time to make entries in a patient's notes and that there is a tension between providing quality clinical care and the requirement to document that care in a comprehensive manner. Dr Brett referred to the fact that the average length of patient admissions has decreased over the past 25 years. This means that there is less time available to make effective discharge plans and further adds to the pressures that staff must grapple with.[207]

168. The situation is not helped by the enormous pressure on inpatient beds at hospitals, including RPH. Dr Febbo and Dr Brett both said they were aware of times where patient care was compromised by the relentless demand for inpatient beds and the push to discharge patients as quickly as possible. As Dr Brett noted, this is clearly a resourcing issue and additional funding would be required if this type of pressure is to be reduced.[208,209]

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[204] ts 04.09.19, (Febbo), p117 and see also: ts 06.09.19, (Torshizi), pp180-181
[205] ts 05.09.19, (Brett), p176
[206] ts 05.09.19, (Torshizi), pp186-187
[207] ts 05.09.19, (Brett), p159
[208] ts 04.09.19, (Febbo), pp121-122
[209] ts 05.09.19, (Brett), pp158-159 and p176

Follow-up call after discharge

169. In accordance with the 7 Day Post Discharge Patient Follow-Up Policy - Mental Health (Follow-up Policy),[210] Mr Voight, made a follow-up call to the deceased on 30 November 2016 and recorded the outcome of that call in an electronic system known as PSOLIS.[211]

170. The purpose of these follow-up calls seems to be to ensure that patients are progressing well and that discharge arrangements are in place. In the deceased's case, the PSOLIS entry made by Mr Voight is very brief, in accordance with the instructions Mr Voight said had been given.[212]

171. Whether or not this is what Mr Voight was instructed to do, I note that his assertion does not appear to accord with the Follow-up Policy, which requires the person making a successful call to a patient after discharge to:

> Add details of follow-up in comments, e.g., "7 Day follow-up phone call to patient, doing fine, has appointment tomorrow with ATT, no further action."[213]

172. In any event, it is impossible to assess the quality of the discharge follow-up phone call made by Mr Voight on 30 November 2016 because he had no independent memory of the deceased generally, or the follow-up call in particular.[214]

173. Notwithstanding Mr Voight's inability to recall his conversation with the deceased, it seems unlikely that the fact that referrals to the deceased's GP and JCMHS had not been made was actually identified during the follow-up call, otherwise Mr Voight's notation would hardly have been:

> Successful contact. Nil further action required.[215]

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[210] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, Att. 7: 7 Day Post Discharge Patient Follow-Up Policy
[211] Exhibit 1, Vol. 1, Tab 32, PSOLIS entry (30.11.16: 12.40 pm)
[212] ts 04.09.19, (Voight), p39
[213] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, Att. 7: 7 Day Post Discharge Patient Follow-Up Policy, p6
[214] Exhibit 1, Vol. 1, Tab 28B, Statement - Mr Voight, para 19 and ts 04.09.19, (Voight), p9 & p39
[215] Exhibit 1, Vol. 1, Tab 32, PSOLIS entry (30.11.16: 12.40 pm)

Medication error

174. For the sake of completeness, I note that in her evidence, Mrs Strange described an incident where a nurse attempted to dispense the wrong medication to the deceased. Mrs Strange says the deceased did not recognise the medication and queried what it was. The nurse then went away and returned with the correct medication.[216]

175. Mr Voight was asked whether he was aware of this incident and he said he wasn't.[217] Dr Febbo and Mr Voight both confirmed that the standard practice for dispensing medication is for the relevant team member to check they have the right patient, the right medication and the right dose.[218]

176. In a letter to Mrs Strange dated 21 August 2017 (the Letter), the Deputy Premier and Minister for Health dealt with a number of concerns raised by Mrs Strange. With respect to the medication issue, the Letter stated:

> In relation to your concerns about the dispensing of Paul's medication on one occasion, it would appear from your description of events that the nurse had not performed correct checking procedures. RPH staff have asked me to pass on their apologies and I have been reassured that Ward 2K will continue to review and monitor staff education regarding drug administration and related policy/procedures.[219]

177. The medication error described by Mrs Strange is clearly of concern and a 'near miss' of this nature should have prompted an investigation. However, there is no evidence about when and in what circumstances this incident is alleged to have occurred nor is there any evidence of an investigation. In those circumstances, I am unable to take the matter any further.

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[216] Exhibit 1, Vol. 1, Tab 15, Letter: Mrs Strange, received 30.03.17, p2
[217] ts 04.09.19, (Voight), p27
[218] ts 04.09.19, (Voight), p27 and ts 04.09.19, (Febbo), p77
[219] Exhibit 1, Vol. 1, Tab 15, Letter from The Hon. Roger Cook, MLA (21.08.17), p2

LEAD UP TO 9 DECEMBER 2016

178. The evidence about the deceased's mental state in the period following his discharge is limited. Mrs Strange said he came to her workplace and did some voluntary work but it was: "*evident he was not travelling well*". She said that in view of the "*depressive state*" of Ward 2K, she was reluctant to take the deceased back there.[220]

179. A friend of the deceased (who had known him for several years) spoke with him by phone during the day on 5 December 2016 and again that evening. The deceased said his sports science degree had been a waste of time and that he had wasted his life. He was also very down about his "*on again off again*" girlfriend who he knew he needed "*to let go of*". He said he liked having a girlfriend even though she was "*playing with him*".[221]

180. The deceased's friend arranged to meet him for lunch the next day (6 December 2016) with her sister and mother. The deceased was very late, which was unusual for him, and the deceased's friend noticed seemed a lot quieter than usual.[222]

