IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2012 4865

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

Section 67 of the Coroners Act 2008

Deceased:	**GERARD HELLIAR**
Delivered on:	18 April 2018
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	16, 17, 18 and 19 November 2015
Findings of:	**CORONER PETER WHITE**
Representation:	Mr R Goldberg appeared during the inquest for Peninsula Health. Submissions were received on 5 March 2018, through the good offices of Ms A Salter, now corporate counsel for Peninsula Health. Mr C Wilson, the deceased's brother, represented the family of Gerard Helliar.
Assisting the Coroner:	Sergeant D Dimsey, Police Coronial Support Unit.

Catchwords: Suicide in Psychiatric Hospital by a long term patient who had earlier received in excess of 200 unilateral and bilateral ECT treatments, the latter of which followed his involuntary admission and were undertaken over his objection. Application of the Victorian Charter on Human Rights and Responsibilities Act, 2006.

I, PETER WHITE, CORONER, find that the identity of the deceased was GERARD HELLIAR, born on 31 March 1950, and that death occurred on 16 November 2012, at Frankston Hospital,

from: **1 (a) Cerebral ischaemic injury due to hanging,**

In the following circumstances:

BACKGROUND

1. Gerard Helliar (Gerard) was 62 years of age at the time of his death. Gerard had been diagnosed with bipolar affective disorder in 1994.[1] Thereafter he was treated at Frankston Hospital, as both an outpatient and an inpatient, during which period he had received in excess of 200 electro convulsive therapy treatments. (ECT) [2]

2. Gerard's applicable Community Treatment Order (CTO) was revoked on 4 September 2012, due to his then deteriorating mental health, suicidal thoughts and suicidal behaviours and he was held at Ward 2b (West), Frankston Hospital as an involuntary patient. He remained as an involuntary patient until 7 November 2012, when he self-harmed by hanging.

3. He died at the Hospital on 16 November 2012, after a decision was made to take him off life support.

4. The statement from Gerard's GP, Dr Andrew Taylor, which had earlier supported the revocation of the CTO advised that, *Gerard had extremely severe and treatment resistant*

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[1] Bipolar Disorder is a mood disorder characterised by episodes of mania and depression. He was diagnosed and had been treated at Frankston Hospital over an 18 year period prior to his death. See exhibit 2 page 1-2 and exhibit 3(a) at page 1.

[2] See evidence of Dr Carmen Peavey, Consultant Psychiatrist and Director of ECT at Peninsula Health at paragraph 97 below.

mental illness and was often non-compliant with medication even when closely monitored by treatment providers. [3]

5. A difficulty expressed by Gerard's treatment providers was that he could rapidly switch from depression to mania. He had significant risk factors during both his manic and depressive episodes, with the risk of aggression and poor financial management during mania, [4] and the risk of self-neglect and suicidal ideation during depression.[5]

6. On 18 September 2012, the Mental Health Review Board established under the Mental Health Act (MHA) 1986, confirmed an involuntary treatment order placing Gerard under the care of Psychiatrist, Dr Binta Sharma. Specifically the Mental Health Review Board convened at Frankston Hospital, and pursuant to Sections 8 and 35 of the MHA determined that the continued treatment of Gerard as an involuntary patient was necessary and,

   that the authorised psychiatrist has prepared, reviewed or revised the patient's treatment plan in accordance with the Act and that, the treatment plan is capable of being implemented.[6]

7. The application document was prepared by Dr Mahammad Alam, a psychiatric registrar who had been engaged in providing treatment to Gerard, and named Dr Benita Sharma as the monitoring Consultant Psychiatrist. I note here that the application stated that Gerard was not able to give informed consent and had limited contact with his family, and that, family members were not involved in treatment decisions. Rather the treatment plan had been discussed with Gerard's, close friend and house mate WG. [7]

8. As to the nature of that plan see further discussion below under Comment.[8]

9. The application noted Gerald's opposition to continued ECT. It went on to state that (he), *does not agree with his diagnosis but his ability to provide informed consent can vary depending on his mental state, he does not agree with ECT despite this being historically*

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[3] Letter from Frankston Healthcare exhibit 11 page 10.
[4] Ibid.
[5] Exhibit 11 page 141.
[6] The Mental Health Review Board determination was located in the medical records and for completeness is now added as exhibit 11(a).
[7] WG was a former patient in Ward 2b.
See also conflicting evidence touching on his family availability at paragraphs 33-40.
[8] See Comments from paragraph 316 below.

the most effective treatment for his Bipolar illness. Historically (he) has poor insight and poor compliance with treatment. [9]

10. As above, apart from one outing in the company of a friend, Gerard remained an inpatient treatment at Ward 2b Frankston Hospital until he self-harmed on November 7.

Inquest Focus

11. Two primary questions were identified for consideration prior to the commencement of the inquest.

a) Treatment

12. On admission to Frankston Hospital psychiatric ward on 4 September 2012, Gerard was assessed as a high risk of suicide.[10] A formal risk assessment indicated that he was expressing suicidal ideation and intent, with an identified plan. Due to his high risk rating he was placed on 15 minute observations. As above Gerard had been previously admitted to the psychiatric ward on numerous occasions since 1994, and received a total in excess of 200 ECT treatments, both while an outpatient and as an inpatient.[11]

13. The treatment plan on admission, (later adopted by the Mental Health Review Board), was to conduct a physical examination, administer regular medications and consider an alternative mood stabiliser.

14. It was also further intended to monitor mental state and risk, and again introduce ECT, while seeking an external opinion regarding the efficacy of such therapy. This external opinion was obtained at the request of Dr Sharma who was concerned about Gerard's medical history and his ongoing opposition to the plan. Her evidence is considered below commencing at paragraph 39.

15. The Director of the ECT Unit, Consultant Psychiatrist, Dr Carmel Peavey also supported this request as she was also concerned about the number of previous ECT treatments and Gerard's ongoing objection. Dr Peavey's evidence is reviewed from paragraph 92 below.

16. The external opinion was obtained from Consultant Psychiatrist, Professor Daniel O'Connor on 9 October 2012. Professor O'Connor, *supported the continuation of ECT as*

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[9] The Report on Involuntary Status prepared for the Mental Health Review Board, see exhibit 11 pages 144-48.
[10] Statement of Dr Sharma exhibit 3. This same review prepared by psychiatric registrar Dr Alma, was included as the treatment plan, and later formed the basis of the Mental Health Tribunal Order discussed above.
[11] The figure of 210 as the number of Gerard's earlier ECT treatments was not disputed by Peninsula Health.

a reasonable and necessary treatment option due to the severity of his illness and poor compliance and response to treatment.[12] His assessment of Gerard, which I note was addressed to Dr Peavey, is reviewed below commencing at paragraph 72.

17. This additional inquiry was later extended to include testing by a neuro-psychologist, so as to provide for the administration of a depression rating scale both before and after ECT, this to seek to monitor his response to that treatment. Neuro-psychological testing was conducted, on 15 October 2012 by Ms Anna Ciotta, who coincidentally had also reviewed Gerard, in a home setting in 2005. Discussion of Ms Ciotta's evidence commences below at paragraph 76.

18. During the initial inpatient admission Gerard was commenced on a mood stabiliser, sodium valproate, and continued on the antipsychotic medications, olanzapine and paliperidone.

19. Gerard continued to express his strong disapproval of any plan, which allowed for further ECT treatment. Gerard was initially reviewed twice weekly by Dr Sharma, which was reduced to once weekly. [13] His last medical review and risk assessment conducted by Dr Sharma, occurred on 31 October 2012. At this time Gerard expressed that, *he would like to die but would not do anything to actively end his life.* [14]

20. His next review with Dr Sharma was to occur on 7 November 2012, the day of his hanging, and did not take place.

21. From a consideration of this material, questions arose as to the decision to continue with ECT against Gerard's wishes and without consultation with his family and whether appropriate protocols existed at that time, and exist now, to support informed decision making on that issue.

b) Supervision

22. On 7 November 2012, Gerard was being managed in the Ward 2b west, low dependency area (LDA) on hourly observations, (having been admitted as an involuntary patient approximately two months earlier). The medical records indicate that nursing staff were conducting twice-daily, structured risk assessments utilising the Acute Inpatient Risk

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[12] Exhibit 5(a).

[13] See Dr B Sharma's statement at exhibit 3.

[14] Ibid paragraph 12.

Assessment Tool, as well as documenting in some instances, limited information about Gerard's mental state. On some occasions within this period, mental state assessments were not able to be completed.

23. Gerard denied any active suicidal intent when asked by nursing staff during morning and afternoon reviews, but nursing notes from 4 November 2012 indicate,

no current plan or thoughts to suicide, although this is incongruent with his presentation.[15]

24. On 5 November 2012, nursing notes indicate that Gerard guaranteed his safety on the ward but was concerned about discharge and that he was observed to be expressing, *hopelessness and a sense of failure.*

25. On 6 November 2012 nursing notes indicate that Gerard denied any suicidal ideation but felt as if he, *had no future*.

26. On the Acute Inpatient Risk Assessment Tool from 1 November 2012 until 3 November 2012, Gerard was rated as low risk of suicide. From 4 November until 6 November 2012, Gerard was rated as medium risk of suicide. On the morning shift on 7 November 2012, his contact nurse was Alison Boyte. At an unknown time she recorded in the nursing progress notes and on a risk assessment tool, that Gerard was now rated as, a *low risk of suicide*.

27. The circumstances in which these reviews were conducted and the fact that in some instances, including 7 November, mental state assessments were not able to be undertaken, is examined below commencing within Nurse Boyte's evidence from paragraph 185.

28. Nurse Boyte's departure from the Hospital before the conclusion of her shift, while being the contact nurse for Gerard and other patients, is also relevant.[16]

29. I note that visual observation charts in the medical records indicate that the frequency of Gerard's visual observations were hourly from at least 8 am on 5 November 2012 until the time of his death. Registered Nurse, Justin Jose was responsible for the visual observations of patients from 3pm on the afternoon of 7 November 2012. He observed Gerard at 3.00pm

[15] Notes of Nurse John Christenson at exhibit 11 page 159. See similar observations concerning his low mood and affect, made later that day by Nurse S Graves.
[16] Transcript 157.

in the corridor, answering questions in response to patient SL, and documented this event. [17]

30. At Around 3.20pm, Nurse Jose entered the room occupied by Gerard, looking for his room-mate. He found Gerard hanging on the bedroom side of the toilet door and initiated an emergency response.

EVIDENCE

Kate Campbell

31. Ms Campbell stated that,

Dad was diagnosed with Bipolar disorder and had been receiving treatment for the last 20 years, with numerous stays in psychiatric wards during that time… He was placed in Frankston ward 2 West on 4 September 2012, as a result of his Community treatment Order being revoked. Dealing with Dad's illness strained our relationship with him at times, resulting in my sister and me distancing ourselves from him in later years. I would speak quite frequently to him on the phone although visits were much less frequent. My sister and I tried to visit Dad in hospital with our children about a month before he passed away, but unfortunately we missed him as he was out with his friend, WG.

32. *At 3.21 pm on 3rd November 2012, I had a missed call from Dad, and he left a message saying… "(giving details of his will and his solicitors), concluding with Do your best, I love you Kate, bye bye. I have written this thing in the hospital". This didn't alarm me as he had discussed as he had discussed Will amendments with me on numerous occasions over the years. Also as he was in hospital I felt assured he was in safe hands. At approximately 3.00 pm on 7 November 2012, I had another missed call from Dad. I listened to the message he left (at around 4 pm) but he was talking quietly and it was difficult to hear clearly...The part that I did hear was that he loved Gemma and I very much and that he was sorry. I then deleted the message not thinking too much about it. A short time later I received a call I received a call from Dr Binita Sharma, Dad's Doctor at 2 west… I later spoke to the ICU… the Doctors told me Dad had hung himself... Over the next 9 days my sister and I continued to visit Dad in hospital… He was heavily sedated… On 16 November a decision was made to take him off life support… He passed away very quickly that afternoon. Dad had for a long time suffered from mental illness…*

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[17] See his statement at exhibit 6(c) and testimony from transcript 148. His further evidence was that his role did not include substituting as Gerard's contact nurse, (following Nurse Boyte's departure).

33. *Dad's issues progressively got worse from my late teens, and it was in the early to mid, 90's when I first remember him going into a psychiatric ward… From then on the Hospital stays became a regular occurrence. It was a roller coaster of highs and lows, and during his episodes of mania, he could be very unreasonable and argumentative… I found it progressively harder to give him the energy and support he wanted…*

34. *Over the last few years he was experiencing fewer high episodes and more prolonged periods of depression. Although there were many factors contributing towards his low moods, he consistently told me how much he hated having the ECT. As he was an involuntary patient this could be forced upon him without his consent. He would regularly call me after an ECT session, very distressed and confused. This would last for about a day but left his long term memory more permanently affected. I believe he received over 100 treatments of ECT… Naively I thought the Doctors really new best and that I probably wouldn't have much say in his treatment plan so I never followed this up with his Doctors… he'd talked about it (suicide) so many times in the past but never actually acted upon it… I especially felt that he was safe and protected from harm during his hospital stays under the care of psychiatric staff.* [18]

35. In oral testimony Ms Campbell was shown a document purporting to be her father's will, dated 5 October 2012.[19] She agreed that the arrangements set out in the will were similar to the arrangements Gerard had discussed with her during the phone conversation on 3 November.

36. Ms Campbell confirmed that she had never had occasion to discuss her father's treatment with his doctors.

37. **Q**. *Did you have an idea that his condition appeared resistant to treatment, that his doctors were having great difficulty in finding an appropriate course of medication or indeed any other course which would assist him?*

    Ans. *Yes, I did realise that.*

38. **Q**. In regard to ECT did your father discuss that with you?

    Ans. *Yes he did… He would often discuss with me how much he hated having it… and how much it effected his mental capability and mental function… and he would call me after his*

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[18] Exhibit 2 page 1-2.
[19] See exhibit 2(a).

session and he was very distressed and upset and confused… so yeah on many occasions he discussed it with me and the problems he saw with it. [20]

Dr Benita Sharma

39. Gerard's CTO was revoked by Dr Thorley, who was his psychiatrist in the community, as his mental health was found to have deteriorated and he was having suicidal thoughts.

40. Dr Sharma treated Gerard at Frankston Hospital following his admission on 4 September 2012. She stated,

(Gerard's) primary condition was bipolar mood disorder. During this admission, the effect of his bipolar mood disorder was depressive at first, but at times it would fluctuate between depressive and manic. This is referred to as mixed.

(Gerard's) bipolar mood disorder was very difficult to treat because,

It was very severe within the spectrum of the illness;

*It was treatment resistant-and in this regard, the most effective treatment was ECT, a treatment to which (he) was opposed, and which also became less effective over time;**

It was "brittle", in that it was very difficult to stabilise him. When treating his depressive symptoms, he would often become more manic and visa-versa; and

His compliance with medication was poor in the community, and he was also resistant to treatment whist an inpatient. [21]

Due to his reluctance for ECT during this admission, a second opinion was sought from Professor O'Connor at Monash Health.[22]

41. On 3 October 2012, Dr Sharma wrote to Professor O'Connor, setting out Gerrard's history of bipolar affective disorder since 1994, with manic and depressive episodes of intense severity.

42. She also advised Professor O'Connor of Gerrard's history of ECT management, and of Gerard's disapproval of the proposal that he continue with ECT.

