IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2011 0260

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the ***Coroners Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of DANIEL JOHN WOODBURN

without holding an inquest:

find that the identity of the deceased was DANIEL JOHN WOODBURN

born 17 July 1988

and the death occurred on 20 January 2011

at the railway overpass near Newmarket Train Station, on Racecourse Road, Flemington Victoria 3031

from:

1 (a) MULTIPLE INJURIES – FALL FROM A HEIGHT

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. Daniel John Woodburn was 22 years of age at the time of his death. He lived in Ascot Vale at the home of his parents, Dianne and Robert. Daniel completed his high school education at Essendon Keilor College and was an apprentice electrician.

2. Daniel's medical history included epilepsy from the age of eight, as well as severe acne which had previously been treated with isotretinoin.[1] He also had an episodic history of polysubstance abuse involving marijuana, ecstasy, steroids and occasional binge drinking of alcohol. There was no evidence of recently escalating substance abuse.

[1] Isotretinoin (roaccutane), is indicated in the treatment of severe acne. It has several side effects including extremely dry lips, eyes and skin, and vulnerability to depression but only while taking it.

3. At approximately 1.20am on 19 January 2011, Daniel woke his mother and told her that he believed he had shot someone. He appeared confused and delusional. Mrs Woodburn tried to calm her son and woke her husband.

4. Daniel went into the kitchen and retrieved a large knife, placed it beside him on a bench and repeated that he had done bad things and that the police were coming to get him. His family tried to calmly engage with him and encourage him to return to bed.

5. Daniel went back into his room, taking the knife with him. Daniel's brother Steven eventually managed to remove the knife from the room, and the family hid all the other knives that were in the house. Daniel woke a short time later and began searching for knives, stating that he needed to protect himself and that there were people in the shed and under his bed wanting to get him.

6. At approximately 6.00am, Mrs Woodburn called emergency services with concerns that her son may harm himself or someone else. Police attended and Daniel was taken by ambulance to the Royal Melbourne Hospital (RMH) Emergency Department.

7. Daniel reported increased paranoia for the past 18 months that had worsened in the past month. He presented with auditory hallucinations, all derogatory and some command in nature. He had attended court the day before for minor charges relating to car damage.

8. At 10.30am, Enhanced Crisis Assessment and Treatment Team (ECATT) Senior Registered Psychiatric Nurse Lynette Wade assessed Daniel as being at a high risk of violence and aggression and was aware of his thoughts of harming himself and others. He reported a previous attempt to jump off a bridge while intoxicated, and that his parents had been with him and returned him home. Daniel was provided with 10mg of diazepam and subsequently admitted as a voluntary patient to Orygen Youth Health (OYH) Inpatient Unit (IPU), a part of Melbourne Health, at Footscray with an admission diagnosis of first episode psychosis.

9. Upon Daniel's admission to the low dependency unit of the IPU at approximately 4.30pm, Psychiatric Registrar Dr Mark Vella and Nurse Josie Tomolo assessed him in the presence of his parents. Dr Vella acknowledged Daniel was evidently unwell and would need an approximate 10 to 14 day admission, indicating that he would not be able to leave the IPU for some time until he was stabilised with medication.

10. According to Mrs Woodburn, Dr Vella indicated their son would be commenced on antipsychotic medication and that he would be given some sleeping tablets. At the end of the consultation, Dr Vella indicated that he was going on leave that day and other doctors would be

treating Daniel. Following instructions from staff at the IPU, Mr and Mrs Woodburn left their son and planned to return the next morning on 20 January 2011.

11. The *Nursing Admission* form completed by Nurse Tomolo recorded the following *Interim Management Plan* for Daniel's first 24 hours of admission:

    - Depressed mood – frequent engagement
    - Hallucinations – monitor m/s (mental state) *undecipherable frequency*. Low stimulus environment
    - Self-injury – close observation next 24/24.

12. Nurse Tomolo's records include a description of Daniel as being at 'significant risk to self, due to unclear AH (auditory hallucinations), depressed mood...' The progress notes document Daniel was due for a review with a consultant psychiatrist the following day.