181. On 7 December 2016, the sister of the deceased's friend (who was also a friend of the deceased) spoke to him by phone. She had been trying to call the deceased for two days after noticing a message on his Facebook page that said: "*sorry all*".[223,224]

182. When she spoke to the deceased, he told her he was really depressed and wondered why no girl seemed to want him. She said this was out of character for the deceased and that she spoke to him about possibly moving out of home with friends. Although the deceased agreed with the idea, she subsequently felt he was just saying what she wanted to hear. As the call was ending, the deceased said: "*I love you bestie*". The deceased friend later said she thought he had called her to say goodbye. [225]

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[220] Exhibit 1, Vol. 1, Tab 15, Letter - Mrs Strange to the Court, received 30.03.17, p2
[221] Exhibit 1, Vol. 1, Tab 12, File Note - Discussion with Ms K Wyse (18.07.17), p1
[222] Exhibit 1, Vol. 1, Tab 12, File Note - Discussion with Ms K Wyse (18.07.17), p1
[223] Exhibit 1, Vol. 1, Tab 11, File Note - Discussion with Ms C Wyse (28.07.17), p2
[224] ts 04.09.19 (Milham), p6
[225] Exhibit 1, Vol. 1, Tab 11, File Note - Discussion with Ms C Wyse (28.07.17), p2

THE EVENTS OF 9 DECEMBER 2016

183. The deceased's sister is the last person known to have seen him alive. In her statement to police, Ms Strange said that at about 4.05 pm on 9 December 2016, she left the deceased at her parent's place while she dropped her daughter at a school function. Whilst her daughter was at the function, Ms Strange went to her own home to attend to a few jobs.[226]

184. Before leaving the deceased, Ms Strange had a conversation with him about some work experience he had recently done at a local school and his thoughts about pursuing teaching as a career. The deceased said he had initially enjoyed the work experience but more recently, had found it quite hard. Ms Strange spoke with the deceased about persisting with the work experience and he said he was going to keep trying. She thought he seemed well and was "*not overly moody or different*".[227]

185. Ms Strange arrived back at her parent's home at about 7.35 pm, having collected her daughter from the school function. She went into the deceased's room and on finding he wasn't there, she went looking for him. She found the deceased on the back patio with an electrical extension cord around his neck, hanging from a bicycle that was attached to the wall.[228]

186. A neighbour, Mr Wrigley, who was alerted by Ms Strange calling out the deceased's name, came to help. He lifted the deceased up and freed him from the electrical cord before laying him down and starting CPR.[229] Emergency services were called and an ambulance arrived. Ambulance officers took over resuscitation efforts and transported the deceased to JHC.[230]

187. Despite the efforts of Mr Wrigley, ambulance officers and hospital staff, the deceased could not be revived. He was declared dead at 8.42 pm on 9 December 2016.[231]

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[226] Exhibit 1, Vol. 1, Tab 13, Statement - Ms N Strange, paras 2-3 and 9-10
[227] Exhibit 1, Vol. 1, Tab 13, Statement - Ms N Strange, para 2; 5-8 and 17
[228] Exhibit 1, Vol. 1, Tab 13, Statement - Ms N Strange, para 11-15
[229] Exhibit 1, Vol. 1, Tab 14, Statement - Mr D Wrigley, para 2-26
[230] Exhibit 1, Vol. 1, Tab 8, St John Ambulance: Patient care record
[231] Exhibit 1, Vol. 1, Tab 3, JHC - Death in hospital form

CAUSE AND MANNER OF DEATH

188. The deceased was formally identified at JHC by his brother in the presence of Senior Constable Adrian Smith at 10.15 pm on 9 December 2016.[232]

189. Dr Cadden, a forensic pathologist, conducted an external post mortem examination of the deceased's body on 13 December 2016. Dr Cadden found a ligature furrow marking to the deceased's neck consistent with the given history of the ligature being an electrical cable. There were no other significant findings.[233]

190. Toxicological testing found therapeutic levels of the antidepressant medication Effexor, as well as diazepam in the deceased's system. The testing was negative for alcohol, amphetamines, cannabinoids, opiates and other common drugs.[234]

191. Significantly, quetiapine was not detected in the deceased's system.[235] As noted, this medication had been prescribed to the deceased on his discharge from RPH. The fact that quetiapine was not detected suggests that the deceased was not taking it at the time of his death and this inference is clearly open.[236] If the deceased was not taking quetiapine at the time of his death, then the symptoms it was prescribed to address, namely: depression, anxiety and impulsivity could have worsened.[237]

192. At the conclusion of his examination, Dr Cadden expressed the opinion that the cause of death was consistent with ligature compression of the neck (hanging).[238] I accept and adopt that conclusion.

193. I find that death occurred by way of suicide.[239]

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[232] Exhibit 1, Vol. 1, Tab 4, P92 - Identification of deceased person form
[233] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report
[234] Exhibit 1, Vol. 1, Tab 7, Toxicology Report
[235] Exhibit 1, Vol. 1, Tab 7, Toxicology Report
[236] ts 05.09.19 (Smith), pp138-139
[237] ts 04.09.19 (Febbo), pp111-112
[238] Exhibit 1, Vol. 1, Tab 6, Post Mortem Report
[239] I note that this finding is one of the limited verdicts available to the Court. In her statement, Mrs Strange said: "*I do not believe my son took his own life, this horrible disease called depression took his life*". I completely understand the sentiments expressed by Mrs Strange in this regard. See: Statement - Mrs Strange and ts 06.09.19 (Strange), p249

ISSUES ADDRESSED BY EXPERT REPORTS

194. The Court was greatly assisted by reviews of the deceased's care undertaken by:

i. Dr G Smith (Office of Chief Psychiatrist);

ii. Dr A Brett (independent consultant psychiatrist); and

iii. Dr A Torshizi (consultant psychiatrist, RPH).