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[20] Transcript 11-12.
[21] Dr Sharma is a Consultant psychiatrist, and was employed in that capacity from Peninsula Health from 2010. She treated Gerard following his admission on 4 September 2012.
[22] See witness statement at exhibit 3.

43. She further wrote,

His illness poses significant risk-both during manic and depressed episodes. During manic episodes he is vulnerable to overspending and financial exploitation. There is also a long history of aggression and violence when manic, (gets into fights with strangers and has assaulted staff when unwell)…

While in the ward he is treated with Sodium Valproate, Olanzapine and Paliperidone depot. ECT has been stopped pending second opinion, optimum trial on Valporate.

The team remains concerned re his minimal improvement on the current regimen and the risk of further deterioration, secondary to non-compliance with medications.[23]

44. Dr Sharma's in her witness statement stated that initially Gerard had been assessed as a high risk of suicide because he was guarded and not open in discussing his mental state. [24]

45. She assessed him on 31 October 2012. At this assessment he initially denied any suicidal thoughts and rated his mood at 7 out of 10. Later at that meeting he expressed that he would like to die but gave an undertaking that he would not do anything to actively end his own life. A mental state assessment was undertaken at this time, which I note was before the commencement of bilateral ECT.

46. *Mr Helliar was appropriately dressed and maintained adequate eye contact. His speech was soft but relevant, coherent and adequate. His effect was depressed and communicable. His reactivity was considerably improved. There was no hopelessness and he denied suicidal intent.*

47. In testimony Dr Sharma further elaborated on their meeting on 31 October. He had not had ECT that day, but did so on the following day. Assessments are avoided after an ECT. [25]

48. She explained to him that they were going to change his then unilateral ECT to bilateral ECT.

49. *If someone complains of memory problems we generally do the unilateral, however bilateral has more efficacy for people with depression.* [26]

[23] See exhibit 3(a).
[24] Exhibit 3 page 2.
[25] Transcript 26-7.
[26] Transcript 25.

50. Dr Sharma was planning to see him again on Nov 7. She stated that she happened to see him during a cooking session that morning and told him that she would see him later that afternoon. He said, *OK.* [27]

51. In her later testimony Dr Sharma spoke further about her earlier meetings with Gerard. She explained that prior to the re-introduction of ECT, his bipolar mood disorder led to him displaying depressive symptoms, which when treated with antidepressant medication, led to him becoming manic within a few days.

52. *He was on regular treatment but unfortunately was never compliant with it.*[28] *He was on Lithium, a mood stabiliser but he didn't like it and so he was put on Sodium Valporate. At the same time he was also on Lanzapine and Palperidone Depot, also used for mood stabilisation. So although he was improving he was not improving that much (so) we suggested bilateral.*

53. In reference to the use of ECT, *it is used for people who suffer from severe depression, especially people who are suicidal, people who are catatonic, which means not eating or drinking*. *ECT is very good for people who have psychotic depression. In reference to the manic phase… there is a significant substantial body of literature… in the manic phase ECT helps to control manic behaviour and bring them down to a baseline… also some patients need maintenance ECT to maintain the improvement.*[29] *The success of ECT could not be measure after one treatment. A series of 3 or 6 treatments would be needed.* [30]

54. In Gerard's case just before he came back to hospital on 4 September 2012 he was having outpatient ECT, but he was opposed to it, *so we had stopped the ECT and they were trying on the medication while we were waiting and then when he came into the ward he was opposed to it, so we suggested we do a second opinion and I was waiting, so I would say for about one and a half months or so he was off ECT and then we decided we'll start it again.*[31]

Mr Wilson:

55. **Q**. *Did Gerard ever talk to you about magnetic therapy? Were you aware of trials taking place at the Alfred Hospital?*

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[27] Transcript Ibid
[28] Transcript 19.
[29] Transcript 25-6.
[30] Transcript 27.
[31] Transcript 27-8.

Ans. *Yes, (I was aware). Repetitive Transcranial Magnetic Stimulation, RTMS.... It was at that time in the experimental phase... I am not an expert in this area. Now it is being used for mild to moderate depression.* [32]

Mr Goldberg:

56. Later in answer to questions from Mr Goldberg, Dr Sharma described her role as a consultant psychiatrist to Gerard, as assessing his mental state and then advising nursing staff as to how frequently they should observe the patient, and also in respect of medications. On the days that she would do a mental state assessment she would be accompanied by the (contact) nurse who would also complete the risk management tool. Either Dr Sharma or the registrar Dr Alma would see the patient at least twice a week.[33]

57. In response to further questioning Dr Sharma testified that she had seen Gerard on a total of 17 occasions between his admission on 4 September 2012 and 31 October 2012.

He came in as he was starting to feel depressed again, and he was voicing suicidal thoughts, thoughts of jumping in front of a train and on the CTO it was also noted that he was talking about over dosing. There were concerns about his management and about medication compliance as well.[34]

58. On the initial review on this admission 5 September, the record noted that Gerard, *was dishevelled and un-kept, quiet, softly spoken, less spontaneous but cooperative and appropriate, dysphoric mood, flat effect, no discernible psychotic symptoms, reasonable insight and judgement and Impression bipolar effective disorder with depressive episode.*

Undergoing ECT as an outpatient and on a weekly basis. Planned to be seen by Dr Peavey on Friday for a second opinion re ECT File review. Epilem verses Lithium. Continue Paliperidone and Olanzapine at the moment and hold up ECT, at present until review by Dr Peavey.[35]

Over the period until he was said to be improving he still remained softly spoken but like his intensity of the voice was not that quiet. He had reasonable insight and judgement…

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[32] Transcript 29-30.
[33] Transcript 40-1.
[34] Transcript 33-4.
[35] Transcript 34.

now feeling safe here. I said we will take a second opinion (on the ETC) before… we will continue with the meds, and he was agreeable with that.[36]

59. **Q.** Under additional examination from Mr Goldberg, Dr Sharma was asked if somebody such as Mr Helliar, *who has severe… bipolar and the treatment resistance that he did… would you describe him a chronic suicide risk?*

Ans. *Yes, the suicide risk in people who have severe bipolar is always there, like literature suggests 10 to 15% of people who have bipolar end up committing suicide, so it is high risk… at all points in time.* [37]

60. In regard to his condition Dr Sharma stated that she thought he was improving as a result of the ECT treatment. (*I think so yes).*[38] He was at the same time continuing with the medication previously supplied and had been given bilateral treatments because, *unilateral and lower dose treatments are not helpful*.[39]

…he was on the same medication so he was also on other medications but he was on the same medications before ECT started and he continued with it and we added the ECT and he started improving after that.[40]

Court:

61. **Q**. *Now on the 7th he was being managed in the low dependency area?*

Ans. *Yes, Yes…*

62. **Q**. *According to your belief he had been improving as a result of the three provisions of ECT treatment during this stay?*

Ans. *He was improving*.

63. **Q**. *He had been there on previous admissions?*

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[36] Exhibit 3(c) 2, provided to the Court by Mr Goldberg purports to be a timeline setting out the occasions on which Dr Sharma reviewed Gerard following his admission on September 4, 2012. This is supported by clinical notes indicating visits by various clinicians. I accept that these documents all tend to establish medical reviews by Dr Sharma, sometimes with Registrar Dr Alam, took place on 5, 7, 13, 19, 25, of September and again on 10, 17, 22, 24, 26 and 31 October, but not after that date.
I note that a second opinion was sought by Dr Sharma from Professor O'Connor on 3/10 exhibit 3(a), and was later provided in a report addressed to Dr Peavey dated 9/10, see exhibit 5(a).
[37] Transcript 37.
[38] Transcript 43.
[39] Ibid. Adopted by Dr Sharma from the report of Professor O'Connor.
[40] Transcript 43.

Ans. *Yes he had lots and lots of ECT*, (on previous admissions)… *I would have participated in the roster for doing ECT, so I would surely have done it, but I can't recall how many times.*[41]

64. **Q**. *When you saw him on 7 November in the kitchen how was his mood on this occasion?*

    Ans. *I didn't have a big conversation with him, I saw him and he was helping with cutting vegetables, so I did say I wanted to see him and that I would come back later. He said OK. I didn't observe anything different, or very alarming.*

65. Mr Goldberg: *(I have a time line showing 8 treatments during this admission, the most recent being on 5 November).*

66. **Q**. *When you saw him on the 7th might he have thought he was about to have another ECT?*

    Ans... *I was not going to talk to him about a consent for another ETC. I was just going to observe how things are going for him.*

67. **Q**. *Would he have known that?*

    Ans. *Yes.*

68. **Q**. *So how many of these eight were bilateral?*

    Ans. *Two were bilateral... On the 1st and the 5th.*

69. **Q**. *Would they have caused greater confusion because they were bilateral?*

    Ans. *Bilateral ETC definitely causes more confusion than unilateral… Following ECT for an hour or so, he always used to get confused but then later he would pick up and he wouldn't be so, he did not seem confused…* [42]

70. Dr Sharma further testified that she authorised 6 ECT treatments to be taken commencing on 10 October and to be completed on 18 October, (signed 7 September), and a further six to be commenced on 18 October and completed on 11 November, which authority was signed on the 17 October. [43]

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[41] Transcript 44.
[42] Transcript 48.
[43] Transcript 53 and documents at exhibit 3(c) 2, the time line tendered by Mr Goldberg sets out the dates upon which ECT was provided to Gerard following his admission. The time line suggests the provision of ECT on 10, 13, 17 of September and then a break until Dr Sharma signs the second authority to perform ECT on 17 October, (during which period, Professor O'Connor's opinion (9/10) was provided).

71. **Q**. *It appears that the full course that had been authorised by the first document that was signed by you on 7 September, had not been completed?*

Ans. *Yes… OK. So with the first series as I said Gerard was having ECT while he was still in the community… so when he got admitted we said we'll continue with ECT in the ward. Later I've written "Talked to Gerard re ECT." He was unhappy with ECT. So then I planned to stop ECT for now and we were waiting for a second opinion, so that's why we stopped. So the first one was done before that. And the second one was done after I got the consent…* (The) *recommendation by Professor O'Connor.*

Professor Daniel O' Connor [44]

72. On October 9 2012, Professor O'Connor responded in writing directly to the ECT Director and Consultant Psychiatrist Dr Carmel Peavey, having read Dr Sharma's summary and spoken with, Dr Peavey's, *nursing and medical colleagues, and Mr Helliar, and having read his medical file including the ECT documents.* [45]

73. He wrote, *I am satisfied that Mr Helliar suffers from a severe bipolar affective disorder, which has affected all parts of his life. When depressed he is barely able to function independently. When manic he behaves in a typically erratic, disinhibited fashion. As a result he is unable to work, his family support has crumbled and his accommodation is uncertain.*

He is often reluctant to take mood stabilisers, despite clear evidence of their effectiveness and so relapses have usually needed to be treated with ECT. Altogether he believes he has now received over 200 treatments. His recent treatments have all been high energy and bilateral in nature on the grounds that unilateral and or lower dose treatments are not helpful.

Thereafter ECT was performed under the 2nd authority commencing on 22/10 and continuing on 25/10, 29/10, 1/11 and 5/11. This timeline is consistent with the rest of the evidence and I accept it as accurate.

[44] Professor O'Connor was at the relevant time the Professor of Old Age Psychiatry at Monash University. His written response to the request from which his views are taken, became exhibit 5(a).

[45] See Professor O'Connor's letter to Dr Peavey dated 9 October 2012. The evidence of Dr Peavey establishes that Professor O'Connor travelled to Frankston to review Gerard personally. See transcript 126.
In this regard see the ECT Manual issued by the Chief Psychiatrist, through the Mental Health Branch, DHS, in January 2000, (applicable in 2012), which stipulates that where the Authorised Psychiatrist (Dr Sharma) proposes ECT for an *involuntary, security or forensic patient, that a second psychiatric opinion should be obtained. This opinion should be recorded in writing in the case notes before the ECT is given. In remote areas where it may not be possible or practical to have a second psychiatrist examine the patient, other options such as tele-psychiatry or telephone consultation should be considered.*

*You and your colleagues are confident, however, that ECT works better and faster than antidepressant and antipsychotic medications.**

Mr Helliar is clearly very depressed at present. He admits to having a very low mood and has spoken with nurses about making a will, suggesting that he is contemplating ending his life. He dislikes ECT…

It is reasonable in the circumstances to continue to administer acute and maintenance ECT to Mr Helliar, if necessary on an involuntary basis.

74. Professor O'Connor offered further advice in respect of medication support.

75. In conclusion he suggested that,

It would also be helpful to record in discharge summaries that ECT was helpful, if indeed you believe this to be the case. You might also like to complete a mood rating scale before and after ECT to demonstrate to Mr Helliar, that treatment has proved effective. [46]

Anna Ciotta

76. Anna Ciotta a clinical Neuro-psychologist, conducted an assessment on Gerard at Frankston Hospital on 15 October 2012.

She reported as follows,

77. *Background*

Mr Helliar is a 62 year old man with a history of Bipolar… since 1994, including numerous hospital admissions for rapid cycling in mood, from manic episodes to periods of depression… He is currently in hospital under revocation of a CTO for relapse into depression with suicidal ideation. He was referred for neuropsychological assessment on this occasion following self-reported memory complaints, such as not being able to recall people's names, which he attributes to past ECT treatments.

He presents with… rapid switching to manic episodes following treatment for a depressive episode. He also presents with risk of physical and verbal aggression towards staff when his mood is elevated and has been at financial risk… When depressed he presents as staying in bed all day, with feelings of low self-esteem and hopelessness, and suicidal ideation including jumping in front of a train or jumping off a bridge.

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[46] See the review of Mr Helliar provided by Professor O'Connor to Dr Carmen Peavey, at Exhibit 5(a).

Mr Helliar has a history of non-compliance with treatment in the past, requiring assertive follow up and ECT treatment, both as an inpatient and an outpatient. He has been trialled on several mood stabilisers… and had an earlier neuropsychological assessment in 2005, which disclosed, (a relatively modest level of disability). [47]

On presentation (on 15 October, 2012), Mr Helliar was somewhat dishevelled. Affect appeared low, eye contact minimal, with increased response latency and significant psychomotor retardation. Despite his presentation, Mr Helliar denied any depressive feelings currently rating his mood at 7/10… He stated that he had 210 shock treatments in the past and this had effected his memory and ability to recall things… Mr Helliar was generally co-operative with formal assessment, but reduced effort and motivation was a characteristic feature…

78. *Assessment*

Our current assessment was that Mr Helliar was well orientated to time, place and person. His memory capacity was assessed in the average range… His information processing range… was reduced at well below normal limits… Within the verbal domain as a measure of concept formation and abstract reasoning was within the low average range… Self-monitoring was intact throughout, with no repetition or rule breaks evident. Mr Helliar's performance in the visual domain was within the low-average range. Visual reasoning and problem solving skills were within the average range. Mr Helliar's copy of a complex geometric figure was intact, with a well-planned approach to the integration of the various components evident.