13. The *Nursing Care Plan* completed by Nurse Tomolo recorded:

    - Feeling paranoid that people are talking about him. AH (auditory hallucinations) telling him to do things – develop rapport and trust, frequent engagement 15-30/60. Further assessment of psychotic symptoms and nature of AH. Assessment and documentation of symptoms and level of risk. Offer frequent 1:1 time, validate Daniel's feelings, give reality feedback, consider recommendation if Daniel changes mind about hospitalisation. Commence antipsychotic, monitor increase for side effects. Provide psycho-ed.
    - Reports feeling depressed, grabbed knife prior to admission – document mood and changes. Regular engagement. Engage in activities that are positive. Offer use of gym, Daniel states he enjoys jokes, humour etc. *Search on admission and on return from leave.
    - Preparation for discharge – consider a referral to EPPIC. Liaise with family re further collateral [history]. Meet OCM (Orygen case manager) prior to discharge, provide ongoing education.

14. The IPU progress notes documented Daniel as "appeared to be asleep on all checks overnight." The observation records indicated Mr Woodburn was awake in his bedroom from 6.45am, in the television room from 7.00am until 8.00am, in his room at 8.18am and in the television room at 8.29am, which was his last recorded sighting by nursing staff until he was noted missing.

15. On 20 January 2011, at approximately 8.45am, Daniel's allocated nurse, Registered Psychiatric Nurse Sarah Mac Mahon could not locate him. Nurse Mac Mahon informed the nurse in charge

and began filling out the absent without leave procedure form.[2] Footscray police were contacted and Daniel was reported as missing.

16. Between 9.30am and 10.00am, Daniel was observed by witnesses on the railway overpass near Newmarket Train Station on Racecourse Road, Flemington. Daniel climbed the wire fence and jumped from it, falling several metres. A number of witnesses ran to Daniel's aid and performed cardiopulmonary resuscitation, but he was unresponsive. Ambulance paramedics arrived shortly afterwards and declared him to be deceased. Police subsequently attended the scene.

INVESTIGATIONS

Forensic pathology investigation

17. Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an external examination on the body of Daniel, reviewed a post mortem computed tomography (CT) scan and referred to the Victoria Police Report of Death, Form 83. Dr Bedford's anatomical findings were consistent with the known mechanism of injury. Toxicological analysis of post mortem blood did not detect alcohol, or common drugs or poisons.

18. Dr Bedford ascribed the cause of Daniel's death to multiple injuries secondary to a fall from a height.

Police investigation

19. The circumstances of Daniel's death have been the subject of investigation by Victoria Police on my behalf. The police investigation did not identify any evidence of third party involvement, and no "suicide note" was located. Police obtained statements from Daniel's mother Dianne Woodburn, and two witnesses.

20. Having reviewed the coronial brief, I directed that further statements from OYH and the RMH were to be obtained. Form 4 requests for statements[3] were served. Subsequently, I received statements from OYH Psychiatry Registrar Dr Mark Vella dated 18 August 2011, OYH Registered Psychiatric Nurse Sarah Mac Mahon dated 17 February 2012, and RMH Senior Registered Psychiatric Nurse Lynette Wade dated 10 April 2012.

21. Nurse Wade reported that on assessment at RMH, Daniel was oriented to time, person and place, but demonstrated significant impairment with both his concentration and memory. Nurse

---

[2] NorthWestern Mental Health *Missing Patient* MH01.09 provided to CCOV on 12 March 2014.

[3] The Form 4s - 'Documents and prepared statements required by coroner', were issued pursuant to section 42(2) of the *Coroners Act 2008*.

Wade noted that he displayed limited insight with impaired judgment but was accepting of the need for help. Nurse Wade stated that in view of Daniel's marked deterioration and his high risk of further deterioration, it was felt that community treatment would not be appropriate and that he would require an admission to OYH. However, as Daniel was accepting of and agreeing to an admission it was decided to admit him as a voluntary patient. Nurse Wade said she explained to Daniel and his parents that if he decided he no longer agreed to an admission or if his mental state deteriorated further, she would need to recommend him under the *Mental Health Act 1986* (Vic)[4] (the Mental Health Act) to be admitted as an involuntary patient.