195. Each of these experts also gave oral evidence at the inquest and the issues they identified are set out below.

Safety plan

196. At the time of the deceased's admission, the EMHS policy "*Care Coordination in Mental Health*", makes the following brief reference to safety plans:

> A patient safety plan / consumer wellness plan needs? to be completed which includes a description of early warning signs and triggers.[240]

197. Contrary to that policy, the deceased was not the subject of a documented safety plan during his admission to RPH. The evidence of Dr Febbo was that the deceased did have a safety plan, it was just that it was not documented.[241]

198. In my view this is a significant omission, especially given the deceased's known history of self-harm and his self-harm attempt on 15 November 2016.

199. As Dr Torshizi pointed out, the development of a safety plan for the deceased, in conjunction with his family, was crucial:

> Especially considering the fluctuating and dynamic nature of Paul's suicidality which was only partially resolved, at best, upon discharge.[242]

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[240] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, p52: see Att. 5, para 3.2, (endorsed July 2016)
[241] ts 04.09.19 (Febbo), p78
[242] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 113

200. Since the deceased's death, the requirements with respect to safety plans have been made more explicit. The Royal Perth Bentley Group policy entitled "*Clinical Care of People Who May Be Suicidal Policy*", provides that where a patient is assessed as a suicide risk, a safety plan will be documented and is to include: specific triggers; agreed actions; strategies to reduce risk, actions to be taken in the event of a crisis (when and by whom); follow-up responsibilities and scheduled reviews of the plan.[243]

201. A further requirement is that:

> The Safety Plan will be shared with the patient, their family and support person. Where agreement regarding decisions in the Safety Plan cannot be reached with the patient/support person, this needs to be documented.[244]

202. The requirement to document a patient's safety plan is clearly important. Doing so helps to ensure that all members of the treating team are aware of the patient's triggers and the required actions in the event of a crisis.

203. It is clearly unacceptable to rely on the discussion of a verbal safety plan at handovers and multidisciplinary team meetings – but this is what is said to have occurred in the deceased's case. The potential for misunderstanding in the absence of a documented plan is simply too great. Counsel for the EMHS properly conceded that the deceased's safety plan should have been documented.[245]

Involvement of family in the deceased's care

204. The deceased had a close, loving relationship with his family and at various times said that his family and his mother in particular, were protective factors. During his admission, members of the deceased's family and his friends visited regularly. His family took him off the ward on day leave and he was to be discharged into the care of his parents.

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[243] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, p97: see Att. 8, para 3, (endorsed 04.10.18)
[244] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, p97: see Att. 8, para 3, (endorsed 04.10.18)
[245] ts 06.09.19 (Paljetak), p261

205. It is therefore clear that the deceased's family were involved in his care, regardless of any reported view he may have expressed.

206. I have already referred to the fact that the deceased's wishes in regards to the involvement of his family in his care were not recorded in his notes and are now the subject of differing recollections. I have also noted that any views the deceased expressed about not wanting his family involved should have been revisited with a view to changing his mind.[246]

207. I agree with Dr Torshizi's suggestion that where a patient indicates that they do not want their family to be involved in their care, this must be clearly documented in the patient's notes and on the mental health care transfer summary. I also agree with Dr Torshizi's suggestion that future revisions of the *Care Coordination in Mental Health* policy should include a section requiring a patient's treating team to document the steps taken to obtain a patient's consent to involve their family or support person in their care.[247]

208. Even in circumstances where a patient does not consent to their family being involved in their care, both Dr Smith, Dr Febbo and Dr Brett agreed with Dr Torshizi's assertion that:

> [I]t is good practice and appropriate to contact [a patient's] family or personal support person to get their views on discharge without breaching patient confidentiality.[248]

209. Further, Dr Febbo, Dr Smith and Dr Brett[249] all agreed with Dr Torshizi's suggestion that the Office of the Chief Psychiatrist (OCP) be asked to issue guidelines about:

> [W]hat communication can be had with a family or support person in circumstances where a competent and voluntary patient is refusing the involvement of their family or personal support person.[250]

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[246] ts 06.09.19 (Torshizi), pp185-186
[247] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 115
[248] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 116
[249] ts 04.09.19 (Febbo), p89-90; ts 05.09.19 (Smith), p146; and ts 04.09.19 (Brett), p165
[250] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 116 and ts 06.09.19 (Torshizi), p185

210. Dr Febbo added that guidelines of this nature would be of great help to clinicians as they attempt to deal with what is a very difficult situation.[251]

211. As Dr Smith pointed out, applying a blanket approach to engaging with the deceased's family, especially given the close relationship he had with them, "*may not have been the only or wisest option*", noting:

> Even if the family were not able to be engaged in the development of the discharge plan, consideration could have been given to ensuring that they were aware of the elements of the plan and information about what options were available in the case of deterioration in his mental state.[252]

212. Dr Torshizi, Dr Smith, Dr Febbo and Dr Brett all agreed that it would not breach patient confidentiality to provide a patient's family with information about: emergency services; signs and symptoms to look out for that may indicate a deterioration in mental state; and advice that the risk of self-harm in the period following discharge from an inpatient unit is often elevated.[253]

213. In my view, the failure to take active steps to involve the deceased's family in his care was not only a lost opportunity, it was a significant omission.