When called upon to undertake word grouping Mr Helliar complained of being tired, and after a delay he could recall very little of the information earlier given, *and recognition prompting did not assist with retrieval.*

79. *Opinion and Recommendations*

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[47] See Anna Ciotta Assessment Report at exhibit 4. The neuropsychological assessment undertaken in 2005 was also completed by Anna Ciotta, who stated that this (2005) assessment took place during a community follow up, *following self-reported difficulties in carrying out usual work responsibilities.*
According to this report no significant mood disturbance was observed at this time but motivation to complete testing was reduced and effect somewhat irritable, increasing as the session progressed. Assessment findings revealed that Mr Helliar was well oriented with above average basic attention, but some difficulty in dealing with competing stimuli or more than one task at a time. Very mild difficulty also emerged for complex problem solving and verbal reasoning and working memory and the ability to monitor performance in non-structured situations... On the basis of this assessment, it was suggested that Mr Helliar may benefit from memory aids (calendar, diary written notes etc)…

On current presentation he presented with significant psychomotor retardation, in addition to lowered effect, minimal eye contact and increased response latency in conversation…

His neuropsychological profile was relatively similar to the previous assessment conducted in 2005 but with poorer levels of attention, working memory and processing speed evident on this occasion.

His clinical presentation suggesting a significant depressive illness, is likely to have significantly impacted on his performances on current assessment. It is also possible that his performances could improve with stabilisation of his mood disorder. Review neuropsychological assessment would therefore be recommended following adequate treatment of depression, with consideration of any future ECT and associated cognitive side effects, during treatment. [48]

80. In further oral testimony, Ms Ciotta stated that her purpose in reviewing Gerard was to provide an assessment of Gerard's memory and thinking skills. Her additional purpose was to compare the results he had achieved in the earlier testing so that she could understand if there had been an increase in his cognitive impairment between the dates of the two reports 2005 and 2012, because of the ECT treatment provided during that period. Her further purpose was to provide a baseline, because she understood ECT treatment was going to recommence, *so it would be pre and post ECT*.

81. **Q**. *Did you make any recommendation as to whether there should be ECT?*

    Ans. *No, that's not my role no… the decision to continue with or prescribe any treatment would be up to the treating team and consultant psychiatrist.*

82. Ms Ciotta further offered that there had been a break between his last course of ECT while an out-patient, and the course he was about to re-commence that was intended to allow for him to overcome the confusion or memory problems, which may arise in the 6 to 8 weeks following a course of treatment. [49]

83. ECT patients often suffer from memory impairment but it is difficult to say whether he suffered memory impairment as a consequence of his depression, or because of the ECT.

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[48] Ibid.
[49] Transcript 65.

84. He had an average assessment in regard to other indicators and his memory was not consistently impaired. [50]

85. **Q**. *Whereas unlike dementia, someone whose presentation might be the product of depression and possibly complicated by the use of ECT, would simply be forgetting material, which had previously been well based?*

Ans. *Yes… also in addition it is largely dependent on attention and concentration and motivation, motivation to attend to the material, the level of engagement during the tasks as well as… effort.* [51]

86. **Q**. *The person who is suffering from bipolar who is having ECT, might well become confused, which is consistent with what the specialists who saw Mr Helliar observed, but notwithstanding that ECT may act as a treatment, an effective treatment for bipolar?*

Ans. *I have seen it work effectively.*

87. **Q**. *We've seen quite a few cases in this court where it is said that ECT is really a very good treatment for people suffering from bipolar, or are about to withdraw into a catatonic state because of bipolar or… psychosis, but it is associated with memory loss and confusion and some degree of dissatisfaction, systematically people are not happy with it, although overall it might be seen on balance as doing them some good.*

Ans. *It can be yes... From my report he was presenting as stable at that time… as stable in mood, as I have not made any comment as to the presence of any significant depressive symptoms.*

88. Also (any) contrast between the two reports 2005 and 2012 occurred because of his lack of attention on the earlier occasion. He did agree to do more memory testing on this occasion. In 2005 he refused to complete a verbal memory task.

89. **Q**. *Did you have any sense that when you saw him in 2012 that there had been a deterioration in his level of depressive illness?*

Ans. *No.*

90. **Q**. *You thought they were broadly similar?*

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[50] Transcript 66-7.
[51] Transcript 68.

Ans. *I had no real experience of assessing (him) during a depressive illness so I didn't have really anything to compare. I could just comment on how he was presenting at the time.* [52]

91. And further, that he had a similar neuropsychological profile in 2005, and in October 2012.[53]

Dr Carmel Peavey

92. Dr Peavey testified that she is a Consultant Psychiatrist and Director of ECT at Peninsula Health, where she had been employed since 2011.

93. As a Director she was asked to review and provide a second opinion regarding the future ECT treatment during (Gerard's) in patient admission.

My notes of this opinion are contained in the medical records dated 7 September 2012. In providing a second opinion for any client including (Gerard). I conducted a file review of the available clinical notes and I interviewed Gerard. [54]

In addition, I considered his past experience and benefit from ECT and noted that he had experienced improvement in his symptoms with past ECT treatment.

On interview with (Gerard) my notes indicate that he suffered from some executive dysfunction placing him at additional risk of impulsivity and reduced decision making ability. In addition it was clear that his bipolar effective disorder was significantly treatment resistive to medication.

Accordingly I was satisfied that ECT was an appropriate treatment for his illness in such circumstances and I supported the continuation of ECT as an appropriate intervention… Professor O'Conner was asked to review the ongoing use of ECT in Mr Helliar's care. He supported the continued use of ECT even on an involuntary basis.

Professor O'Connor is a recognised expert in ECT treatment and management. [55]

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[52] Transcript 70.
[53] Transcript 75.
[54] See exhibit 3(c).
[55] See also authority for further ECT authorised by Dr Sharma on 7 September at exhibit 3(d) (1). I further note below Gerard's own feelings on these matters at that time. See exhibit 3(c), nursing notes at 7 September at 18.40, which refer: *Gerard confused, angry, overwhelmed, affect flat, restricted in effect… states he has many things going through his head… described being upset as he believed he was getting a rest from ECT and states it has not been effective in the past; stated that he doesn't understand why he is on Sodium Valproate, if ECT is the choice of treatment. Stated that in*

94. In further testimony, Dr Peavey was questioned about the efficacy of ECT treatment for patients who relapse into bipolar affective disorder and the period over which ECT might be provided. She explained that the period for treatment will depend on the presentation with a patient suffering from manic relapse only needing one or two treatments, and others with a depressive relapse maybe needing more.

95. *So on average the number of treatments for a course (of ECT) in Victoria is 11.3 currently… but people may have multiple courses of treatments, throughout the treatment of their illness... But in a single treatment course it is around 11…including both bilateral and unilateral.*

96. ***Q.*** *The frequency of those 11.3 treatments is?*

Ans. *In America they use three times a week and in Europe twice a week We use twice a week at Peninsula Health, to try and reduce the cognitive effects*.[56]

97. **Q**. *Are you aware of the evidence given in various statements of Mr Helliar saying he has had somewhere between 200 and 210 treatments?*

Ans. *Yes… when I saw him he had had over 200; that's why we asked Professor O'Connor whose an expert and now our Deputy Chief Psychiatrist, to give an external opinion, because I was concerned… about the number of ECT's… and our difficulty in withdrawing him from the ECT and the prolongation of his treatments.* [57]

Professor O'Connor was aware of this issue… During this period he was also being provided with the depot medication Paliperidone at a maximum dose… also he was on Olanzapine which is a second antipsychotic, but he was requiring two antipsychotic medications and at a reasonable dose. [58]

98. **Q**. *How do you know if the ECT treatment was effective?*

Ans. *I guess it had been effective in the past in that he had been able to go on leave, he had been able to be discharged from the Hospital. It is used as a last resort, but at the*

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the community he would be near the train tracks as it is the easiest way. Stated he is also embarrassed about memory loss following ECT… Complaining of memory loss, is orientated in person, place and time. Understands his depressive symptoms, understands the importance of treatment… refusing ECT and told nurse that he would make it hard for staff and staff would need to hold him down.

[56] Transcript 78.
[57] Transcript 79.
[58] Transcript 80.

times he had (previously) had that treatment, my understanding is… he was able to stop the ECT treatment for some times. So one assumes he had become well enough to manage without it.

99. Dr Peavey testified that it was the treating Consultant Dr Sharma, *who made the decision (to provide ECT) and that her own role was just to provide a second opinion…. because he had had quite a number of treatments.*

100. **Q**. *Was there an alternative treatment?*

Ans. *That's my role… to see if there is any other possibility… that's why I looked through all the treatments that he had and I could not see any other course of treatment given his presentation… he told me he wanted to jump in front of a train. He was already on maximum treatments, medication. My view was then and now, that we should try and alleviate his suicidal thoughts and then see what else could be done.* [59]

101. In further explanation of the objective of the treatment Dr Peavey testified, *we measure the degree of brain waves before the treatment and after the treatments and it quietens the brain and it seems to stop… often our patients have this constant sort of recurring thought and it seems to reduce those recurring thoughts particularly of self-harm… They can't stop thinking about that and it seems to quieten the brain and take away those particular thoughts without harming other parts of the thoughts. There is no change to the brain structure as such. There is evidence that the brain circulation,* [60] *increases to the front of the brain in that time, and there's extra oxygenation goes to the front of the brain, following this neuro stimulation of the brain.*

102. Dr Peavey further testified that prior to her appointment as Director of the ECT Unit she had worked in this same field over the previous three years. During this period and in the three years since she had never worked with a patient who had been administered 200 plus ECT treatments, which is why, *we sought an external opinion.* [61] This evidence was later corrected to say that while working in another service she had dealt with such a case and was aware of others.[62]

103. Dr Peavey was then asked about academic work in the area to prove or disprove its usefulness, to which she stated that, *this was the reason why neuropsychology assessments*

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[59] Transcript 81-2.
[60] I believe the witness either referred to, or intended to refer to, 'blood' circulation.
[61] Transcript 83.
[62] Transcript 83-4.

were undertaken, *to see whether … (there were) permanent cognitive memory deficits, and for the majority of patients the answer is no.*

Court

104. **Q**. *I got a sense when talking to the last witness (Neuro-psychologist Ciotta) that it was very difficult to establish (deterioration), and whether it came from the ECT, or the underlying condition?*

Ans. *Yes, we seek the opinion for two reasons. One is that Mr Helliar was very concerned and I was hoping we might be able to establish that there had been no change, and in fact there had not been a deterioration… the second reason was to try and tease out exactly that, but unfortunately he was not well enough to tease out either of these two things.*

105. **Q**. *So in this case it wasn't possible to say whether or not the… was as a result of a deterioration in his condition, or because of the effects of the treatment, (which was the position taken by Ms Ciotta)?*

Ans. *I think it's true that when she did the assessment it was very difficult to tell because he was so depressed. So from that point of view, yes.*

106. **Q**. *Ms Ciotta saw him on the 15 October and the bilateral ECT authority was signed on 17 October and (treatment…some five bi-lateral ECT's, see para 5 x) commenced on 22 October.*[63]

Ans. *The evidence is that a bilateral ECT does tend to work more quickly and require a slightly less number of treatments than the unilateral ECT. So if you have a patient who is seriously unwell, then the prescribing psychiatrist would usually suggest a bilateral ECT if there was a serious concern about suicide… If a person is not responding to unilateral ECT you would also then go to bilateral ECT.*[64]

107. **Q.** *Is there some written research on this subject, (the efficacy of bilateral ECT in cases where a patient has previously been treated with a similarly large number of unilateral ECT treatments)?*

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[63] In fact I am now satisfied from the evidence of Dr Peavey that Bilateral ECT commenced on November 1. See paragraph …

[64] Transcript 85-7. Bilateral ECT allows for a both sided delivery of the electrical impulse, which is intended to cause a seizure, as distinct from a unilateral impulse, which is delivered to one side of the brain only.

Ans. *I am afraid ECT is not something people wish to research a great deal. But there has been quite a lot of research into the effect on memory of ECT and the evidence is that for the majority of patients during the ECT, it certainly effects there memory, but if the ECT can be stopped for the majority of patients, that there memory ability returns.*

Their ability to learn new information (also) returns, if they are not depressed or they don't have a manic episode.[65]

108. **Q**… w*hat alternative was there*?

Ans. *I believe it was a last resort. Honestly at the time with his presentation and what he said to me about his suicide risk, I felt there was no other option for his treatment*

109. **Q**... *was there a facility where he could be kept permanently without ongoing ECT, or semi permanently?*

Ans… *unless he was treated… he needed immediate treatment… because no facility … other than a gaol, and even then if someone wants to suicide they can. It was an immediate risk and a high risk.*[66]

Mr Goldberg for Peninsula Health:

110. **Q.** *What was your role?*

Ans. *The role is an administrative role to ensure that the treatment is carried out in a professional manner according to the guidelines provided by the Chief Psychiatrist… once a week I review the actual treatment to see that the patient is getting the appropriate dose of treatment that will administer… that will result in improvement in the patient, and that's my area of expertise.*

This would include the strength and dosage and whether the treatment was unilateral or bilateral… *it's most unlikely that the right unilateral would have been able because he would have needed very very high doses for the unilateral,* (to be effective), *because of the doses he needed to get an effective treatment with the bilateral treatment.*

I don't review him personally, but I do review the tracings… there is an electronic recording… And I review the clinical file to see the person's progress. We take into account the persons clinical progress, which I take from the notes, the clinical notes, and the ECT,

[65] Transcript 91-2.
[66] Transcript 93.

and I speak with the co-ordinator to see if there have been any problems, such as anaesthetic problems or any difficulty in the administration of the ECT:

Coroner's Officer Dimsey:

111. **Q**. *Referring to the clinical notes for 29 October… Can you explain… the dose is not indicated there?*

Ans. *Not on the ECT time out but it is mentioned on the ECT clinical review, which is the second sticker that we put and that's the summary that we do, that's the weekly clinical ECT review… I've written down that the poor morphology suggests that the ECT on that particular occasion it wasn't… that we needed to increase the dose, and that's where I recorded that we increased the dose… Bilateral, which means that the patient was undergoing a bilateral course of treatment… it's not a static thing… there are a number of parameters where we check… the amount of charge that we need to provide to the patient increases normally, as the patient goes on. We need to produce the lowest amount of charge that will produce a response… a threshold,* (to achieve a convulsion or fit). *So I looked at the tracing and saw that at this stage this person needs a slight adjustment to their treatment dose.*

112. **Q**. *Page 160 of the inquest brief. Again the progress notes entry for 5 November?* [67]

Ans. *Yes, I completed that… "Increase dose, second dose to 120" So as you can see over time if you looked at the previous one he was then on-at that stage on a dose of 90%, on 5 November, this is quite a bit later and the patient is now needing an increased dose… the treating psychiatrist (Dr Sharma), gave him the treatment but that didn't work…*

It was noted that the anaesthetist had to give an increased anaesthetic, (Propofol), so that we could adequately give treatment.

Q. *And that reflects an increase in charge ordered for 5 November is that correct (from 90% to 120%)?* **Ans**. *Yes… it wasn't going to work if we continued at the current dose.*

Q. *So the first line can you read the first line to me?* **Ans**. *Note increased Propofol due to extra dose…" It's required for the second fit."*

So the increase to 120% refers to the electrical charge?

Ans. *That's right.*

113. **Q**. *Did that relate to the electrical charge that was given on 5 November?*

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[67] Transcript 97-100.

Ans. *The clinical review is to indicate to the next person the administering psychiatrist who is going to give to give the ECT at the next treatment.*

And… *Did this clinical review ECT refer to there being an increase on 5 November?*

Ans. *It would be for the next treatment after 5 November.* [68]

114. **Q**. *Just in relation to treatment on 29/10, that would have been as indicated?*

Ans. *That's right.*

115. He was treated on 29/11 with a then increased charge to 90% charge and later on 1/11 but Dr Peavey couldn't say what charge was delivered on 1/11, because she didn't review him after every treatment.