22. Dr Vella stated that while he had believed Daniel to be significantly psychotic and potentially at risk on 19 January 2011, Daniel had been able to state that he was 'not right in the head' and was able to agree to speak to a nurse if he became troubled by increasing suicidal, distressing or violent thoughts. Dr Vella noted that he had also agreed to remain in hospital and accept medication. Given this, and his anxiety and the circumstances with which he had come to the ward, involving police and ambulance, as well as his prior persecutory ideas involving the police, Dr Vella assessed that it was 'entirely inappropriate' to invoke the Mental Health Act. Dr Vella stated that he did, however, note that Daniel was to be nursed on 15 minute observations with a low threshold for recommendation under the Mental Health Act if he should try to leave, suspecting that this could occur in response to a delusion of control or a command hallucination.

23. Nurse Mac Mahon reported that when she spoke to Daniel after 8.00am on 20 January 2011, he had presented as pleasant and polite and showed no sign of agitation or distress during their brief interaction. When she had not been able to sight Daniel for a visual observation at 8.45am, Nurse Mac Mahon finished all other clients' observations and while doing so checked each room and corridor for Daniel. She had broadened her search to the back garden and then the front of the hospital, before informing the nurse in charge and beginning the absent without leave procedure.

[4] I note that the *Mental Health Act 1986* (Vic) has now been superseded by the *Mental Health Act 2014* (Vic).

Coroners Prevention Unit investigation

24. Upon review of the additional statements, I determined to refer this matter to the Coroner's Prevention Unit[5] (CPU) to review the clinical care received by Daniel in particular at OYH.

25. The CPU review identified that Dr Vella and Nurse Tomoro documented Daniel's increased risk due to paranoia, his recent threats and use of weapons, command hallucinations and the fact that staff could not be sure how severe his auditory hallucinations were. The nursing care plan referred to the need for frequent engagement and monitoring of Daniel's mental state.

26. However, the review noted that after Daniel was initially assessed by Dr Vella and Nurse Tomoro, he was not assessed by any other staff while admitted to the IPU. His progress notes and the observation tick-off sheet contained no records of mental state examination or reassessment of risk by the staff. The monitoring was confined to establishing his whereabouts in the unit.

27. It was well documented in the medical files that Daniel was paranoid and had refused pathology tests at RMH. Daniel did not eat any of the OYH provided food after his admission to the IPU, but there was no documented attempt by the nursing staff to establish the possible reason, such as not trusting the content of the food.

28. The CPU review identified that it appeared the onus for reporting the existence or effects of any command hallucinations and level of distress rested with Daniel. The medical file record evinced Daniel was quiet overnight, and the review identified it was possible that staff considered him to be free of distress. If correct, this represented a significant improvement from his presenting symptoms at RMH and on admission at OYH, and in itself warranted at a minimum, documentation.

29. The review also referred to evidence of the dangerousness and increased risk associated with command hallucinations.[6] It was identified that distress is not always overt, especially in patients with paranoia who tend to disengage because they do not trust staff and are fearful or can feel threatened.

---

[5] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations, as well as assisting in monitoring and evaluating the effectiveness of the recommendations. The CPU comprises a team with training in medicine, nursing, law, public health and the social sciences.

[6] Department of Health, Mental Health, Drugs and Regions – Clinical practice guidelines suicide, page 35.

30. On 22 May 2014, the Court wrote to Dr Leeanne Fisher, Medical Director of OYH explaining that the investigation had identified some apparent issues regarding:

    - the implementation of care plans;
    - nursing knowledge of risk associated with paranoia; and
    - medication administration changes.

31. Dr Fisher provided a response on behalf of OYH by signed letter dated 14 July 2014.

32. Clarification was sought on the clinical rationale for Daniel not having a documented mental state review over either shift, in the context that Dr Vella had recommended a low threshold for use of the Mental Health Act.[7] Dr Fisher explained that Daniel was observed to be asleep throughout the night, and this precluded any other description of his behaviour or appearance, that would have formed part of an overnight mental state examination. Dr Fisher stated that Daniel appearing to be asleep was a significant observation in its own right.

33. Dr Fisher was also asked to clarify the material available to the OYH IPU that is specific to the assessment and monitoring of clients with command hallucinations of self-harm, especially with acute onset and paranoia. Dr Fisher stated that nursing staff are expected to undertake annual training in risk assessment. Dr Fisher further noted that the presence of command hallucinations forms one part of the phenomenology taken into account when making the overall risk assessment.