Compliance with care coordination policy

214. At the time of the deceased's admission, his care was subject to an EMHS policy called "*Care Coordination in Mental Health*" which was endorsed in July 2016.[254]

215. In my assessment, the deceased's care during his admission to RPH was only partially compliant with that policy. Although some collateral history was obtained from the deceased's mother, his recovery and care plan was not developed collaboratively with the deceased's family, his GP or community health services.[255]

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[251] ts 04.09.19 (Febbo), pp89-90
[252] Exhibit 1, Vol. 1, Tab 24, Report - Dr Smith, p3
[253] ts 04.09.19 (Febbo), p88; ts 05.09.19 (Smith), p144; ts 05.09.19 (Brett), p163; and ts 06.09.19 (Torshizi), pp185-186
[254] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, Att. 5: Care Coordination in Mental Health
[255] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 66

216. Further, the following policy requirements were not complied with:[256]

i. A safety plan identifying early warning signs and triggers was not documented;

ii. The deceased's discharge summary was not sent to JCMHS;

iii. There is no evidence that either the deceased or his family was given any information about how to re-enter the previous level of care through a re-assessment process;

iv. No contact was made with receiving agencies, whereas the policy states that telephone contact is a "minimum" requirement; and

v. There is no evidence that a follow-up phone call was made to JCMHS, the service the deceased was supposedly being referred to.

Mental health care transfer summary

217. On the basis of Dr Torshizi's evidence, I find that the deceased's mental health care summary was suboptimal. The summary should have referred to the deceased's recent medication change and the fact that his medication needed to be reviewed. The summary does not record the deceased's recent ceased medications and does not refer to his safety plan. Further, there is a discrepancy in the deceased's formal diagnosis as between the mental health care summary and his discharge summary.[257]

218. It appears that there are no policies or guidelines that relate to how mental health care summaries should be completed. I agree with Dr Torshizi's view that clinicians would benefit from policy guidance in this area especially with respect to the proper documentation of medications, inclusion of the patient's safety plan and a reference to who the patient wants involved in their care.[258]

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[256] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 66
[257] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 117 and ts 06.09.19 (Torshizi), pp182-183
[258] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 119

Medication change

219. The dose of the deceased's medication was increased four days before his discharge in circumstances where his mood and suicidality continued to fluctuate. The usual practice is that medication changes are not made in the week prior to discharge.[259,260]

220. Even if I accept Dr Febbo's evidence that there can be clinical reasons why this practice is not always followed,[261] given the deceased's fluctuating mental state, Dr Torshizi must be right when he says that this should have made it:

> [I]ncumbent on the treating team to follow-up the patient more assertively, like making sure a referral was made and received by the Acute Treatment Team (ATT) of the Joondalup Community Mental Health Clinic for follow-up.[262]

221. The fact that the deceased was discharged without this safety net in place is a significant omission.[263]

Discharge planning

222. I agree with Dr Torshizi's assessment that in the deceased's case, there is: "*unsystematised, scattered discharge planning throughout the medical records*".[264] Further, as Dr Brett notes, the discharge planning process in the deceased's case does not comply with the standards for clinical care published by the OCP in 2015.[265,266]

223. Further, the discharge planning in the deceased's case did not comply with the requirements of the Discharge Policy,[267] which applied at the time of the deceased's admission to RPH, but which was revoked in March 2018.[268]

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[259] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, p120
[260] Exhibit 1, Vol. 1, Tab 34, Statement - Dr S Febbo, para 22 and ts 04.09.19 (Febbo), p119
[261] ts 04.09.19 (Febbo), pp120-121
[262] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 120 and ts 06.09.19 (Torshizi), para 183
[263] ts 06.09.19 (Torshizi), para 181
[264] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 93
[265] Exhibit 1, Vol. 1, Tab 24, Report - Dr Smith, p3
[266] See for example: Exhibit 1, Vol. 1, Tab 26, Chief Psychiatrists Standards for Clinical Care, para 3.1.2
[267] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, Att. 4: *Discharge Planning in Mental Health Services*
[268] ts 06.09.19 (Paljetak), p262

224. The Discharge Policy requires that the patient's personal support person must be involved in the discharge planning process unless the patient's consultant reasonably believes this is contra-indicated or the patient refuses consent.[269] Significantly, the Discharge Policy provided that where it is considered that:

> [C]linically there is a risk to the patient or to others in not informing a personal support person of details of the patient's discharge plan, information may be provided to these parties **without patient consent**.[270] (emphasis added)

225. In my view, this section of the Discharge Policy applied directly to the deceased, especially given the fact that his chronic risk of self-harm was noted in the clinical review conducted prior to his discharge.[271]

226. It is difficult to understand why, in those circumstances, his family were not informed of key elements of his discharge plan, even if the deceased's position about the involvement of his family was as recalled by Dr Febbo or Dr Afroz.

227. I have already made comments about the involvement of the deceased's family in his care and I repeat those comments with respect to the planning process for his discharge.

228. In my view, a more concerted effort should have been made to involve the deceased's family in the development of his discharge plan. I agree with Dr Brett's observation that:

> Ideally, a discharge planning meeting should have occurred with Mr Strange, his community team and anyone else he wanted included. Ideally his carers would have been involved in this meeting. This did not occur.[272]

[269] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, Att. 4: *Discharge Planning in Mental Health Services, pp1-2*
[270] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, Att. 4: Discharge Planning in Mental Health Services, p2
[271] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes, (28.11.16)
[272] Exhibit 1, Vol. 1, Tab 22, Report - Dr Brett, p8

229. It seems almost certain that if a discharge meeting had been held (with or without the deceased's family) the fact that none of the planned referrals to external agencies had been properly made would have been identified and, presumably, addressed.