Coroner: referring to Brief page 151,

116. **Q**. *That would indicate there was an increase to 90% recommended on the 29th and I presume that would have been implemented on the 1st and the 5th?*

Ans. *No not necessarily.*

117. **Q**. *On the 1st he would have had that treatment?*

Ans. *The treating psychiatrist at that time from my notes and what I recommended, would almost certainly have said, "increase the amount"*

118. **Q**. *Well… this would indicate that there was an increase to 90% and it is bilateral?*

Ans. *Mmm***.**

119. **Q**. *Is there anything to indicate that there was an increase… and that would have taken place at the next ECT, which was on the 1st?*

Ans. *Yes. It is in what we call the ECT pathway.*[69]

120. **Q**. *I want you to read through and tell me how, if at all charges, were altered during that time?*

Ans. *ECT was provided on 22 October. Titration was 20%. Unilateral and then he had had a good response so we put it up to 60% at that time…*

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[68] Transcript 101-04.
[69] Transcript 106. See exhibit 5(b) ECT clinical pathway.

121. **Q**. *So up to 60% for subsequent treatments?* **Ans**. *That's right.* **Q.** *So if it was effective on the 22nd at 20%, why was it put up to 60%?*

Ans. *OK. You establish what is called a threshold, but if you treat someone at the threshold they become extremely confused and they don't get better, so you have to establish by multiplication, something called a supra threshold. So it was then you treat at what we call a supra threshold. So… we've treated at three times, which is the recommended amount, and he has had a 60% treatment. It was unilateral at that stage… So we do what we called a titration. We have to see what the minimum amount is (to cause a fit) and then you give a treating dose.*

122. **Q**. *So a minimum amount was 20%?*

Ans. *Yes.*

123. **Q**. *And that was given?*

Ans. *He had… what we do is titration on the very first treatment, this is the start of this particular pathway… He has a starting dose, you find out the minimum amount and then you give… you keep the patient anaesthetised and you give them a second dose and that's what we did.*[70]

124. **Q**. *So on the 22nd he got two doses?*

Ans. *Yes he did. And that happens again later.*

125. **Q**. *Up to 60% on the 22nd?*

Ans. *Yes… But then we found on that date it still wasn't sufficient because he the trace showed that he actually did need an increased dose on that… to get better.*

126. **Q**. S*o why do you say that he needed… what was the information that you received on the 22nd, which told you that the increase to 60% was not satisfactory?*

Ans. *The duration of his ECT, should be between 20 and 25 seconds and his was 86 seconds. You can go up to 50 seconds and still be satisfactory, but his was over that, it was 86 seconds.*

[70] Transcript 108-09.

… the charge starts a person to have a… the brain to have a fit and so we are measuring… there are two factors here… One is to start the brain. The smallest amount of charge that you need to get the brain to respond, but what we then do is wait and then we give a treating dose. We establish a threshold dose, then we give a treating dose.

127. **Q**. *So the threshold dose was 20?*

Ans. *The threshold dose was 20 yes*.

128. **Q**. *And the treating dose was 60?*

Ans. *Yes but it was not going to be sufficient. If we stayed at 60 he wouldn't get better.*

129. **Q**. Y*ou said that 20% was used?*

Ans. *Yeah*.

130. **Q**. *And (after) a good response and it was put up to 60%?*

Ans. *Yes, but it was not going to be sufficient. If we stayed at 60 he wouldn't get better... the patient would have woken up very confused and would not have got better, there would have been no clinical response. So that tells us to keep the patient under the anaesthetic, we then administer a second dose at an algorithm where we multiply by 3. Once we establish… that it seemed it would still not be sufficient… for him to respond, and this is quite unusual.*

131. **Q**. *How do you glean that he wouldn't respond? What tells you that he won't respond?*

Ans. *Well first of all we can't even tell even from the E.., it's looking at a person's response clinically, plus their response to the E.. It might take … 6 or 7 treatments before we get it exactly correct. And that's what in fact happened with Mr Helliar. There was a period of trying to get his treatment correct.*

132. **Q**. *So at the end of the treatment on the 22nd you determined that a shock of 60% was inadequate?*

Ans. *That's right and its counter intuitive… so on the 22nd… I recommended that the next treatment the (shock level) was increased. It is counter intuitive, you think that if the response is inadequate-well our normal process would be to increase.*

133. **Q**. *To what?*

Ans. *70... (unilateral) on 25 October.*

134. **Q**. *What happened on 25 October?*

Ans. *It was actually administered at 80%, but that would be the discretion of the administering psychiatrist who may have reviewed the E--, and decided that they would increase it to slightly more, which they did... I can't speculate why that happened.*

135. **Q**. *And on 29 October?*

Ans. *It was 80% again…*

136. **Q**. *And then on 1 November?* [71]

Ans. *It was changed to bilateral. Now it's the discretion of the treating psychiatrist to indicate to us whether they want unilateral or bilateral… Yes and once again you need to go back and re-titrate because this threshold, the amount of charge needed for bilateral is different to unilateral. And its lower often a lower dose…*

137. **Q**. *What was the charge delivered on 1 November?*

Ans. *He had two ... they gave a treating dose at 30% ...and then you give a second dose at... with an algorithm, which is different, its one and one half, so you would give a treatment of ah… 50 %.*[72]

138. **Q**. *And on 5th of November?*

Ans. *They were still unhappy. With the E-- on 1 November. When they gave the treatment at 80% Mr Helliar didn't have a response, so they increased the dose… the Propofol, which we were trying to keep low, was needed to be… the patient had a second treatment again…*

139. **Q**. *What occurred on 5 November in terms of dose?*

[71] Transcript 110-12.
[72] I am satisfied from her evidence set out at paragraphs 127 and 128 above that Dr Peavey intended to say that the lesser dose was a *threshold* dose.

***Ans**. He was given a dose of 80% for the first treatment, and quite correctly as there was no response... his dose was increased to 100%, but again there was no response. Which suggests that the dose needed to go up.*

140. **Q**. *And that is the origin of the note we are looking at?*

Ans. *Yes. At page number 150.*

141. **Q**. *To increase from 100% to 120%?*

Ans. *Mmm.*

142. **Q**. *Is that correct?*

Ans. *That's correct.*

143. **Q**. *So it was 100% on the 5.th*

Ans. *Yeah.*

144. **Q**. *And the suggestion was that it was going to be increased to 120% thereafter?*

Ans. *Yes.*

145. **Q**. *Bilateral?*

Ans. *That's right.*

146. **Q**. *So it wasn't up from 90 %, it was up from 100%?*

Ans. *Remember that ... the 90% would have been the appropriate dose for unilateral, but now the patient has been… we've been instructed to by the treating team to give bilateral treatment and so the doses are completely different.*

147. **Q**. *So it wasn't up from 90%, it was 100% on 5 November and after that it was for increase to 120%?*

Ans. *Yes. And bilateral commenced on 1 November and continued on 5 November…*

148. **Q**. *Increasing from 50% to 100% on 5 November?*

Ans. *That's correct, yes.*[73]

149. In further evidence, Dr Peavey confirmed that in her view the delivery of treatment had occurred in compliance with the Chief Psychiatrists protocol.

150. Dr Peavey further testified that the calming agent clonazepam, is usually stopped for someone who is about to take ECT, because they can inhibit that treatment and make it less effective… *I am not certain whether it happened in this case. It wasn't mentioned in the list of medication… on the pathway, which we are given at the start of treatment* (on checking), *that would be what I would expect.*[74]

151. Dr Peavey was then asked about her experience with one other case where ECT treatment had been provided, on this… number of occasions, Dr Peavey then told the court that over the evening adjournment, she had found a New York study, which dealt with ten people who had received, *over 100 treatments… The broad conclusion was that there were no cognitive… memory side effects in that study.*

152. **Q**… *that means they didn't have the side effects that the treatment appeared to have on Mr Helliar, where he experienced great confusion?*

Ans… *there is acute confusion immediately post ECT and during the course of treatment with ECT. When the ECT stops and the patient is well, then we hope that – the expectation is that their memory will improve. With Mr Helliar unfortunately he wasn't able to be tested at a time that he was well, because he was so unwell for most of the time.*

153. **Q**. *So what does the NY study tell us in terms of what happened to Mr Helliar?*

Ans. *I guess it tells us that it is possible to treat, it was a small study… only 10 people, because most services would tell (of) someone who has the treatment resistance of Mr Helliar maybe one or two patients in their care. So it's a small number over all. What I believe is that people can have large numbers of treatments with ECT without permanent damage. That's what that study would suggest. As I have said, I have not had the opportunity to fully read the article.*[75]

154. **Q**. *Now the new Mental Health Act changed the system quite dramatically… What would now happen to Mr Helliar?*

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[73] Transcript 114-15.
[74] Transcript 119.
[75] This article subsequently became exhibit 5(e).

Ans… *In effect our practise would not be a great deal different in that we would provide a second opinion, we would still provide an external third opinion, if needed which is prescribed under the new Mental Health Act from July 2014... But (then), we would have had those opinions and then the prescribing psychiatrist would… fill out a mental health form and then the patient would receive the treatment without the benefit of a tribunal. Now the prescribing psychiatrist will fill out a form MHA132 then that request for an ECT Mental Health Hearing, which is in effect another opinion as well-and then the patient and their family and the doctors all go to the tribunal and present their case as to why they believe ECT should be given. And it is not up to the psychiatrist to decide within the Hospital, it is an external body… that decides a patient should have ECT.* [76]

155. Dr Peavey additionally testified that this would include patients who didn't have the capacity to consent and patients like Gerard, who did not consent. *Such patients, if they have been treated with ECT before and have responded, will get better.*

156. **Q**. *It might take longer but they will respond?*

Ans. *Some of our patients respond very quickly to ECT and become well within two or three treatments.*

157. **Q**. *But, Gerard hadn't responded quickly?*

Ans. *He had at times in the past and become well and it had stopped… But then he might have had an acute ECT, there is acute ECT and maintenance ECT, so someone has to be weaned off ECT.*

158. **Q**… *but he hadn't been treated successfully over these 200+ episodes, and I am just wondering if there is a point where you consider that it was improbable that there is likely to be any successful resolution…*

Ans. *That's why we asked Professor O'Connor.*

159. **Q**. *Yes, but I am (not) talking about someone reaching a stage where he might receive occasional ongoing treatments to maintain a level. This hadn't been achieved in Mr Helliar's case. He was constantly going up and down to the point where you could not evaluate what effect it was having upon his cognitive state. He was not sufficiently well for you to understand that there had been an improvement?*

[76] Transcript 122.

Ans. *I guess there is a difference between the cognitive state and his symptoms. As I said, my expertise is here on ECT. I didn't treat Mr Helliar over a long time, apart from the ECT…*

160. **Q**. *There was no consistency in terms of his treatment. He seemed to be constantly… under the effect of Bipolar?*

Ans. *Yes and that's at the end of the day why we asked Professor O'Connor to come and give an external opinion, because we were stuck. That's exactly right. We were concerned about him having this number of ECT's. It was not usual. Our patients, I was expecting once again that he would respond, but each time he would get better he would just quickly relapse again.*[77]

161. **Q**. *Well I suggest to you that there was no basis for believing that he could respond in a positive way. Given the large number of treatments that had been provided before these series of treatments in late 2012?*

Ans. *The fact that he had intervals-would suggest that perhaps it had been helpful. Yes, and I had seen him improve… and leave the hospital.*

162. **Q**. (put again), *no grounds for belief he was likely to improve… He couldn't stay indefinitely… two months stay at Frankston Psychiatric unit is, by the standards of that unit and every other unit in this state, an extremely long stay?*

Ans. *That's right.*

163. **Q**. *There were no alternative place for him to be sent?*

Ans. *That's right.*

164. **Q**… *I am wondering if there are people other than Professor O'Connor who may have an expertise in… chronic Bipolar, who may have a different approach to the treatment of Bipolar.*

Ans. *That would be up to the treating psychiatrist. It's not my role… Professor O'Connor would have a great deal of knowledge and treat patients with bipolar affective disorder.*

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[77] Transcript 124-45.

165. **Q**. *Having regard to the requirements of the Mental Health Act 2014 and the delivery of ECT, as well as to the circumstances of Mr Helliar, was there a less restrictive way for him to be treated…*

Ans. *That was the question we asked Professor O'Connor as well as ourselves, was there any alternative treatment (all had been tried)… I could not think of a less restrictive option for him.*

166. **Q**. (Hypothetically), *under the new Act, if he had reached a point where he was able to give informed consent could he under the new system have also given an informed disapproval?*

Ans. *Yes*.

167. **Q**. *Which was to continue to apply at all times of his life?*

Ans. *Yes. You can make advanced directives about what you wish and you can also-he could do that when he is well. That's only just come in with the new Mental Health Act as well. I also believe that's a very… something that people could do with their families and it is a very important part of the new process.*

168. **Q**. *And that can't be trumped by some later event that occurs?*

Ans. *The Mental Health Tribunal is directed to take an advance directive into account.*

Mr C Wilson:

169. **Q**. *I ask you on behalf of the family… you said ECT was the last resort… was there anything else like meditation group, therapy, psychological sessions, alternative stuff like Reiki therapy or anything like that?*

Ans. *I can't say…*

170. **Q.** *You have anaesthetic combined with ECT?*

Ans. *Yes. We actually tried a completely different anaesthetic (Remifentanil). Unfortunately he had a very bad reaction to it… he became very agitated… that was used on 22 October… After the ECT he became very agitated we gave him some extra anaesthetic just to try to make him feel… and that made him feel quite calm.*

171. **Q**. *The long term plan for Gerard, were they just going to persist with ECT for the rest of his life?*

Ans. *My expectation and hope… was to get him well enough try him on other medication. That's always the aim.*

172. **Q**. *See, I used to hear him complaining he would come out of hospital and be on such a heavy dose of medication?*

Ans. *Yes.*

173. **Q**. *That he just couldn't run his life you know what I mean he just wanted to stay in bed all day. Was there anything that could have been done to lower his medication, to lower things, to trial things. He had a good response to lithium…*

Ans. *Well I didn't…*

174. **Q**. *So Lithium are you saying was successful… you used either lithium or Epilim is it used for people who have epileptic fits?*

Ans. *No it was found as a side effect, that for people with Bipolar that it kept their mood quite stable.*[78]

175. **Q**. *I mean it is an alternative?*

Ans. *Yes.*

Mr Goldberg:

176. **Q**. *Was his Bipolar the most difficult you have had to treat?*

Ans. *I would say the most difficult I have come across… I think because he had the most severe symptoms to harm himself… his thoughts to harm himself were so present in his mind… he seemed quite tortured to me when I saw him.* [79]

177. **Q**. *What do you mean by treatment resistant?*

Ans. *There are usual therapeutic ranges for treatment, so if someone has failed to respond to an adequate dose of medication… in the usual manner, usually between three*

[78] Transcript 134-35.
[79] Transcript 136.

therapeutic trials then that person would be considered to have a treatment resistant illness.

178. **Q:** *So Mr Helliar is compliant with medication and ECT, was poor in the community, and he was also resistant to treatment (medication), while an inpatient?*

Ans. *Yes.*

179. **Q.** ... *In the context of a patient who was very difficult to treat for bipolar, is non-compliance with medication a common occurrence?*

Ans. *Yes… poor insight... they don't understand the need for medication… because they feel well.*

180. **Q**. *Does anything cure bipolar?*

A. *No.*

181. **Q**. *ECT does not cure bipolar either?*

Ans. *No… ECT is particularly effective for mania. It is much more likely to work quickly and effectively and you are much more able to stop it fairly quickly. It is for the depressive phase that takes much longer to respond... I don't know why.*

182. In regard to ECT for treatment to acute bipolar affective disorder as distinct from maintenance ECT, Dr Peavey further testified that the combination would not necessarily involve the same dose being administered each time, and it would be reviewed on a weekly basis depending upon his response, which may involve re-titration if he is not responding. [80]

183. In response to a question asked by a family member, Dr Peavey stated that there was no evidence that his medication intake contributed to his suicidal ideation.