34. The Clinical Risk Assessment and Management (CRAAM) form provided by Dr Fisher listed command hallucinations and paranoid ideation about others as aggression dynamic factors (that is, factors that are subject to change) but not as risk factors in either suicide or self-harm. Dr Fisher provided a revised Adult and Youth Acute Inpatient CRAAM guideline document, dated 3 December 2013, and identified the now greater emphasis on meaningful patient engagement as compared to the 2010 CRAAM guidelines.

35. The 2013 CRAAM guidelines included greater emphasis on the frequency of engagement and describes at page 5 a 'process of engagement to include mental state assessment and risk review'. It also described 'regular engagement' to include:

---

[7] It was noted that the nursing care plans appeared to be based on the comprehensive assessments, however scrutiny of the inpatient health records did not provide evidence the nursing staff "offer frequent 1:1 time, validate Daniels' feelings, give reality feedback" or documented a mental state examination over the evening or night shift.

- an allocated nurse to be aware of patients between regular engagements – visual checks, involved group activities, whether they are with visitors, etc; and
- patients who are isolative or reluctant to engage may require monitoring in some other way, e.g. regular attempts at engagement.

36. The 2013 CRAAM was also clearer regarding the documentation of staff risk rating and the rationale of how they reached the risk category/rating for each patient.

37. Dr Fisher was asked to clarify the clinical rationale for not commencing any psychoactive medications for Daniel, and whether it was usual for patients with psychotic symptoms to carry the onus for recognising their need for medications and asking staff for it.

38. Dr Fisher noted the OYH's 2010 *Australian Clinical Guidelines for Early Psychosis* recommend trying to have a period of observation of between 24-48 hours with no antipsychotic treatment, offering potentially the only time in the course of the illness when the presentation is not influenced by the use of medication and/or their side-effects. Treatment offered in that initial phase is usually limited to the use of benzodiazepines for the relief of stress and anxiety.[8]

39. Dr Fisher stated that the charting of the antipsychotic on an 'as needed' basis should have carried the indication of 'severe' or 'extreme agitation'. She said that typically it is the decision of the consultant psychiatrist to commence regular medications in the case of someone presenting with a first episode of psychosis, and Daniel would have been seen by a consultant psychiatrist on the morning of 20 January 2011. Dr Fisher added that there was no expectation on the patient that the onus for use of medications is solely theirs.

40. Dr Fisher agreed there was no evidence of nursing staff providing psycho-education to Daniel about medications and assumed that Dr Vella, the prescriber, would have done so, which, according to Dianne Woodburn, had not occurred in their shared contact with Dr Vella.

Issues arising following the Coroner's Prevention Unit review

41. A number of issues primarily relating to Daniel's care remained of concern following the CPU review and receipt of Dr Fisher's letter. I directed that a Mention Hearing be held. In particular, I had concerns that:

- Daniel was in the IPU overnight, and it appeared that staff made no attempt to assess his mental state during 9.45pm and 8.29am. This was in the context of paranoia which

[8] Dr Vella had prescribed Daniel with diazepam.

frequently results in patient disengagement. Combined with Daniel's documented command hallucinations to harm himself, it appeared that Daniel was vulnerable, and required frequent engagement, as documented by Dr Vella and Nurse Tomolo upon admission. It was reasonable to expect the nursing staff to follow their care plan and interim plan and make attempts to engage with Daniel, and if they were unsuccessful, to document it because no engagement is an indicator of mental state. Frequent engagement and monitoring of mental state are different processes to establishing if Daniel was still in the unit every 15 minutes.