230. The Discharge Policy relevantly provided that a patient being discharged must receive a signed discharge summary that includes:

i. contact details of emergency services;

ii. out of hours contact numbers and other support services including the Mental Health Emergency Response Line;

iii. appointment time and date with the community mental health service **written on an appointment card** (emphasis added);

iv. information on the process of re-entry to the relevant health service if needed; and the name of the mental health clinician or care coordinator.[273]

231. The discharge summary provided to the deceased did not comply with any of these requirements and it should have.[274,275,276]

232. Dr Afroz says she told the deceased to make an appointment with his GP a week after discharge for follow-up, but that:

> There was nothing I was particularly looking for the GP to do because Paul was being referred to Joondalup (JCMHS). The idea behind the appointment was so that Paul could touch base with his GP.[277]

233. I am troubled by the assertion that the treating team saw no specific role for the deceased's GP after the deceased had been discharged.

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[273] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, Att. 4: Discharge Planning in Mental Health Services, p5
[274] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes, Discharge summary (28.11.16)
[275] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, Att. 4: Discharge Planning in Mental Health Services, p5
[276] ts 06.09.19 (Torshizi), p188
[277] Exhibit 1, Vol. 1, Tab 35, Statement - Dr R Afroz, para 43

234. During the deceased's admission, he was prescribed quetiapine to reduce his anxiety and impulsivity, stabilise his mood and to assist with his depression.[278] On discharge, the deceased was only given enough quetiapine for 10 days.[279]

235. Therefore, an obvious role for the deceased's GP would have been to review the deceased's medication and/or to ensure this review had been completed by JCMHS. There is no evidence that any member of the deceased's treating team contacted his GP to discuss his discharge or to advise that the deceased was being discharged with only enough quetiapine for 10 days.

236. The instruction to the deceased to make an appointment with his GP was not mentioned in his discharge summary,[280] and it clearly should have been. It is unclear whether the deceased was asked if he had made an appointment with his GP during the follow-up call made by Mr Voight on 30 November 2016.[281]

237. Dr Afroz says she told the deceased he had been referred to CCI for psychotherapy and that he had been referred to JCMHS for follow-up.[282] Whilst the former referral was made, the latter was not. As I have noted, there is no evidence that any referral was made to JCMHS, and I conclude that no such referral was made.[283]

238. In this case, there was confusion about who was responsible for attending to referrals to external agencies. Dr Febbo thought it was the responsibility of his registrar (who he thought might delegate the task the team's RMO).[284] Dr Afroz thought the referrals would be done by Dr Lynott, the RMO who wrote the discharge summary.[285] Dr Lynott thought Dr Afroz was responsible.[286]

239. In the end, in the midst of all of this confusion, nobody made the referrals.

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[278] ts 04.09.19 (Febbo), p112
[279] Exhibit 1, Vol. 2, Tab 1, RPH In-patient notes, Hospital prescription (28.11.16)
[280] Exhibit 1, Vol. 2, Tab 1, RPH Discharge summary (28.11.16), p2
[281] Exhibit 1, Vol. 1, Tab 32, PSOLIS entry (30.11.16: 12.40 pm)
[282] Exhibit 1, Vol. 1, Tab 35, Statement - Dr Afroz, para 42
[283] ts 06.09.19 (Torshizi), p181
[284] ts 04.09.19 (Febbo), p95,
[285] Exhibit 1, Vol. 1, Tab 35, Statement - Dr Afroz, para 46
[286] Exhibit 1, Vol. 1, Tab 31, Statement - Dr F Lynott, para 11

240. Dr Afroz acknowledged that with the benefit of hindsight, she should have provided greater support to Dr Lynott. However, to be fair, Dr Afroz was busy reviewing all of the patients admitted to Ward 2K over the weekend and simply did not have the time to do this.[287]

241. As Dr Torshizi pointed out:

> The policies at the time were vague about who would be the responsible person for the post-discharge follow-up, including sending the Discharge summary and the Mental Health Care Transfer Summary.[288]

242. On the issue of better defining roles and responsibilities during the discharge process, Dr Torshizi recommended that:

> The policies be more explicit about the roles and responsibilities of staff, both clinical and non-clinical, in relation to the Discharge summary and the Mental Health Care Transfer Summary.[289]

243. I agree with this suggestion and note that Dr Tabasum (an RMO on Ward 2K at the relevant time) also thought that clarification of responsibilities was a very good idea.[290] In any event, if as has been pointed out, a discharge planning meeting (attended by all relevant people) had been held, any issues with referrals could have been identified, regardless of who was actually responsible for making them.[291]

244. As to the treating team's failure to contact JCMHS, I note Dr Torshizi's observation that community mental health services have different clinical teams and it is important to ensure that the patient being referred is allocated to the appropriate team. In this case, the deceased should have been referred to the Acute Treatment Team at JCMHS within 24 – 48 hours of his discharge.[292]

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[287] ts 06.09.19 (Afroz), p225
[288] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 122
[289] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 122
[290] ts 04.09.19 (Tabasum), p60
[291] ts 05.09.19 (Brett), p169
[292] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 121

245. Further, the deceased should have been given an appointment card with the date and time of his first appointment with JCMHS.[293] However, unless the deceased's treating team had actually made contact with JCMHS, there would be no way of knowing whether or not the referral was appropriate and had been accepted.[294,295]

246. As occurred with the CCI referral, there is always the possibility that an agency is unable to accept a referral and alternative arrangements may need to be made. Obviously, alternative arrangements cannot be made when contact has not been made with staff at the receiving agency before the patient is discharged.[296]

247. As the standards for clinical care published by the OCP in 2015 point out:

> The referring service retains the responsibility for the consumer until handover to the receiving service or practitioner or the consumer decides on an alternative process.[297,298]

248. As I have noted, the deceased's care was not handed over to any other service or practitioner, before or after his discharge. Instead, the deceased was discharged into the care of his parents with no follow-up arrangements, in circumstances where his family had not been given even the most basic of safety information. This is perhaps the most serious of all of the omissions in the deceased's care at RPH.