184. In conclusion, Dr Peavey was also questioned about the use of the Chief Psychiatrists guidelines, and whether those guidelines authorised the use of an algorithm to establish a treatment dosage for ECT. She responded by confirming that this matter was not dealt with by the guidelines, but by first obtaining the approval of the Chief Psychiatrist, and then included in training programmes.

[80] Transcript 141.

Relevantly she further observed that, *if it does not work properly you have 60 seconds in which to make a decision about the dose and it might depend on what you saw on the E… and then you have to make a very rapid decision.*[81]

Alison Boyte [82]

185. On 7 November 2012 Nurse Boyte was Gerard's contact nurse. As documented Nurse Boyte testified that she woke him for breakfast. During the morning Gerard undertook activities with the lunch cooking group during which period, Nurse Boyte was not present.

186. In her notes, recorded at an unknown time, Nurse Boyte reported that Gerard was, *guarded on staff intervention.*

I recall that between the hours of 1 and 2 pm, I attempted to speak to him while he was he was in the day room area. My attempt… was unsuccessful as he did not respond to any of my questions or conversation…

I recall that he attended the… cooking group. I was not present during the cooking session. However it was unusual for Gerard to participate in group activities so my assessment was that his participation was a sign of increased motivation and decreased risk…

Although Gerard did not interact on assessment in the Day Area, I was still able to complete an Acute Inpatient Assessment Tool. In the tool, I documented Gerard's risk of suicide as low. This was because there was no significant change in his effect to give rise to escalating concerns and also because… of the fact that he had engaged in the cooking group exercise.

I documented his overall risk as medium, which showed no change in his risk from previous shifts, in his overall risk. Gerard remained on hourly visual observations due to this medium risk rating as per Peninsula Health Mental Health guidelines.[83]

187. Nurse Boyte' s nursing notes as referred to by the witness, together with those made at the cooking class by Nurse S Brown became exhibit 7(a), while the risk assessment tool filled in by Nurse Boyte was admitted as exhibit 7(b).

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[81] Transcript 145-46**.** See also attachment 11-4c
[82] Alison Boyte is employed by Peninsula Health as an endorsed enrolled nurse.
[83] Alison Boyte statement Exhibit 7 page 1 and 2.

188. I note from the clinical notes of Nurse Brown, whose notes precede those of Nurse Boyte that she did not support Nurse Boyte's interpretation of Gerard's condition at that time. Instead they record in part that Gerald,

Was polite and pleasant on approach. Appears to be in a low mood and flat in effect… limited involvement in conversation despite encouragement. Looks lost at times. At one point in group reported feeling unwell and feeling stress in kitchen. Encouraged him to take a break but he preferred to remain in the kitchen to watch.

189. Nurse Boyte further testified in answer to questions from Mr Goldberg for Peninsula Health, that she was Gerard's AM contact nurse on both November 2 and 3, 2012, and conducted risk assessments on those occasions.

190. Nurse Boyte testified that her work on those dates was not the first time she had worked with Gerard as his contact nurse. She had in fact worked with him for a number of years. Non-compliance with her requests was unusual in her experience and she further described that she had a good relation-ship with him[84].

191. She had also nursed him on earlier occasions when he exhibited manic symptoms. [85] More unusually he presented with depressive symptoms.

192. In regard to her November 7 morning shift, Nurse Boyte testified that she commenced at 7 am. *We finish at 3.30 pm, but I have obviously gone a bit earlier that day*.[86]

193. In further evidence Nurse Boyte was unable to recall when she had completed her risk assessment in respect of Gerard. [87] On the risk assessment, she marked him as a low risk of suicide. (I note that his risk of suicide had been assessed as medium prior to November 7).

194. Her further evidence was that on 7 November Gerard did not respond to her attempts to engage in conversation and she marked him as having minimal insight into consequences, and limited insight into his illness, *because she knew him.*[88]

195. She *would have* explained to the incoming nurse on afternoon shift that she hadn't been able to complete a full mental state on him, and expected that he/she would complete a mental state rating, as part of the afternoon shift duty.

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[84] Transcript 162
[85] Transcript 164
[86] Transcript 157.
[87] Transcript 157.
[88] Transcript 156.

196. It was further established that earlier, on both November 4 and 6, risk assessments to be undertaken in respect of Gerard, by respective contact nurses, were similarly not able to be completed. [89]

197. According to the witness a mental state examination was the responsibility of the Duty Nurse, during both AM and PM shifts[90], *and it involves looking at their behaviours their thought forms… whereas your risk is her and now... what's going on with compliance –it's your risk*[91].

198. The risk assessment on the other hand, *is something that if someone is a high risk they will be on 15 minute (observations), so we need to know, we need to keep a closer eye on those patients. If they are not-if they are on medium or low risk, they will be hourly visuals.*[92]

Court:

199. **Q**. *In regard to the risk assessment on 7 November, it could also not be completed, in the sense that, it didn't rely heavily upon information you were getting from him at that time?*

Ans. *The mental state exam, I could not complete that, no.*

200. **Q**. *So when you have recorded that he wasn't expressing suicidal ideas, he wasn't expressing suicidal intent that appears not to be accurate in the sense that he wasn't expressing anything?*

Ans. *No. It was just a visual observation on my behalf.* [93]

201. **Q**. *So are you able to tell me why you assessed him as being at a low risk rating of suicide, despite that inability to communicate (with him), or his wish not to communicate?*

Ans. *I came to that conclusion because of Gerard attending his cooking class, which is very unusual for Gerard, and Gerard staying in communal areas.*[94]

202. Nurse Boyte further testified that it was not uncommon for Gerard to be found asleep or when approached for conversation to assess mental state, be unwilling or unable to communicate because of his low effect or demeanour.[95]

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[89] Transcript 158 as referring to brief, exhibit 11, pages 159 and 161
[90] Transcript 157-58.
[91] Transcript 166.
[92] Transcript 168.
[93] Transcript 160.
[94] Ibid.

203. **Q**. *Do your nursing protocols direct that in a situation where the patient is refusing to comply, refusing to communicate, that you should go ahead and use external factors… to complete the risk assessment tool?*

Ans. *I think we use a lot of different avenues. Our visual, what we see, they might be interacting with a co-patient, their history, their body language.*

204. **Q**. *Did you understand from that relationship that he was personally opposed to undertaking the shock therapy treatment that he was being given at that time?*

Ans. *I was aware of that. Yes… He expressed that to me.*

205. **Q**. *Did he say anything about the level of despair about the situation of which he was in?*

Ans. *I don't recall that conversation.*

Mr Goldberg:

206. Nurse Boyte also testified in answer to questions from Mr Goldberg that she was Gerard's AM contact nurse on both November 2 and 3 2012, and conducted risk assessments on those occasions.

207. She had nursed him on earlier occasions when he exhibited, manic symptoms.[96] There was no difficulty in engaging when he suffered from mania. *He used to like to tell his stories, which he did over and over again. Quite grandiose.*

208. **Q**. *And so for most of your exposure to Gerard, you were accustomed to his manic state?*

Ans. *Yes.*

209. **Q**. *It was a more unusual presentation, which he would come in with depressive symptoms.*

Ans. *Yes…*

210. **Q**. *He gave a lot more response when he was in a manic state?*

Ans. *Yes.* When in a depressed state, *his response would depend on the day. One day you might get a limited (response) out of Gerard and the next you may get… you may be able to comply a full mental state on him, depending on how he felt on the day.*[97]

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[95] Transcript 161.
[96] Transcript 164.

211. **Q**. *So would you agree that you can conduct a risk assessment with limited engagement such as you had with Mr Helliar?*

Ans. *Yes. I would.*

212. ***Q.*** *How can you reach a level of comfort…?*

Ans. *Well I know the history of Gerard. So we are looking at the distal factors there. The here and now- one of the reasons why I marked Gerard for medium as his overall risk is because he has a chronic risk anyway-he always had that chronic risk, so it's our knowledge of that particular patient.*

213. **Q**. *And if you were inclined to upgrade or downgrade the over-all risk what would be the next step?*

Ans. *You'd have to tell the ANUM and then it would be changed and then you would go to 15 minute observations… (and later at transcript 174, the ANUM and the Consultant).*

214. **Q**… *and the fact that you couldn't do a mental state examination, does that impact upon your assessment of the risk.*

Ans. *No.*

Court:

215. *Perhaps you had better elaborate… I have some difficulty in understanding why an inability to conduct a mental state assessment, because of the non-co-operation of the patient, would not impact upon the witness's consideration of his risk assessment.*

Mr Goldberg:

216. **Q**. *Would you agree that there are occasions where if you don't have engagement from a client that would give rise to concerns about their mental state.*

Ans. *Yes…*

217. **Q**. *Would you agree there are occasions where if you had concerns about a deteriorated mental state… you would also potentially be assessing the risk on the risk assessment tool (only)?*

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[97] Transcript 166.

Ans. *Yes…* [98]

218. **Q**… *you were concerned about a lack of engagement and you couldn't complete a mental state examination what parts of the risk assessment tool would trigger your response (in those circumstances)?*

Ans... *there is nothing in the risk assessment tool that would clarify that.*

219. **Q**. *So it is preferable to have a conversation with a client in order to complete a risk assessment?*

Ans. *Yes... when you ask like a patient... do they have suicidal thoughts, do they want to harm somebody else, have they got voices-you can relate all of that to risk assessment... You can still do the risk assessment but probably not in such depth as if they actually were (answering) the questions...* [99]

Mr Golberg:

220. *Does that address the points you raised?*

Court:

221. *Yes it does, but I remain to be persuaded... You will all have an opportunity to make submissions to me about that matter in due course.* [100]

Chief Nursing Officer Fiona Reed [101]

222. Mr Reed commenced her statement by seeking to response to several criticisms made by the Coroner's Investigator, Senior Constable Godsmark, concerning an alleged failure by Peninsula Health to assist Vicpol with its investigation into this matter. I have previously indicated that it is not intended to further investigate those allegations.

223. Similarly an allegation made by WG, a friend of the deceased, suggesting that Gerard was murdered while at Frankston Hospital, has been refuted after investigation and that matter also will not be further examined.

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[98] Transcript 170.
[99] Transcript 171-72.
[100] Transcript 174-75. See also the Courts discussion with Counsel as to his right to seek to recall Nurse Boyte at transcript 122, and the later discussion at transcript 202-03.
[101] Fiona Reed is the Chief Nursing Officer (Mental Health) at Peninsula Health, and at the time of the making of her witness statement (9/2015) she had held that position for 7 years.

224. Turning now to the finding of Gerard following what I am now satisfied was his act of self-harm, I note from the statement of CNO Reed that on 17 November she met with police member Mark Garrett, and that a belt retrieved from the Nurse Unit Managers (Peter's), filing cabinet believed to be found at the scene of the hanging of Gerard, was handed to SC Garrett, who also took photographs of the room where the incident occurred.

225. In her testimony, Ms Reed confirmed that on 7 November she recorded at brief page 162, that she had contacted,

family member Kate, that Gerard had been transferred to ICU after he was found having attempted hanging in bedroom… that he had tied a knot in the belt. Dr Singh stated that he had been sighted by a nurse at approximately 1500 hours and then had been sighted again…with emergency call made immediately when Gerard was found, which was approximately within 20 minutes of his last sighting or possibly within a shorter time frame to this.. Doctor Sing explained by phone that Dr Sharma had contacted her being the time of the emergency call but at that time was an attempted hanging.

Plan 1) Dr Sharma to meet tomorrow with family to provide support.

2) Any correspondence with family in regard to Gerard's condition to be his clinical doctor.[102]

226. And later,

Feedback given to ICU Consultant re possible timeframes of when Gerard was last sighted at 1500 hours for observation and then last seen talking to a client in hallway. Found by staff member at approximately 15.15 to 15.20 hours.

NUM thought that Code Blue attendance by the team was at approximately 15.15 hours.[103]

227. After reviewing the clinical notes concerning family contact, Ms Reed was questioned by Sergeant Dimsey concerning her knowledge about whether Nurse Boyte had completed risk assessment, on November 7.

228. Ms Reed stated that… *from my perspective risk assessment and a mental state examination go hand in hand, when you are conducting a mental state examination you are looking at a variety of domains such as mood, appearance, presentation affect, if the person presents*

[102] Clinical notes by CNO Reed at brief page 162 time 18.20 hours.
[103] Transcript 190.

with any thought disorder, and the mental state examination directly links into the risk assessment.

229. *If someone reports that they haven't had a level of engagement with a client there are a number of factors that can be considered… and that includes proximal and distal risk factors.*

So you are looking at longitudinal history in regard to the level of risk… you are looking at current risk factors, if they had been participating in events on the ward, if the person had a disagreement with another client, or had received an unwanted phone call… the assessment of risk as we all know is fluid and constantly changing, so it is not a one off event when you are assessing risk, it needs to happen at multiple times when you have contact with that client.[104]

Further if a person is a sleep (we) would make reference to that and the basis upon which the mental state has been assessed, which may include earlier contact, and also include why the full mental state examination could not be undertaken.

230. The witness was then questioned about the risk assessment tool, completed in respect to Gerard, between November 4 and 7. [105]

The issue is about the level of engagement because we have had a nurse waking a person up, asking them to come to breakfast… involvement in group activities, there are elements on that risk assessment where the clinician has been able to tick yes around feelings of hopelessness, isolation and loneliness.

So I would be expecting that clinician to be able to conduct a risk assessment, if there had been that level of engagement.[106]

231. Ms Reed further explained that morning shift commence at 7am and continue until 3.30pm with there being an overlap with the afternoon shift, which commences at 1pm. She was unable to say when Nurse Boyte's review was completed, but advised that clinicians are now required to document the time of recording.

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[104] Transcript 195.
[105] See exhibit 7(b).
[106] Transcript 202. (As to Nurse Boyte's level of engagement with and opportunity to observe Gerard, see her evidence referred to at footnotes 60, 65 and 66 above. I further note that Nurse Boyte did not offer that she had formed her opinions, based upon her interaction with him when she woke him for breakfast).

232. Ms Reed was aware of Nurse Boyte's evidence that Gerard was normally very compliant and co-operative, and also that according to the incoming observation (not contact) Nurse, Nurse Justin Jose, that there were no issues raised with him about Gerard.

233. If Ms Reed had have been concerned about Mr Helliar's suicide risk or mental state, *it would be expected that such a matter would be escalated directly to the Acting nurse unit manager,*

So that's the nurse in charge of the shift, and the consultant who is part of the treating team. At no time can a primary nurse… increase or decrease the frequency of visual observations unless it's gone through an escalation process.[107]

234. In regard to the safety of Gerard's environment in the LDU, Ms Reed further offered that in view of the clinical assessment and the risk assessment at the tie, the LDU was appropriate.