- Dr Fisher dismissed the apparent discrepancy between Nurse Tomolo's nursing care plan and the actual care received by Daniel. Dr Fisher said 'I have formed a differing opinion than that stated as the basis for your question'. This suggested Dr Fisher viewed the lack of mental state examinations and engagement between 9:45pm and Daniel's disappearance at 8:29am the following day as appropriate in the context of him having slept until 6:45am. Even if I accepted Dr Fisher's opinion, there was no documented assessment of Daniel's mental state even between 6:45am and 8:29am when Daniel was awake.
- Dr Fisher's opinion that Daniel being asleep was a significant observation in its own right, does not acknowledge that such a description does not imply he was settled and fails to clarify whether staff completed head checks from the doorway or actually entered his room. There was no documentation of an attempt to assess if his level of disengagement was in fact due to him being settled or rather because he was in an unfamiliar environment for the first time and possibly fearful of staff.
- There was no documented attempt by nursing staff after Daniel's admission by Nurse Tomolo, to assess his need for or willingness to take the *pro re nata*[9] (PRN) diazepam, or to explain the indication for its use, its risks and benefits. The assumption appears to have been that if he was not overtly agitated, he was therefore asymptomatic and without the need for medication. The issue of Daniel not receiving any medication is significant in the context of staff not engaging with him over the 10 hour period, and not providing an assessment of need or education to him regarding its availability.
- Furthermore, while Dr Fisher stated that there are no expectations on patients that the onus for use of medication is solely theirs, in the absence of meaningful engagement or assessment it is difficult to challenge this perception. While Daniel's judgment was

[9] *Pro re nata*, or PRN means 'as needed'.

considered impaired and his insight limited, nevertheless he was considered able enough to decide if he needed medication he was unlikely to understand, and reliable enough to notify staff if the auditory command hallucinations and his mental state deteriorated such that he needed their assistance. This approach appears to disregard that paranoia inherently brings with it many barriers to a patient trusting and reporting their experience to the nursing staff.

- The 2013 CRAAM guidelines had greater clarity about the expectation of staff to engage with patients to assess their mental state. However, the lack of a clear, specific requirement for night staff to engage with certain patients to assess mental state and inform risk prior to the morning clinical handover, renders the 2013 CRAAM guidelines deficient and does not mitigate the risk of a similar situation occurring in the future. It remained unclear whether a patient with a significant risk of self-harm and command hallucinations could still be admitted to the low dependency unit at OYH IPU, be left undisturbed for 10 hours within the first 24 hour period and prior to a consultant psychiatrist's review, without an attempt by staff to assess their mental state and thereby changes in their risks.

Correspondence with parties and the Mention Hearing on 16 December 2014

42. A Mention Hearing was held on 16 December 2014, in order to progress my investigation and hear the interested parties on whether or not an Inquest should be held.

43. In the months prior to the Mention Hearing, the Court had received correspondence from the interested parties which indicated that related civil proceedings issued by Mrs Woodburn were on foot. K&L Gates, on behalf of Melbourne Health, provided the Statement of Claim and Court Orders relevant to the civil proceedings, and requested that I suspend the coronial investigation to avoid unnecessary duplication of inquiries.[10] A Form 26 Request for Inquest, providing reasons why the coronial investigation should not be delayed, was subsequently received from Maurice Blackburn Lawyers on behalf of the Woodburn family.[11] As a result, I also sought to resolve the conflicting views amongst the interested parties regarding the significance of civil proceedings and how they might impact upon my investigation.

[10] Communication received by letter dated 29 October 2014.

[11] Communication received by facsimile dated 14 November 2014.

44. In the lead up to the Mention Hearing, Maurice Blackburn Lawyers had also provided an expert report by New South Wales Consultant Psychiatrist Dr Paul Read, along with a memorandum highlighting a number of concerns relating to Daniel's treatment.[12]

45. Dr Read opined that the care provided by OYH was not appropriate. In particular, Dr Read noted that the documentation provided no record of any discussion with the consultant psychiatrist covering the inpatient admission on 19 January 2011. Dr Read stated that it would be important to review the decision pathway as to the placement of Daniel in an unlocked unit and the reasons not to commence some regular medication at that time. Dr Read viewed 15 minute observations to be of insufficient frequency, given Daniel's symptoms. In addition, Dr Read stated that it was not appropriate for Daniel to have been a voluntary patient, given the severity of his symptoms, including no longer feeling in control of his own volition.