249. In my view, the discharge process should be amended so that it is not possible to discharge a mental health consumer until all referrals, especially those to external agencies, have been finalised. This could be achieved by a checklist being added to the discharge summary form on the NaCS system, where the person drafting the summary would have to verify that the referrals had been made and appointments obtained, before the discharge summary could be printed off.[299]

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[293] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 121
[294] See discussion with Dr Brett on this point: ts 05.09.19 (Brett), pp166-167
[295] See also: ts 05.09.9 (Smith), p147
[296] ts 05.09.9 (Smith), p140
[297] See for example: Exhibit 1, Vol. 1, Tab 26, Chief Psychiatrists Standards for Clinical Care, p22, pt 5
[298] ts 05.09.9 (Smith), p141
[299] See: ts 05.09.9 (Smith), p147 and ts 05.09.9 (Brett), p174

250. The question of whether there should be a standard format for discharge summaries in Western Australia was the subject of evidence at the inquest. Whilst there may be some merit in a standard format the preponderance of the evidence was to the effect that the quality of the discharge summary (in terms of the information it conveys) is far more important than the format of the document.[300]

Follow-up phone call on discharge

251. One explanation for the practice of making follow-up calls within seven days of a patient's discharge could be the fact that, as I have just noted, the referring service retains responsibility for the consumer until their care has been appropriately handed over to the receiving service or practitioner.[301]

252. Another explanation pointed out Dr Brett is that these follow-up calls are part of each hospital's key performance indicators (KPI).[302] Clearly, this KPI is not satisfied merely by making the call. The quality of the call, in terms of the issues canvassed with the person who has been discharged is obviously critical.

253. I agree with Dr Smith's observation that whilst it would be best if the call is made by someone who was involved in the patient's care, the content of the call is much more important than the person who actually makes it.[303]

254. In this case, the PSOLIS entry regarding the follow-up call made to the deceased is clearly inadequate. The entry provides no basis on which the quality of the content of the call can be assessed.[304]

255. For example, was the deceased's mental state assessed, was he asked whether he had made an appointment with his GP and so on.

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[300] See for example: ts 05.09.9 (Brett), pp167-168 and ts 06.09.9 (Torshizi), p187
[301] Exhibit 1, Vol. 1, Tab 24, Report - Dr G Smith, p3
[302] ts 05.09.9 (Brett), p174
[303] ts 05.09.9 (Smith), p150
[304] Exhibit 1, Vol. 1, Tab 32, PSOLIS entry (30.11.16: 12.40 pm)

256. Dr Brett said that the PSOLIS system is unwieldy and difficult to use and there were issues with accessing the information it stores. He noted that another system, BOSSnet also had some issues but that the information it contained was more accessible. In the end, Dr Brett made the sensible point that it would be helpful if all health services used the same electronic system, whether that was BOSSnet or some other system.[305]

257. Clearly it would be appropriate for staff who are required to make these follow-up calls to be given guidance as what matters should be addressed during the call and further, the importance of making a sufficiently detailed notation of the call should be reinforced.

258. That guidance could include a requirement to detail the patient's mental state and risk, what care arrangements have been made, whether the agencies the patient has been referred to have been in contact, and if not, what alternative arrangements need to be considered.[306]

Training for new staff

259. Ensuring that hospital staff are familiar with relevant policies is a constant challenge. Dr Brett made some helpful practical suggestions about how to address this issue including: handing new staff a list of the top 10 policies they should be aware of and discussing key policies (including any changes to those policies) at regular team meetings.[307]

260. Dr Brett also emphasised the important mentoring role that consultants can play in ensuring that clinical staff have a good working knowledge of relevant policies.[308]

261. At the relevant time, there was no regular refresher clinical training available to staff with respect to discharge planning and/or the discharge of patients from a mental health unit. That is still the situation.[309]

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[305] ts 05.09.19 (Brett), pp172-173
[306] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 123
[307] ts 05.09.19, (Brett), p170
[308] ts 05.09.19, (Brett), p171
[309] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 103

262. However, Dr Torshizi said he was aware that a "*policy awareness document*" is currently being formulated. This would require team leaders to attest to the fact that their staff have undertaken training in relevant policies.[310] In my view, this is a positive development and should be implemented without delay.

263. Dr Torshizi (with whom Dr Smith, Dr Brett and Dr Febbo agreed)[311] suggested that new staff (including allied health staff) should receive training in how to appropriately plan a patient's discharge and how to make effective and timely referrals.[312] Dr Smith observed that the time allocated for staff development was often limited and suggested that time should be set aside for staff to familiarise themselves with relevant policies.[313]

264. In my view, these suggestions make a great deal of sense, particularly given that in this case, Dr Afroz said she was unaware of the Discharge Policy at the time of the deceased's discharge.[314]

Managing risks for 'out of area' patients

265. As I have mentioned, the fact that the deceased was admitted to a hospital that was out of the catchment for his local community mental health service raised a number of potential risks including miscommunication and interruption of care.[315]

266. In light of those risks, a far more assertive referral process should have occurred, so as to ensure that before the deceased left RPH, he had an appointment with JCMHS.