Obviously as he needed more intensive care and support and monitoring he would have been transferred to the High dependency unit our acute management area and in that area there is a higher staff to patient radio and more frequent monitoring.[108]

235. **Q**… *the role of the observing nurse?*

Ans. *The purpose of visual observation is about therapeutic engagement, it is about observing the client, if there is any difference to how they normally present and that would inform any alteration to the treatment and management of that person.*[109]

Mr Wilson:

236. **Q**. *Ambiguity about who was looking after Gerard… Mr Jose went into see the other patient and that's when he saw Gerard… so it was just by chance, would that be right?*

Ans. *No response.*

237. **Q**. *Vague (discussion) at 1500 hours in clinical notes? Page 218 whose is that signature?*

Ans. *I am not sure.*

238. **Q**. *It is not your responsibility to look after the patients at all, you just oversee the place?*

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[107] Transcript 205.
[108] Ibid.
[109] Transcript 207.

Ans. *No it is not my responsibility to look after the patients. That signature looks very similar to the 15.20 notation. (The evidence is that's Justin Jose).*

239. **Q**. *Alison Boyte… you know it wasn't her job apparently, and it wasn't Jose's, so who was actually the overseer of Gerard?*

Ans… *on the morning shift Alison Boyte was the primary nurse.*

240. **Q**. *She wasn't taking responsibility for it and Justin wasn't taking responsibility. So who was that who was that nurse that actually had to check on my brother, which would have been one of the four patients observed every hour?*

Ans. *Alison remained the (responsible) contact nurse… Jose had taken over responsibility for the periodic visual observations.*

241. **Q**. *Alison mentioned that she had left early that day? Was a proper handover performed?*

Ans. *I'll have to… I can't comment on that sorry I didn't know that Alison left early.*

Court:

242. **Q.** *Did she give a time do you recall? It was before the incident.*

Sergeant Dimsey:

243. *It was before 3pm. Yes.*

Ms Reed:

244. **A**. *Well that's the first I knew, I'd be expecting normal practise would be that they would start at 7. And finish at 3.30. There wasn't a proper crossover then, changeover.*

Mr Goldberg:

245. *We can make enquiries as to who the incoming nurse was, but…*

Mr C Wilson:

246. *Well, it should have been found out by now…*

247. **Q**. *There was an appointment for Dr Sharma to see him at 3 pm…*

Ans. *(Yes).*

248. **Q**. *So what happened there, the appointment didn't take place?*

Ans. *I am unable to comment…*

249. **Q**. *When Dr Peavey interviewed my brother on 7 September as part of his second opinion assessment she expressed that she was concerned about the severity of his suicidal ideation and in this was the main reason for her recommending… continuing with the ECT? I am wondering if this concern was reflected in my father's daily risk assessment and hence frequency of observations? So because he was involuntary shouldn't he also have been observed more often than just on an hourly basis?*

And he wasn't communicating couldn't communicate, you can't make a real assessment… wouldn't that (cause) alarm?

Ans. *But then we have the comment of the occupational therapist on the same day… about participating in the lunch group.*

250. **Q.** *But he wasn't… he wasn't talking with the overseer, you know he didn't want to really engage there?*

Ans. *I am not making excuses but I don't know what happened during that time frame*.

Court:

251. **Q**. *Do you have any further comment on the suggestion by the family that in the circumstances Gerard should have been put on a more frequent observation regime?*

Ans. *We were getting a different picture throughout the day… and then he was about to see a Consultant at 3 o'clock who would have engaged him further…*[110]

252. The witness further discussed the distinction between distal and proximal risk factors and proffered that there is now a standard tool for conducting mental state assessments, and risk assessments at Frankston Hospital [111]

Professor Sean Ording-Jespersen[112]

253. Professor Jespersen confirmed that Gerald was being held in the LDA at the time of the hanging. *He was dressed in his own clothes which included wearing a belt. This was in*

[110] Transcript 216.
[111] Transcript 217.
[112] Professor Jespersen has been the clinical director of Peninsula Health Mental Service since August 2009.

keeping with the Clinical Practise Guidelines of Peninsula Health Mental Health Service, and is in line with recommendations from the Chief Psychiatrists Investigation. 2008-10, which requires that the safety and security of the unit needs to be balanced with patients' rights and privacy within the therapeutic environment.[113]

254. He considered that based on risk assessments and the clinical impression of the treating team which included hourly nursing visual observations, that the risk rating of medium, in place on November 7, was appropriate and that the presentation was, *not consistent with the patient being at acute or imminent risk.*[114]

255. In regard to the measure of protection from opportunities to self-harm prevailing at Frankston Hospital, Professor Jespersen offered that in line with the Chief Psychiatrists Investigation 2008-10 that the quarterly ligature point audits, *are conducted and were up to date at the time of the hanging.*[115]

256. His further advice was that the Peninsula Mental Health Service believed that its current practises with regards risk assessment, risk management, access to belts and access to ligature points, *were in keeping with contemporary practise and the expectations of the Office of the Chief Psychiatrist and were supported by the findings of the mortality review Root Cause Analysis,* which was attached to his statement. Following a review of its Clinical Practise Guidelines by the Peninsula Health Mental Health, *no specific changes or actions have been initiated.* [116]

257. In further evidence Professor Jespersen offered that the persons involved in conducting the quarterly audits of potential hanging points within the unit, did not involve external participants, but rather, *our nursing staff and engineering staff the people responsible for making the changes.* Attachment 16 further suggested that the audits to that point, had all been conducted by nursing staff. [117]

258. In response to further questioning Professor Jespersen informed that the maximum limit between nursing observations of patients classified as being of medium risk of suicide, had been reduced from 60 to 30 minutes.

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[113] Statement of Professor Jesperson, at Exhibit 10 page 1. It was not in dispute that the belt used by Gerard and subsequently held by the ANUM, was Gerard's own belt.
[114] Ibid page 2.
[115] Ibid.
[116] Ibid page 3.
[117] See discussion and Courts response at transcript 237.

To my knowledge this wasn't as a direct result of this, it was part of our review of CPG's, and benchmarking with other services.

259. Professor Jespersen agreed that there was now a specific tool on which such observation recordings were to be made. It is also the case that such records were to be made by both morning and afternoon shifts and were to have the time of the recording (rather than the time of the making of those observations), noted on each such record. [118]

260. The witness was then referred to the incident under examination and advised that he was away from the hospital when he was informed of it, at approximately 4 pm, and that he became involved in meetings with family and staff the following morning.

261. Professor Jespersen's assessment of Gerard's current medical status, prior to and then ss a patient in the ICU, was provided to the family.

262. His assessment was that, *Gerard had suffered a significant hypoxic brain injury and that he had been cooled and sedated and was on life support, with his prognosis to become clearer over the next two or three days*.[119]

263. His further notes to discuss with family outlined, *the chronic high risk and severity of his bipolar illness, the mania, the mania and depression brittle, plus difficult to treat complicated by resistance to treatment.*

This had been a long admission with a slow response, ECT and a second external opinion. Benita Sharma had concerns about discharge to community treatment and was arranging for our community care units, which is a non-secure residential rehabilitation environment. In spite of high long term risk, (suicide) attempt at this time was not expected. Had spoken about it often but never attempted. Likely to have been a considered plan and concealed attempt rather than an impulsive act or reflection of current severe depression… Risk assessment, early observations appear complete and appropriate, seen plus/minus ten minutes before attempt, so hanging for about 10 minutes. Set up time. Belt around neck and knot over door… Incident response seems to have been very well managed. [120]

264. Professor Jespersen's additional view about the approximately 210 earlier ECT treatments was then sought.

[118] Transcript 239.
[119] Transcript 240.
[120] Transcript 241 and Dr Jespersen's notes at exhibit 10(a).

265. Dr Jespersen had been aware of his case since 2009 or 10, when he worked as an inpatient Psychiatrist. Gerard was well known to the majority of clinicians.

He was a difficult patient to provide treatment for and he was frequently discussed with me in my role as clinical director… He didn't want ECT, but sometimes it is necessary… And I firmly believe that if there had been an alternative to ECT we would have done that it was unusual; for us to seek an outside expert opinion… this was a reflection of how uncomfortable we felt giving someone ECT, when they really didn't want it. It was difficult to know whether his complaints of some cognitive side effects and memory problems and whilst this is a known side effect of chronic mental illness, and it can be very difficult to know whether those cognitive side effects are due to ECT, or due to something else. [121]

Court:

266. **Q**. *Was there any other course available to Gerard to seek to be able to stop that treatment, could he have gone to another authority?*

Ans. *He could have under the old Mental Health Act… my recollection is that they could appeal their involuntary status. And that appeal would certainly take into account their objection to ECT, but the provision was not as specific as now… But to my knowledge he didn't appeal to the Mental Health Tribunal and I am fairly confident that right would have been explained to him… we expect every client is orientated to their rights and the avenues of appeal.*[122]

267. Dr Jespersen was then questioned about the collection of information needed to make a mental state finding and how the absence of that material should impact upon a suicide risk assessment. He testified that it was difficult to consider a mental state assessment, *to be complete, or not complete… it is simply your observation of what you see… and you take it and (compare) it with the history you have from them, the documentation that you have about them… and the nursing observations.*

So in this particular case I do think it is reasonable for the nurse in question to have attempted to engage Mr Helliar, I would really like to think that she made you know more

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[121] Transcript 243.
[122] Transcript 244-45. See earlier reference to Gerard's appearance before the Mental Health Review Board.

than a cursory attempt to engage him and had a few goes at doing it. And then did a mental examination with what observations she had. [123]

268. **Q**. *This was a low dependency ward?*

Ans. *Yes. Even in a low dependency unit they are very acutely unwell people… So actually it is not all that common to get an absolutely full picture from just the mental state examination.* [124]

269. **Q**. *In relation to the risk assessment there are places where you must tick to answer and there is a tick "no" for suicide ideation and a "no" for any thoughts of suicide? Would you need to have a conversation to be able to tick yes or no to these boxes?*

Ans. *You could form an impression without them telling you, but no you couldn't no.*[125]

270. Dr Jespersen then gave further evidence as to the functioning of the new Mental Health Act, 2014. His advice was that if a patient who is not incapacitated and is able to form an opinion, refuses to give consent to ECT, then ECT will not be given, and the case will not get to a tribunal. If on the other hand he/she refuses to consent and later becomes ill and then incapacitated then a new application can be made to the tribunal by the treating body, and it becomes a matter for the Tribunal to determine.

271. Additional evidence was then given about the use of ECT and how a successful use may then give the patient the intellectual ability to plan and undertake an act of self-harm, and precautions that might be taken to interrupt this phenomenon.[126]

272. Mr Wilson then questioned whether the tops of the room doors might be cut away to take away this ligature point… with reference then made to the Chief Psychiatrists investigation and the frequency of hanging deaths in Psychiatric Hospitals.

273. **Q**. *Have you exhausted all possibilities… taken all steps to reduce ligature points?*

Ans. In response Dr Jesperson suggested that a balance needed to be struck between safety and privacy and if they were persuaded it would make a difference they would have done it.[127]

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[123] Transcript 247.
[124] Transcript 248.
[125] Transcript 249.
[126] Transcript 257.
[127] Transcript 262-63.

274. **Q**. *Do you think it is your right to take away a belt from a patient… especially one who has been made involuntary?*

Ans. *Because they have been made involuntary means other rights have been restricted… it is actually the reason we don't wish to restrict them further… Also voluntariness is different from suicidal risk… But I take your point and I think my point is that it comes down to the risk assessment in each case.*[128]

FINDING

Failure to deal with risk issues involved in further ECT.

275. Although Gerard had a known history of suicidal ideation, medical practitioners were not aware of any prior suicide attempts. This was consistent with the report of Gerard's daughter Kate Campbell, who became desensitised to his frequent statements about suicide.

276. Gerard left a voicemail on his daughter's phone about his Will on 3 November 2012. Ms Campbell reported not considering this a cause for concern, as her father had frequently spoken to her about his Will over the years. A handwritten Will was found in Gerard's room, which was dated 5 November 2012, the day of his last bilateral ECT. From all of the evidence I find that Gerard was planning his suicide for a period prior to 7 November 2012.

277. The treatment plan, which formed a mandatory part of the application made by Dr Alam on behalf of his Consultant Dr Sharma to the Mental Health Board, was prepared on 4 September 2012 and stated,

Admitted involuntarily CTO revocation; Physical examination; Bloods; Chart regular Meds and (words letters unclear pw)*; Consider another mood stabiliser; Second opinion for ECT; Monitor mental state and risk.*[129]

278. The orders of the Mental Health Board made on 18 September 2012, confirmed that, *the continued treatment of Gerard as an involuntary patient was necessary and confirmed his involuntary treatment order,* and further stipulated that it was satisfied that the planned treatment which included ECT, *was capable of being implemented*.

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[128] Transcript 265

[129] See treatment plan at exhibit 11 page 144, with details reported to Mental Health Board on 18/9 as referred to in paragraph 2.1, which adopted Gerard's treatment plan drawn up on his admission on 4/9, as reviewed on 13/9.

279. I take this to mean that the Mental Health Board was satisfied that it was more probable than not that such treatment could be implemented with a reasonable chance of success, and without causing harm.[130]

280. Having regard to Gerard's medical history, as provided by Dr Sharma, the ECT unit director Dr Peavey as well as Gerard's daughter, Kate Campbell, and having particular regard to the minimal information made available to the then Mental Health Review Board, (and in view of the lengthy history of earlier ECT treatment), I find that those concerned with this matter had no reasonable basis for any confidence that further acute ECT could be implemented in respect of this mentally unwell patient with a reasonable chance of success, and without causing harm.[131]

281. It is relevant that soon after the Mental Health Board approved the application, Dr Sharma acting in accord with the treatment plan, sought a further opinion from Professor O'Connor, this after Gerard again objected to further ECT. [132]

282. I note here that in addition to the requirements of the treatment plan adopted by the Mental Health Board, that the matter was also referred because both Doctors Sharma and Peavey were troubled by the fact that Gerard had experienced such a lengthy history of ECT without success, and that he maintained his opposition to further such treatment.

283. Dr Sharma also understood that Gerard was soon to be discharged and had concerns as to where he would be accommodated and cared for following his release. Dr Sharma's belief that ECT became less effective as time passed is also relevant. [133]

284. It was in these circumstances that Professor O'Connor travelled to Frankston to see Gerard and later reported his findings to Dr Peavey.

285. From this information I observe that in fact the central issues addressed to Professor O'Connor were whether there could be any confidence in proceeding with further ECT treatment, and whether any alternative treatment might be employed.

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[130] The view that treatment should be designed so as not to cause harm is believed to have emanated from the teachings of the Greek physician Hypocrites, during the 5th century B.C.

[131] See discussion commencing at paragraph 316 below concerning the Victorian Charter on Human Rights and Responsibilities Act, 2006 and the Mental Health Act 2014.

[132] It is not clear why the Mental Health Board was requested to approve the application before seeing the report to be obtained from Professor O'Connor.

[133] See paragraph 40*.

The basis of Gerard's objection is set out in his comments made on 7 September 2012, as set out in footnote 55 above. I note from Dr Sharma's letter to Professor O'Connor exhibit 3(a) that she did not claim that ECT had been successful in treating Gerard in the past. I also note that in his response letter to Dr Peavey exhibit 5(a), Professor O'Connor's did not suggest that he saw Dr Sharma when he visited Gerard at Ward 2(b).

286. Having reviewed the material before him Professor O'Connor recommended ongoing ECT, on the basis that Dr Peavey had previously claimed some success with the ECT treatment provided to Gerard. [134] This occurred over Gerard's earlier articulated objection set out above, and the absence of any evidence of any lasting improvement over a series of treatments, (both acute and maintenance), which by then had exceeded 200.