46. Dr Read added that Daniel should have been administered medication, given he was acutely psychotic and extremely distressed by his symptoms. One option could have been to use a benzodiazepine whilst titrating in an antipsychotic medication. Another approach would be to introduce an antipsychotic medication alone. Dr Read clarified that the antipsychotic or mood stabilising effects of atypical antipsychotic medications are not immediate, but benefits in terms of distress, agitation and arousal are frequently observed before marked resolution of psychotic symptoms.

47. At the Mention Hearing, I advised the parties of the likelihood that I would make adverse comments in relation to OYH, and that I had not been entirely satisfied with restorative and preventative measures indicated thus far. I also queried whether Dr Read had given consideration to the differing legislative frameworks in Victoria and New South Wales, relating to involuntary admissions. I asked the interested parties to provide any further submissions and expert opinions by 1 April 2015, and that after the receipt of these I would be able to make decisions regarding the future course of the investigation.

Expert opinions and submissions provided on behalf of Melbourne Health (OYH)

48. By way of letter and email dated 31 March 2015, Ms Jess Bayly of K&L Gates provided submissions on behalf of Melbourne Health, attaching an expert report by Professor of Psychiatry Nicholas Keks dated 6 January 2015, and a statement from Associate Professor Peter

[12] Communication dated 24 October 2014.

Burnett, Director of Clinical Governance at NorthWestern Mental Health,[13] dated 27 March 2015.

49. Ms Bayley submitted that OYH remains of the view that the medical treatment and management provided to Daniel, including his admission as a voluntary inpatient to a low dependency unit, was consistent with reasonable medical practice in Victoria at the time.

50. Ms Bayley said OYH conceded that it would have been preferable for Daniel's management plan to be discussed with the on call consultant psychiatrist, but said there was evidence that this would not have altered the management plan, or resulted in a treatment plan that would have prevented him leaving the IPU, or averted the outcome.

51. Ms Bayley submitted that it was consistent with the recommendations of the Australian Clinical Guidelines for Early Psychosis 2010 not to immediately commence antipsychotic medication on admission, and that in any event it would have taken days or weeks to reduce psychotic symptoms. In addition, Ms Bayley submitted that the administration of PRN medication was available to Daniel. She contended that as the medication would have had a sedative and anxiolytic affect, in circumstances where he was observed to sleep through the night and was not visibly agitated, it was not reasonable to require its administration.[14]

52. In response to my preliminary comments regarding an apparent failure of nursing staff to adhere to the original risk assessment for frequent contact and assessment, Ms Bayley submitted that there was no evidence before the Court to support a finding that the nursing management was not appropriate or consistent with the medical management plan. Ms Bayley pointed to Professor Keks' opinion, consistent with evidence of Associate Professor Burnett, that the nursing care provided to Daniel during his admission was consistent with reasonable medical practice.[15] Professor Keks opined that 15 minutely observations were appropriate and continuous observation was not required. Associate Professor Burnett said the nursing care as detailed in the records was entirely consistent with reasonable nursing practices. Ms Bayley stated that notwithstanding the view that the nursing management was appropriate, the introduction of the CRAAM Guidelines at Orygen has provided clarification as to the expected

---

[13] NorthWestern Mental Health is a division of Melbourne Health.

[14] Professor Keks noted that Dr Vella had prescribed tranquilising (olanzapine and diazepam) and hypnotic (zopiclone) medication for use if needed. Professor Keks said that while Daniel was noted to be anxious in the IPU, he did not manifest behaviours which suggested the need for pharmacological reduction of anxiety or behavioural disturbance which would merit tranquilisation: Professor Nicholas Keks' expert opinion @ Paragraphs 106-107.

[15] Professor Nicholas Keks' expert opinion @ Paragraph 130.

level of engagement and observation for patients who are assessed as a 'low risk', 'medium risk' and 'high risk'.

53. Professor Keks stated that with respect to the issue of whether Daniel should have been admitted as an involuntary patient, it was important to note that according to the Mental Health Act, clinicians must treat patients in the least restrictive environment or setting possible. Professor Keks opined that as Daniel understood that he was being offered psychiatric treatment and repeatedly indicated he was agreeable to receive that treatment, including hospitalisation, there was no ambiguity in this case. In addition, Professor Keks stated that while there were significant risk issues in Daniel's presentation, in his opinion there were also no grounds for his admission to a secure high dependency unit. As Daniel had partial insight and was agreeable to treatment, Professor Keks stated it was appropriate for him to be admitted to an open ward.