267. Dr Smith observed that:

> Rates of suicide are much higher amongst people who are out of area placements than people who find services within their own area.[316]

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[310] Exhibit 1, Vol. 1, Tab 36, Report - Dr Torshizi, para 103
[311] ts 05.09.19, (Brett), p170; ts 05.09.19, (Smith), p151; and ts 04.09.19, (Febbo), p113
[312] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 125
[313] ts 05.09.19, (Smith), p152
[314] ts 06.09.19, (Afroz), pp225-226
[315] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 126
[316] ts 05.09.19, (Smith), p134

268. Dr Torshizi referred to a new mental health emergency service which will begin operating at RPH on 16 October 2019. The service consists of eight inpatient beds and the risk of admitting 'out of area' patients is being addressed by the creation of the role of 'community integration nurse'.[317]

269. It is anticipated that this innovation will help ensure that patients admitted to the service (especially those admitted 'out of area') are appropriately linked to community services, before they are discharged.[318]

270. I agree with Dr Torshizi's suggestion that:

> [T]his role be extended in the future to cover discharges from psychiatric inpatient wards like Ward 2K. This role can further, in the future, be developed into a new "Post Discharge Follow-up Team" on its own to bridge the gap that still exists between patient's discharge from our service until they are picked up by the receiving service, especially in the case of out of area admissions.[319,320]

271. Ironically, Dr Febbo said that when he was a registrar, a nurse was employed specially to manage these types of issues.[321]

Root cause analysis

272. Following a critical incident, RPH generally investigates the matter to determine whether clinical improvements are required. This process is referred to as a root cause analysis.

273. In the deceased's case, a clinical incident management form was "*inactivated*" on 6 February 2017. The comment in the "*further details*" section of that form states:

> [C]ase reviewed clinicians unable to identify harm specifically caused by health care workers. Adherence to 7-day follow up policy occurred. PMR requested – should any further information come to our attention, happy to review and reopen incident.[322]

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[317] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 127 and ts 06.09.19, (Torshizi), pp188-189
[318] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 127 and ts 06.09.19, (Torshizi), p188
[319] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 127 and ts 06.09.19, (Torshizi), p188
[320] Dr Brett also agreed that this would be a good idea, see: ts 05.09.9 (Brett), p175
[321] ts 04.09.19, (Febbo), p114
[322] Exhibit 1, Vol. 1, Tab 33, Clinical incident management form, p1

274. Dr Torshizi confirmed that the root cause analysis of the deceased's case had been re-opened in August 2019 and that in his view, this was: "*another move in the right direction*".[323]

275. I agree with that assessment but would add that the deceased's case should have been the subject of a clinical investigation at the time of his death. Had that occurred, the omissions I have detailed in this Finding would have been detected at a much earlier stage.

276. During the inquest, I was told that the results of the root cause analysis are expected in the next few weeks and counsel for the EMHS undertook to provide a copy of that analysis to the Court.[324]

277. By email dated 27 September 2019, counsel for the EMHS provided the Court with a draft of the EMHS clinical incident investigation report relating to the deceased's death. The conclusions in the draft report are broadly in accordance with the findings I have made. Counsel's email advised that the final version of the report will be provided to the Court as soon as it has been finalised.[325]

Alteration of discharge summary

278. Once discharge summaries are completed they must be "finalised" on the NaCS system. In cases where this administrative step is missed, a report of 'unfinalised' summaries is generated and forwarded to the relevant registrar for attention.[326]

279. Shortly before the inquest, it emerged that the deceased's discharge summary had been amended by Dr Lynott, prior to the deceased's discharge. That amendment appears to have been required to correct an error in the deceased's prescribed and ceased medications.[327]

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[323] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, para 128 and ts 06.09.19, (Torshizi), p179
[324] ts 06.09.19 (Torshizi), p193 and ts 06.09.19 (Paljetak), p263
[325] Email to the Court from Ms Paljetak, counsel for EMHS (27.09.19)
[326] ts 06.09.19, pp233-234
[327] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, paras 104-106

280. The deceased's discharge summary was brought to the attention of Dr Afroz after his death, because it had not been finalised on the system. Dr Afroz completed this administrative step on 27 March 2017.[328]

281. Although nothing appears to turn on the matter, it would have been preferable for a note to be placed on the finalised discharge summary explaining when, why and by whom the administrative step of finalisation had been made. Dr Afroz agreed that this was a good idea.[329]

[328] Exhibit 1, Vol. 1, Tab 36, Report - Dr S Torshizi, Att. 9 & ts
[329] ts 06.09.19, (Afroz), pp234-235

COMMENTS ON QUALITY OF CARE

282. On the basis of Dr Smith's opinion, I have concluded that the treatment and care provided to the deceased during his admission to JHC from 9 – 10 November 2016 was adequate.[330]

283. However, in my view, it is very unfortunate that because of a lack of beds, the deceased could not be admitted to the mental health unit at JHC.

284. The deceased was clearly very unwell when he was admitted to RPH on 11 November 2016. That much is obvious from the fact that Dr Febbo instructed that if the deceased tried to leave RPH contrary to medical advice, then consideration would be given to making him an involuntary patient under the MHA.[331]

285. During his admission to RPH, the deceased was appropriately involved in occupational therapy groups and received psychological counselling. His medication was reviewed and when his mental state did not improve, he was placed on a different antidepressant, which seemed to improve his mood, at least initially.

286. From that limited perspective, the deceased's treatment at RPH can be said to have been appropriate.[332]

287. However, as I have outlined, there are a number of areas where the deceased's treatment was unacceptable. First, the deceased's safety plan should have been clearly documented in his inpatient notes.

288. Next, the deceased's reported reluctance to have his family involved in his treatment and care should have been documented. This issue should have been revisited during the deceased's admission, particularly given the fact that his were demonstratively engaged and supportive and the fact that the deceased was to be discharged into his parent's care.