287. In all the circumstances however I also find that it would be very difficult for any clinician to answer the questions raised by Dr Sharma's request. Underlying this difficulty was the dearth of scientific data affirming of or not affirming of a proposal to continue with ECT in these circumstances. [135]

288. According to Dr Peavey it was also clear that Gerard's, *bipolar effective disorder was significantly treatment resistant to medication.* She considered however, *that he had experienced improvement with past ECT treatment,* and wrote a second opinion supporting that approach. In response to further questioning she also set out the rather flimsy basis on which this assessment had been reached.[136] She further discussed her concern about, *our difficulty in withdrawing him from the ECT and the prolongation of his treatments*.

289. Dr Peavey conceded that the treatment undertaken was, *a last resort* and felt, *there was no other option...*[137] She also explained that there had been little research in the area.

290. Dr Peavey further informed that the average number of ECT treatments usually required in a course of treatment in Victoria was 11.3 and by inference the fact of the large gap between that number and the number of treatments provided to Gerard.[138]

291. Thereafter and following Professor O'Connor's advice, unilateral and then bilateral therapy was reintroduced, with the latter commencing on 1 November.

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[134] See paragraph 73*.
[135] See New York study exhibit 5(d). Dr Peavey offered in evidence an article Absence of Cognitive Impairment after more than 100 lifetime ECT Treatments Am J Psychiatry July 1991. (See paragraph 151). I observe that this article, introduced into evidence but not previously viewed by Dr Peavey, suggests that from the 11 patients who participated in the study who had had more than 100 ECT treatments, that there was no evidence that following long term follow up, they were found to have suffered measurable cognitive impairment.
The fact that each such presentation may depend on a variety of factors leading to a combination of different responses and the long term aspect of this investigation, leads me to the conclusion that the results if known, could have provided only minimal assistance to Gerard's Doctors, concerning the decision to reintroduce ECT.
(The Director of the Ward 2(b) Unit, Professor Jesperson, was also familiar with Gerard's clinical history and the ongoing difficulty surrounding his treatment).
[136] See paragraphs 98-100 and 108-09. See also her evidence set out in response to my questioning at paragraphs 160-67.
[137] See paragraph 108.
[138] See paragraph 95.

292. I note the passage of the series of bilateral ECT treatments provided on November 1 and November 5 as set out in paragraphs 111-148 above. Dr Peavey further explained how the determination of the appropriate shock level is determined and how the patient's reaction to shock treatment should ideally be achieved within a 20-25 seconds, period. An appropriate level is needed to ensure a brain fit which, in a unilateral therapy, is then multiplied by a factor of 3 to achieve an appropriate treating dose. It was a practise developed through trial and error, which initially established a *threshold level,* and then allowed for the increase in dose to achieve a, *supra threshold.* I also note how the nature of the treatments was recorded in the weekly clinical ECT review. [139]

293. On November 1st the first bilateral treatment following the Mental Health Board order, the *threshold* dose was delivered at 30%, which according to the appropriate algorithm was then multiplied by one and a half times and led to a 50% *supra threshold* dose.

294. In later testimony set out at paragraph 112 above, Dr Peavey detailed how on 5 November an 80% supra threshold dose was first delivered, which was again increased to 120% when Gerard, didn't respond. She later retracted that evidence maintaining that this second charge was increased to 100% rather than 120%, and further explained how the mention of a dose of 120% level shock was a level to be implemented in future, i.e. after 5 November. Given the hearsay nature of the evidence provided on this issue I leave open the question of whether a second bilateral ECT on 5 November was delivered at a level of 100 % or 120%.

295. Having so resolved that matter I further find that the reintroduction of unilateral and bilateral ECT, and the increase in the level of the bilateral ECT dose, between 1 and 5 November, (after the cessation of increasing levels of unilateral ECT and with concurrent on-going antipsychotic medication), all occurred without a basis for belief that ECT was helping Gerard towards relief.

296. Rather the imposition of further pain and discomfort and the resulting stress and sense of hopelessness only added to the symptoms already evident in what was a chronic condition, in a man with severe suicidal ideation. In such circumstances I reject counsel's submission that the resumption of ECT was justified because, *it was the best available treatment allowing for the management of Gerard in a less restrictive manner*. I have reached this view because as above, the priority in delivering treatment to Gerard should have remained

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[139] Dr Peavey's initial evidence, which she later amended, was that a second bilateral dose provided to Gerard on November 5 had increased to a level of 120%.

one that was driven by decision making around Gerard's medical welfare, and keeping him from harm. For similar reason I also reject counsels submission that the taking of weeks or months to explore other medication strategies should not have been pursued. Rather the unique nature of Gerard's history additionally invited the possibility of trialling him at the Alfred hospital on Repetitive Transcranial Magnetic Stimulation, (RTMS), and I find this might reasonably have been pursued through the office of the Chief Psychiatrist. I further find that it is regrettable that a further review evaluating such a possibility, together with all available medication focused options, did not occur. [140]

Failure in care on 7 November 2012

297. On the day of his self-harm, some two days after his last bilateral ECT, Gerard's risk rating was recommended to be changed from a medium risk of suicide to a low risk of suicide. This recommendation was made by Nurse Boyte, who I find had not been able to adequately complete Gerard's risk assessment tool on that day.

298. Having reviewed again her evidence and the various opinions offered about her actions, I find that there was no basis for Nurse Boyte's assessment of Gerard's mental state, which was a key part of her mental health risk assessment and as a consequence that the risk evaluation of Gerard on 7 November 2012, was of little or no value. Nurse Brown's own contrary observations of Gerard during the extended kitchen activity, set out above, are relevant to this consideration.

299. I also find that Nurse Boyte's inability to undertake a mental state assessment on 7 November in a period following two recent bilateral ECT treatments, both causing or likely to cause greater levels of confusion than unilateral ECT, and in circumstances where at least two recent mental state reviews were also incomplete, warranted elevation of the matter to the ANUM or to a Consultant in accord with protocol, and that such an elevation should have occurred.

300. I note that Nurse Boyte's recommendation to reduce Gerard's suicide rating did not result in any immediate reduction to the frequency of observations. It is also the case however that we do not know whether an elevation of the matter of what I find was Gerard's then unknown mental state, would have led to a closer degree of scrutiny, which may have also included his transfer to the High Dependency section of the ward.

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[140] See paragraphs 55 and I69-75.

301. Professor Jesperson additionally responded to questions concerning the danger which can emerge to a person under ECT who may recover to a certain extent following its use, and how that person may then become able to plan and conduct an act of self-harm, of which he or she was not previously capable. Although Dr Peavey testified that improvement was seen following some instances of treatment earlier provided to Gerard, followed by regression, the further evidence does not suggest that any precautions were taken to guard against this phenomenon.

Failure in respect of creating a safe environment in Ward 2b

302. I am satisfied that the ongoing availability of hanging points and the then and still ongoing practise in regard to tolerating potentially dangerous clothing and personal possessions within the ward, which matters were not put in dispute, also contributed to Gerard's death. Recommendations in respect of these two issues are set out below.

Conclusion

303. At the time of his death Gerard suffered from chronic bipolar affective disorder, which condition had not improved despite the various forms of treatment provided at Frankston Hospital over an eighteen year period. I also find that Gerard had reached a point in his life where he was at a serious risk of self-harm, which matter had not been properly evaluated, and that his environment provided an insufficient level of obstruction to that end.

304. The application of the duty of care in a hospital setting has not always limited the care provided, to tried and trusted approaches. This is especially so in respect of the delivery of psychiatric care, which is sometimes based upon some of the less certain areas of medical science.

305. What is consistently the case across all areas of medical science however is that in cases where a patient is unable or unwilling to give consent, that there must be a reasonable expectation that a progress in care will be made as the result of the implementation of a proposed care plan, and that there will be no harm done to the patient as a result of such implementation. This includes the likelihood of gross confusion and dysfunction re-occurring in circumstances where there is no reasonable basis for belief that a medical breakthrough will occur.

306. Having regard to all of the evidence I find that primary error occurred in this case because of a failure to establish during the period of his last admission that there was a reasonable

likelihood that further ECT would provide Gerard with any relief and that it would not cause harm. I note Professor Jespersen's contrary evidence and to the extent of the difference between us on this matter, I reject his evidence.

307. Moreover as set out above error occurred in respect of risk assessment and care within this particular environment, all of which made Gerard's demise much more likely than need have been the case.

308. I further find that Dr Sharma, and Dr Peavey were both left in a difficult position in respect of the care plan, with the latter in a heartfelt moment indicating her concern that on 7 September 2012 he appeared so burdened. [141] I additionally find that direction in regard to care in this case should not have continued to be left to Dr Sharma, but rather that the matter should have been elevated through Dr Jesperson to the then Chief Psychiatrist for his/her advice as to how to proceed. I refer to the relevance of the *Victorian Charter on Human* Rights *and Responsibilities Act 2006 and the UN Convention on the Rights of Persons with Disabilities,* to this matter under Comments set out from paragraph 314 below.

309. I further find myself satisfied that before November 2012, the ECT care provided to Gerard had become largely experimental in nature, this in the sense that there was no basis for confidence in its outcome. I also find that the review by Professor O'Connor who effectively passed the primary issue back to the treaters, should not have been viewed as having impacted upon that consideration.

310. Coming to the mid-afternoon on November 7 2012, and to Gerard's state of mind at that time, I am satisfied that by that afternoon he was upset by the ongoing ECT, to which he had been subjected. I am also satisfied that he felt unable to impact upon the course of treatment, which had been chosen for him. His earlier adverse reaction to a new anaesthesia provided in connection with the unilateral administration of ECT on 22 October 2012, is also relevant.[142]

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[141] See Dr Peavey's evidence set out at paragraph 176. This historical remark was made by Dr Peavey in respect of her assessment of Gerard's level of suicidal ideation when she saw him on 7 September 2012, i.e. some two months prior to his death.

[142] See paragraph 170. Gerard's objection to the continuance of the previously prescribed suite of two anti-psychotic medications, (this continuing after the resumption of ECT), caused him additional distress. See footnote 55. Dr Peavey's comments concerning the adequacy of ECT therapy treatment of bipolar affective disorder in its depressive phase (paragraph 181) and Professor Jesperson's comments concerning the dangers which can emerge in the short term following ECT therapy, are also relevant. See paragraph 301

311. It is also the case that he had recently prepared materials later intended for his solicitor and was heard to have a conversation with a fellow patient, at about 3pm, at or near the door to his room.

312. I further find myself satisfied that his later actions displayed both intent and planning and were coupled with sufficient cognitive ability to carry out his plan and give effect to his purpose.[143] It is also relevant that he was able to take this course in a psychiatric hospital environment, where he was subject to ongoing observation and believed by his family and friends in the community, to be safe from harm.

313. Having regard then to all of the evidence and Counsels submissions, I find that error occurred in the management of Gerard, and that his death was preventable.

COMMENT

314. I am further satisfied that under the Victorian Charter on Human Rights and Responsibilities Act 2006, (and the Mental Health Act 2014), that the State of Victoria has an overriding duty of care in respect of all mentally ill patients placed in care.

315. The Charter on Human Rights and Responsibilities Act 2006, is a Victorian Law that sets out the basic rights and freedoms of all people in the state. It aims to foster a fairer, more inclusive community by requiring the Victorian Government, local councils and other public authorities (such as hospitals and the Office of the Chief Psychiatrist) to specifically consider human rights when they make laws, develop policies and provide services. This means the public bodies must act in ways compatible with human rights, which includes taking into account an individual's human rights when making decisions.[144]

316. Specifically Section 10 the Charter protects an individual from torture and cruel, inhuman or degrading treatment. It states that a person must not be:

(a) Subjected to torture; or

(b) Treated or punished in a cruel, inhuman or degrading way; or

(c) Subjected to medical or scientific experimentation or treatment without his or her full, free and informed consent.

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[143] We know this involved him in taking off his belt, tying off a knot and identifying and placing the knotted end in a secure position at the top of the doorway, and on his person.
[144] Charter Rights may be limited in certain circumstances, but this must be reasonable, necessary, justified and proportionate, per section 7(2).

317. Medical treatment is therefore a fundamental right in the same category as torture and Section 10 specifically prohibits coercive treatment and experimentation unless there is full, free and informed consent.

318. Under the Charter there exist exceptions or limitations to this *fundamental right*.

319. Section 7 of the Charter permits limitations as can be demonstrably justified, *in a free and democratic society based upon human dignity, equality and freedom, and taking into account all relevant factors, including:*

(a) The nature of the right;

(b) The importance and purpose of the limitation; and

(c) The nature and extent of the limitation; and

(d) The relationship between the limitation and purpose; and

(e) Any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.

320. In May 2008 Australia signed and ratified the *UN Convention on the Rights of Persons with Disabilities* (the Convention). Article 12 of the Convention states that signatories shall recognise that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life. To that end, signatories are required to take appropriate measures to provide access by persons with disabilities, to the support they may require in exercising their legal capacity.

321. Further Article 25 requires health professionals to provide care of the same quality to persons with disabilities, including on the basis of free and informed consent, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with disabilities through training and promulgation of ethical standards for public and private health care. Article 12 reflects a prohibition on inhumane/degrading treatment.

322. At the time of Gerard’s death, both the Charter & the Convention were in force. In the light of the passing into law of the Charter in 2008 the Government set about a review of the Mental Health Act 1986 (The 1986 Act), to consider if it was compatible with the Charter.

323. In October 2012, the Department of Health released a policy paper *“A New Mental Health act for Victoria, summary of proposed reforms.”*

324. It stated that central to the proposed reforms was the establishment of a supported decision-making model in the legislation. The model was to be informed and guided by a new set of legislative principles reflecting the Victorian Charter, (and the U N Convention on the Rights of Persons with Disabilities).

325. In particular, the summary set out:

(i) A Mental Health Tribunal would be established to replace the Mental Health Review Board. It was to consist of three members: a lawyer, a registered medical practitioner and a member of the community. It was envisaged decisions made by this Tribunal would take a holistic approach including the patient's goals, preferences and aspirations.

(ii) ECT would be subject to greater oversight than that provided by the 1984 Act. It was anticipated that where a patient could provide informed consent, that the tribunal would then permit ECT. Where the patient did not have capacity to consent, the tribunal would have to consider if the ECT was for the benefit of the person. In doing so, the tribunal would consider the likely success of the ECT in lessening the mental illness and other factors.

(iii) The legislation was also designed to provide a right for compulsory patients to seek a second psychiatric opinion about their treatment. Additional state funds would be available for these second opinions. The treating psychiatrist would have to consider the report and if not adopted, the patient could apply to the Chief Psychiatrist to review the case. The treating psychiatrist would be bound by the Chief Psychiatrist's decision.

(iv) Public Mental Health Services would be overseen by the Mental Health Complaints Commissioner that would be established.

(v) The Chief Psychiatrist was to focus solely on providing leadership and advice to the public mental health sector about the delivery of mental health services and no longer respond to complaints.

326. In February 2013, a draft Metal Health Bill 2014 was tabled in Parliament. It was duly enacted as the Mental Health Act 2014. It came into force on 1 July 2014.

327. It is apparent from the Mental Health Act 2014 (the 2014 Act), that it has incorporated the spirit of both the Victorian Charter and the UN Convention.

328. For example, section 11 establishes fundamental principles, which includes patients receiving mental health services that are provided with treatment that brings about the best possible therapeutic outcome; that patients be supported to make, or participate in, decisions about their assessment, treatment and recovery; and their rights, dignity and autonomy are respected and promoted.