54. Associate Professor Burnett confirmed that at the time of Daniel's death the OYH IPU was operated as an unlocked or 'open' unit. However, there was a discrete part of the unit known as the Intensive Care Area (ICA). This was a locked area, designed as a contained, low stimulus area for very high risk clients. Associate Professor Burnett noted that in general, only involuntary patients could be admitted to the ICA. He added that even if Daniel had been admitted as an involuntary patient on 19 January 2011, he would more likely than not have still been placed in the open ward on 15 minute observations.

55. Ms Bayley stated that OYH accepted that the ability of Daniel to abscond from the IPU was a factor directly relevant to his death. She added that the OYH has detailed for the Court the changes that have since been implemented to respond to risks posed by an open unit and confirmed that OYH IPUs now all operate as locked wards.

56. Associate Professor Burnett stated that following Daniel's death, NorthWestern Mental Health and OYH undertook a review of the management and treatment provided to him. A number of recommendations for potential improvements to practice and policy were made, and key changes were implemented including:

    - OYH has adopted the Clinical Risk Assessment and Management (CRAAM) procedure and training;
    - OYH has re-communicated and emphasised the need for Registrars to notify Consultants of all admissions;

- OYH IPU does not unlock doors in the morning until new patients have been reviewed by a Consultant, with risk assessments and management plans in place.

Submissions on behalf of the Woodburn family

57. By way of email dated 1 April 2015, Ms Emily Hart of Maurice Blackburn Lawyers provided submissions on behalf of the Woodburn family. Ms Hart confirmed that Dr Read, who had provided an expert opinion dated 24 April 2014, was aware of the process for involuntary admissions in Victoria, and that the processes are different to those in New South Wales.

58. *Inter alia*, Ms Hart noted that there was a factual dispute in regard to whether Daniel had in fact been agreeable to be hospitalised for psychiatric treatment. Ms Hart submitted that Daniel was unable to make rational decisions about his own care and had earlier refused treatment at the RMH. She added that the presence of command hallucinations, in conjunction with difficulty in establishing rapport and earlier refusal of treatment, meant it was appropriate to admit Daniel as an involuntary patient to OYH.

59. Ms Hart submitted that there was no evidence in the medical records or statements that staff at OYH had any meaningful engagement with Daniel after the initial admission assessment. In particular, Ms Hart noted that the nursing care plan proposed that staff 'develop rapport and trust – frequent engagement 15-30/60… offer frequent 1:1 time.' She added that there are no contemporaneous nursing notes in the progress notes demonstrating engagement, except for an overnight review stating Daniel was asleep throughout the shift.

60. Ms Hart submitted that the low dependency unit was inappropriate to manage Daniel's condition, and that he needed to be in the high dependency unit or locked ward to appropriately manage the risk of harm to himself and / or others. She added that 15 minutely observations were inadequate, as they meant Daniel was not being observed and able to leave the facility. Ms Hart submitted that Daniel should have been placed on a locked ward, so that any attempt to leave would have at least been halted with the opportunity to arrange for an involuntary treatment order to be made. Ms Hart added that Daniel needed to be either in the high dependency unit or placed on 1:1 observations with a nurse.

61. Ms Hart said that while Dr Vella had noted Daniel was subject to 'a low threshold for recommendation under the Mental Health Act if he should try to leave', there is no specific information about how this would be activated, or that any staff who were not present at the time of his admission were informed of this plan.

62. Ms Hart submitted that while anti-psychotic medications would not have had immediate impact on Daniel's psychosis, the effects of managing distress, agitation and arousal in acutely unwell patients meant their immediate administration would have been appropriate. Ms Hart also communicated her instructions that when Mrs Woodburn left OYH on 19 January 2011, Daniel had been complaining of insomnia. Ms Hart suggested that the PRN sedative medication should have been given to Daniel and that the decision not to administer it was not due to his presentation, but rather reflective of the lack of engagement between staff and Daniel.