[330] Exhibit 1, Vol. 1, Tab 24, Report - Dr G Smith, p1
[331] Exhibit 1, Vol. 2, Tab 1, RPH Inpatient notes (11.11.16)
[332] Exhibit 1, Vol. 1, Tab 24, Report - Dr G Smith, p2

289. The deceased's discharge plan was barely adequate on its face and did not contain a reference to follow-up by his GP. The real problem however, is that the deceased's discharge plan was simply not enacted.

290. There is no evidence that any referral was ever made or sent to JCMHS and the deceased only appears to have been told verbally to arrange an appointment with his GP. The failure to enact the deceased's discharge plan is a critical omission and meant that the deceased was discharged without any follow-up.

291. Further, at the time the deceased was discharged, his family were not given basic safety information (e.g.: signs to look out for, who to contact in an emergency etc.), nor was any member of the deceased's family told that patients are known to be vulnerable in the period following discharge and that they should be especially vigilant for any signs of a deteriorating mental state.[333]

292. Even if I accept that the deceased had said he did not want his family involved in his care, Dr Febbo agreed that information of the kind described above, could have been conveyed to the deceased's family in those circumstances.[334]

293. As I have identified, the overall quality of the deceased's RPH inpatient notes was less than satisfactory. His safety plan was not documented, his reported instructions about limiting the involvement of his family in his care were not documented and the record of the deceased's mental state assessment following his reported self-harm attempt on 15 November 2016 is inadequate.

294. It is my view that when viewed globally, the various omissions to which I have referred mean that the deceased's care at RPH was suboptimal. There is no way of knowing whether the outcome in the deceased's case would have been different had appropriate follow-up arrangements been made prior to his discharge. However, it is obvious that this should have occurred, and the fact that it did not is regrettable.

[333] ts 05.09.19, (Smith), p142
[334] ts 04.09.19, (Febbo), p88

RECOMMENDATIONS

295. In light of the observations I have made, I make the following recommendations:

Recommendation No.1

EMHS consider amending its Care Coordination in Mental Health policy to include a requirement that prior to discharge, mental health consumers are handed a card showing the date and time of all of the appointments that have been arranged with the services they have been referred to.

Recommendation No.2

EMHS consider amending its Care Coordination in Mental Health policy to include a requirement that all discharge summaries issued to mental health consumers must contain: contact details of emergency services; out of hours contact numbers and other support services including the Mental Health Emergency Response Line; details of the appointments made with any service or agency the patient is being referred to (this is in addition to, not in lieu of the appointment card referred to in Recommendation 1); information on the process of re-entry to EMHS (or other relevant health service) if needed; and the name of the mental health consumer's clinician or care coordinator.

Recommendation No.3

EMHS consider amending its discharge procedure so that, except in exceptional circumstances, it is not possible to either print off a mental health consumer's discharge summary, or to discharge that consumer until appointments have been made and an appropriate handover of information has occurred, with all of the services that the consumer is being referred to on discharge.

Recommendation No.4

EMHS consider developing strategies to ensure that clinical and non-clinical staff are familiar with key policies. Those strategies might include handing new staff a list of the top 10 policies they should be aware of and discussing key policies (including any changes) at regular team meetings.

Recommendation No.5

EMHS examine the feasibility of establishing a post discharge follow-up team, especially with respect to 'out of area' admissions, to bridge the gap between the point when a mental health consumer is discharged from an EMHS inpatient service and the point when that consumer is accepted by the receiving service.

Recommendation No.6

The Office of the Chief Psychiatrist consider issuing guidelines as to what communications can be had with a mental health consumer's family or support person in circumstances where a competent and voluntary consumer refuses to have their family or support person involved in their care. Consideration should also be given to issuing an abridged version of any guidelines that are published, as a practice note.

296. I note that the Court sent a copy of my recommendations in draft form to all counsel by email dated 13 September 2019.[335] Counsel were asked to provide me with any comments with respect to the draft recommendations by the close of business on 27 September 2019.

297. Counsel for Dr Afroz advised his client had no comments.[336] Counsel for Joondalup Hospital Pty Ltd provided a comment with respect to recommendation 6.[337] Counsel for the EMHS provided a comment with respect to recommendations one, two and three.[338]

[335] Email from the Court to counsel (13.09.19)
[336] Email, Mr Denman (24.09.19)
[337] Email, Mr Langham (26.09.19)
[338] Email, Ms Paljetak (27.09.19)

CONCLUSION

298. The deceased was a much loved son, brother, uncle and friend who was 30-years of age when he died from ligature compression of the neck (hanging) on 9 December 2016.

299. This case highlights the difficulties of managing the ever-changing risk of suicide and self-harm associated with some mental health illnesses.

300. Where, as was said to be the case in this matter, the mental health consumer places limits on the information about their care that family members can be given, that person's treatment and care necessarily becomes more complicated. However, in those circumstances, the importance of providing the consumer's family with basic safety information assumes an even greater significance.

301. The deceased's RPH discharge plan, which was barely adequate on its face, was not enacted. This left the deceased without any follow-up at an incredibly vulnerable time. Further, for the reasons I have explained, it is my view that when viewed holistically, the deceased's treatment and care at RPH was suboptimal. Greater efforts should have been made to involve the deceased's obviously loving and supportive family in his care.

302. Given the imponderables in this case, it is impossible to know whether any particular action at any particular time would have prevented the outcome in this tragic case. I am therefore unable to conclude that any of the errors and omissions I have identified caused the deceased's death.

303. I have made six recommendations that I hope will enhance the service provided to mental health consumers using services provided by EMHS. It is my sincere hope that the changes I have recommended will provide the deceased's family and friends with some solace for their dreadful loss.

MAG Jenkin
Coroner
27 September 2019