329. There are a range of differences between the 1986 Act and 2014 Act, relevant to Gerard's treatment, which demonstrate compliance with the Victorian Charter and the Convention. For example:

(i) A Mental Health Tribunal (the Tribunal), replaced the Mental Health Review board, and has a wider remit and power, including hearing, determining and revoking Treatment Orders, applications to perform ECT and neurosurgery.[145] It is not limited to purely reviewing orders and treatment plans and hearing appeals on behalf of involuntary patients. A psychiatrist must now apply to the Tribunal for a Treatment Order.[146] The Tribunal must have regard to a patient's views and wishes, including as set out in their Advanced Statement, as well as the views of any nominated person.[147]

(ii) Under the 2014 Act, a Treatment Order can only be made by the Tribunal,[148] which is different to the 1986 Act, which allowed the equivalent order to be made by an authorised psychiatrist.[149]

(iii) The 2014 Act has enshrined and embedded a presumption of capacity, as a fundamental principle. It follows, that there is a presumption that a patient has the capacity to give informed consent, which must be obtained prior to administering treatment.[150]

(iv) Section 68(1) defines a person having capacity if they can understand, remember and weigh up information relevant to the decision, and are able to communicate the decision by some means.

[145] 2014 Act, s.153
[146] 2014 Act, s.53
[147] 2014 Act, s.55(2), s.93(2)
[148] 2014 Act, s.46.
[149] The 1986 Act, s 12, s 12AA, s 12AC, s 14
[150] 2014 Act, s.70.

(v) There is also a new principle embodied in the 2014 Act, requiring the preparation of an Advanced Statement, which outlines a person's preferences/wishes, should they become a patient, in relation to treatments. It is signed by the person and appropriately witnessed.[151] That statement must then be considered by a psychiatrist, later down the line, to the extent that it is reasonable in the circumstances to consider it, including for ECT Treatment where a patient is deemed unable to consent.[152] Should a psychiatrist go against the wishes of the patient as set out in the Advanced Statement, the patient must be told and can be provided with written reasons on request.[153] That decision can then potentially be reviewed by a Complaint's Commission.

(vi) The 1984 Act allowed for a patient to obtain a second psychiatric statement. However, it was not funded by the State. In addition, it was not prescribed within *the* 1984 Act as something the treating psychiatrist or the Mental Health Review Board had to take into account when considering whether or not to administer ECT. There was also no process whatsoever as to what a patient could do with a second opinion. As far as ECT was concerned, the ECT Manual, Part D: Clinical Practice Guidelines (Exhibit 10B at the Inquest) stated the following at page 22,

If the authorised psychiatrist proposes to authorise ECT for an involuntary, security or forensic patient, a second psychiatric opinion should be obtained. This opinion should be recorded in writing in the clinical record before ECT is given. In rural areas where it may not be possible or practical to have a second psychiatrist examine the patient, other options including tele-psychiatry or telephone consultation should be considered.

330. The 2014 Act maintained the need for a second psychiatric opinion, but has significantly improved on their availability and clarified their use. The 2014 Act now provides for funding for the second opinion; importantly it also allows the patient to choose the psychiatrist requested to provide a second opinion. Additionally, unlike the 1986 Act, the 2014 Act imposes an obligation on the treating psychiatrist, to consider the second opinion.[154]

[151] 2014 Act, s.19-21.
[152] 2014 Act, s.93 (2) (b).
[153] 2014 Act, s.73.
[154] 2014 Act, s.79.

331. If the treating psychiatrist does not adopt any recommendations of the second opinion, the patient can apply to the Chief Psychiatrist to consider it and the treatment proposed.[155] The Chief Psychiatrist can then direct the treating psychiatrist to amend a treatment plan, which is binding upon the treating psychiatrist.[156] A patient can also appeal to the Tribunal to have the treatment order revoked on the basis of the second opinion.[157] A second opinion can also be requested by any person on behalf of the patient.[158]

(vii) The 2014 Act has also created Nominated Persons, who are nominated by a patient (in writing) as a person who can receive information and be consulted about treatment and care decisions during compulsory treatment. They are to provide the patient with support in exercising their rights under the Act.[159] In order to assist in exercising their rights, the 2014 Act also establishes the right to access advocacy and support services, created by the Department of Health and Human Services. There is recurring state funding for this representation service of patients. There is also the avenue of appealing decisions of the Tribunal to VCAT.

(viii) There has also been a significant change as far as ECT usage is concerned. Under the 1986 Act, an authorised psychiatrist was able to provide substituted consent to ECT for involuntary patients if they did not have capacity to consent. In addition, a psychiatrist could override a patient's informed refusal of consent (where the patient has capacity) where the psychiatrist formed the view that the ECT was urgently required.

332. In contrast, under the 2014 Act, an ECT can only be performed on a patient with capacity, where there is written consent.[160] Where the patient does not have capacity to consent, then an application must be made to the Tribunal. In making that application, the psychiatrist must be satisfied that the ECT is the least restrictive treatment available, taking into account the patient's views, any alternative treatment, the advance statement, the views of the nominated person and the consequences of treatment not being performed.[161]

333. The 2014 Act has also created the Mental Health Complaints Commission which has a range of functions including managing investigating and resolving complaints relating to

[155] 2014 Act, s.87.
[156] 2014 Act, s.88.
[157] 2014 Act, s.85 (2) (b).
[158] 2014 Act, s.79.
[159] 2014 Act, s.23.
[160] 2014 Act, s.92.
[161] 2014 Act, s.93.

mental health service providers, issuing of compliance notices and to identify, analyse and review quality, safety and other issues arising out of complaints and make recommendations to providers, the chief psychiatrist, the Secretary DHHS, and the Minister.[162]

(ix) The 2014 Act has also changed the role of the Chief Psychiatrist, which is now considerably broader and includes clinical leadership, continuous improvement, promotion of rights and importantly, providing advice to the Secretary.[163] The extended powers include[164]:

a) entering mental health services, and undertaking inspections/investigations,

b) monitoring compliance with standards and guidelines and monitoring quality and safety,

c) undertaking clinical and practice audits. Clinical reviews relate to processes and practices that need to be changed to improve quality and safety.[165] *Section 134* states that the clinical practice audit relates to practices/matters relating to mental health services provided to identify systematic issues to address quality/safety.

d) analysing and publishing data and assist providers to comply with the Act. The Chief Psychiatrist's ECT Guidelines confirm that Designated Mental Health Services are required to report the use of ECT to the Chief Psychiatrist. Information must be provided within a month of treatment. The Chief Psychiatrist then monitors that information, and assists in informing and identifying potential problems and recommendations.

334. Accordingly, it is apparent that the 2014 Act has codified many of the Rights enshrined in the Victorian Charter on Human Rights and Responsibilities Act, 2006 and the UN Convention. It follows that the rights of patients, subject to involuntary treatment such as Gerard, are better protected and regulated by the law now governing this area. It is further apparent that a combination of all of the changes made by the 2014 Act would have resulted in closer scrutiny to the decision to administer further ECT to Gerard, and potentially have prevented his death.

[162] 2014 Act, s.228.
[163] 2014 Act, s.120.
[164] 2014 Act, s.121.
[165] 2014 Act, s.130.

335. In addition it is relevant that the Office of Chief Psychiatrist under the new Act is now mandated to publish data to assist providers. To that end, the Chief Psychiatrist provides an annual report, which contains information relating to ECT Treatment.

336. Having regard to these responsibilities and the information that the Chief Psychiatrist is now called upon to collate, it is further the case that his office is best placed to advise the profession concerning the treatment of people who are diagnosed with bipolar affective disorder, and more specifically as to how those who have demonstrated resistance to medication and ECT Treatments over a prolonged period, might be reasonably treated and protected.

337. I am also satisfied that appropriate accommodation does exist for the ongoing care of persons who are not suitable for further ECT in conjunction with acute management. Specifically pressure on bed space should not be any part of the issue, or the decision to proceed with ECT.[166] Again there is no issue made of this matter, and in my view this is the least standard appropriate to the provision of psychiatric care in a civilised society.

338. I also note however that the Office of Chief Psychiatrist, on behalf of State, is not put in a position where that Office might make appropriate arrangements consistent with the Mental Health Act 2014 and Victorian Charter unless it is informed of the particular difficulties, perhaps the unique difficulties, which may need to be addressed in any one case. Unfortunately and while (understandably) continuing to operate under the 1986 Mental Health Act, the evidence does not suggest that such a communication occurred in this instant.

Advice from the Chief Psychiatrist

339. Recommendation A) below recommends the provision of an advice by the Office of the Chief Psychiatrist which seeks to ensure that interested parties are fully appraised as to how patients who are suffering from bipolar affective disorder and are acutely depressed and who have shown themselves to be resistant to ECT over an extended period, and have objected to its ongoing use, should hence forward be managed.

340. Such a review should be evidence based and so far as is possible, proffer a process which is non conjectural. Such a review might also advise that where ECT treatment has not provided a basis for a reasonable expectation that further similar treatment is medically

[166] See paragraphs 162-5.

appropriate and will not cause harm that henceforward such patients will continue to be treated and maintained within a hospital setting this until clinical progress making the patient suitable for alternative management, is achieved.

The current protocol

341. In regard to the method of delivery of ECT, I observe that while general guidance is given in the current protocol as to when and how therapy should be delivered, that the type of dose and method of calculation of the level of shock to be delivered is not set out in either the then applicable protocol exhibit 5(c), or the present protocol redrafted following the 2014 Mental Health Act. Rather from Dr Peavey's evidence we know that such issues are left to training.[167]

342. I am aware of the success that is regularly achieved by the use of ECT in certain types of cases in our public and private hospitals.

343. However given the evidence, and the dearth of relevant research in this area, there remains an uncomfortable level of uncertainty about the medical management surrounding ECT treatment, and the potential for error in respect of the levels and frequency of ECT treatment to be offered in any one case.

344. In such circumstances I find that the exercise of discretion in terms of ECT type, frequency and dose, should be limited and that such an approach should be subject to specific direction within the protocol and to the continued review by the Chief Psychiatrist under the 2014 Mental Health Act. Given the potential level of functional decline of such patients, the need to offer all possible protection is paramount. Such an approach is therefore in the public interest and likely to add to the reputation of ECT, which is now offered in an area of medical science that has been shown to be difficult in research and inexact in its application.

345. It is envisaged that such an initiative would also help avoid the possibility of inconsistency in approach, which can occur when medical process relies exclusively on a training model of instruction. Recommendation B) refers.

Potentially dangerous items on the ward

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[167] Paragraph 184.

346. In regard to the personal items currently permitted to be kept it is common ground that Gerard was permitted to have possession of the belt used in his act of self-harm, while he remained within the unit.

347. I further note as Professor Jespersen described that Mental Health clinicians strive to balance patient safety against issues of patient dignity and freedom of choice. While such a task is no doubt difficult there are a host of rules and procedures within hospitals, which have been put in place, as they are considered necessary to reduce risk and increase safety for both patients and hospital employees. For example patients cannot freely access their prescribed medications; the doors of the ward are generally locked and access to legal substances such as alcohol are prohibited. Further items that can be used as a weapon, or for self-harm, such as knives, hard plastics or plastic bags are also denied.

348. Restricting access to a possible means of inflicting self-harm as an appropriate defensive strategy is listed by the World Health Organisation, as strongly evidenced based. Earlier coronial inquests have also identified the value in such an approach.

349. Denying access to a means of hanging in a psychiatric inpatient unit is a reasonable and proper purpose within the meaning of the Victorian Charter of Human Rights and Responsibilities Act 2006, and it follows that our defensive strategy should include restriction for patients, preventing access to both ligatures and ligature points.

350. The idea that this issue should be left to individual nursing units as maintained in the present protocol, has been shown in this Court to be too great a risk, and accordingly no longer appropriate. It should be amended as soon as practicable.

351. In the circumstances I therefore (again) recommend a change in the protocol so as to seek to ensure a strict management of the nature of personal items patients are permitted to bring into the ward. Such a course would offer additional protection to the disabled patient and to co-patients, as well as to those practitioners now working both within ECT delivery and within the separate clinical teams who are concerned with the ongoing care provided within the unit. Recommendation C) refers. [168]

Ligature points on the ward

[168] My finding in Inquest Case 4823 of 2012 refers. See also the decisions by my learned colleagues Coroner Spanos in Inquest Case 4587 of 2012, and Coroner Carlin in Inquest Case 531 of 2015.

352. To help better ensure that ligature points are also reviewed with fresh eyes there is a need for greater rigour, together with a contribution to this issue by a team led by an independent and appropriately experienced person. Such a team should endeavour to create a more informed, objective and rigorous assessment procedure for identifying potential ligature points within its psychiatric unit. In carrying out such duties such a body might reasonably seek to follow the direction provided by the Worcestershire (UK) Mental Health tool, for assessing and managing ligature risks in an inpatient unit. Recommendation D) refers. [169]

RECOMMENDATIONS

A) That the Office of the Chief Psychiatrist reviews all relevant research including its own data, and advises the mental health profession at large as to how patients who are suffering from bipolar affective disorder and are acutely depressed and who have shown themselves to be resistant to ECT over a prolonged period (and have objected to its ongoing use), should be assessed and managed in a hospital setting. Such advice should also deal with such other methods of management, which might be employed in such cases, this having regard the Mental Health Act, 2014 and the Victorian Charter on Human Rights and Responsibilities Act, 2006.

B) That the Office of the Chief Psychiatrist amends the December 2015 guidelines on Electroconvulsive therapy so as to provide greater direction to the mental health profession as to the type, frequency and as to the appropriate manner of calculation of the top end limit to the level of shock delivery, in all instances of delivery of ECT to mentally unwell patients. Direction in regard to the delivery of anaesthesia in connection with the condition under treatment, should also be part of such an amendment.

C) That the Office of the Chief Psychiatrist reviews its approach to the bringing into psychiatric hospital units of any personal items of a potentially dangerous nature. Belts, cords and the like are clearly such items.

D) That Peninsula Health creates a new audit team to be responsible for assessment of risk concerning the existence of ligature points, within Ward 2b Frankston Hospital, which team is to be answerable directly to the Chief Executive Officer Peninsula Health, and is to be chaired by an independent person who is possessed of appropriate training and experience in risk assessment in a hospital setting.

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[169] My finding in Inquest Case 4823 of 2012 also refers.

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353. In conclusion I express my sincere condolences to Gerard’s family for their loss. I am also aware of the sense of loss suffered by Frankston hospital Ward 2b personnel, and express my sympathy to that group, who like their colleagues in other similar units are frequently called upon to work through some of the most difficult issues facing hospital workers in the State.

DISTRIBUTION

Mr C Wilson.

Ms K Campbell.

Dr B Sharma.

Dr C Peavey.

Professor D O’Connor.

Ms A Ciotta.

Nurse A Boyte.

Chief Executive Peninsula Health.

Clinical Director Peninsula Mental Health Service.

Chief of Nursing Peninsula Health.

The Chief Psychiatrist.

The Chief Executive of the Royal Australian and New Zealand College of Psychiatrists.

The Chief Executive Safer Care, Victoria.

The Chief Executive Victorian Equal Opportunities and Human Rights Commission.

The Secretary Department of Health and Human Services in the State of Victoria.

The Secretary Department of Justice in the State of Victoria.

The Manager Coroners Prevention Unit.

Dated this 18th day of April 2018.

Peter White
Coroner