63. In particular, Ms Hart submitted that the Woodburn family sought additional material in relation to:

- What specific information was given to nursing staff on the ward at OYH on 20 January 2011 as to the plan for management if Daniel tried to leave?
- What systems were in place at the time of Daniel's death for monitoring of exits to the OYH inpatient facility?

Determination following receipt of submissions

64. As both parties indicated in their submissions that they accepted the matter could be finalised without Inquest,[16] I determined to make an in-chambers Finding.[17] I also determined that, in the circumstances, and as is usual practice in the coronial jurisdiction, it was not necessary to wait for the outcome of the civil proceedings to progress my investigation.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comments connected with the death:

1. The lack of any meaningful assessment and / or documentation of assessment of Daniel in a period spanning more than 10 hours, has necessitated a protracted investigation which no doubt increased his family's distress and grief for the loss of their son and brother. It remains difficult to comprehend how Daniel could be admitted in such an acute state and assessed on a fine line between voluntary and involuntary statuses, and yet 10 hours could elapse without any assessment or indeed any indication of professional engagement in that time. It was reasonable to expect the nursing staff to follow their care and interim plans, and make attempts to engage

[16] By way of email dated 20 May 2016, Ms Emily Hart of Maurice Blackburn Lawyers, withdrew the Form 26 Request for Inquest on behalf of the family.

[17] The parties were advised of my decision by letter dated 28 April 2015.

with Daniel, and if they were unsuccessful, to document it. While it is possible attempts occurred, there is no documentation in the medical files or the statements by staff, suggesting they did not assess his mental state, risk or level of distress after Nurse Tomolo and Dr Vella's assessments on admission.

2. I am unable to reconcile Dr Fisher's statement that Daniel was asleep overnight, with her opinion that this precluded any other description of his behaviour or appearance that would have formed part of a mental state examination. Daniel does not appear to have been engaged between the hours of 9.45pm on 19 January 2011 and 8.29am on 20 January 2011, with the aim of establishing his current mental state. This remained the case, despite the fact that he was awake from 6.45am. Furthermore, there is no evidence as to whether nurses performed head checks from Daniel's doorway or actually entered his room. There is thus no definitive indication of whether Daniel was in fact asleep and settled, or actually fearful and disengaged, or indeed demonstrating other features of the paranoia he presented with.

3. Moreover, given that patients in other health settings engage with clinicians overnight, and Daniel's recent admission with acute symptoms, I do not view his apparent sleep as a reason to negate further investigation as to his mental state. Dr Fisher's correspondence appeared to suggest that Daniel's sleep was more important than a qualitative assessment after he had been admitted in an acute state hours prior. While the therapeutic benefits of sleep are well documented, Dr Fisher has not provided an analysis of the benefit of sleep having regard to Daniel's acute onset of symptoms.

4. I note that Professor Keks and Associate Professor Burnett provided opinions that the nursing care given to Daniel was consistent with reasonable medical practice. However, both of these opinions did not make reference to the inconsistency between the *Nursing Care Plan* and delivery of care to Daniel. It was submitted on behalf of Melbourne Health that the expert evidence of a psychiatric nurse was required to comment on this issue. However, it was contended for the Woodburn family that this was not required as the *Nursing Care Plan* was clearly not followed. On balance and with a comfortable degree of satisfaction, I agree with the family's submissions in this regard.

5. In addition, it is important to note that the monitoring of Daniel's location every 15 minutes, did not equate to frequent engagement and monitoring of his mental state. While I acknowledge the differing expert opinions provided regarding the appropriateness of 15 minutely observations, and the impracticality of more regular or continuous observations, I view this as a side issue, to

the larger considerations of quality engagement with Daniel and provision of a safe and secure environment.

6. I accept that the provision of antipsychotic medication to Daniel upon his admission to OYH would not have had immediate effect and may have even been inappropriate. I note Dr Fisher's statement that treatment offered in the initial phase is usually limited to the use of benzodiazepines for the relief of stress and anxiety. I also note Professor Burnett's opinion that, probably because of notation that he was asleep, Daniel does not appear to have been overtly anxious, agitated, restless or pre-occupied such that he would require the administration of PRN medications. However, the evidence invites an interpretation that the relevance of the lack of medication given to Daniel reflects only the poor level of engagement with him while admitted at the OYH IPU. I have been unable to locate any documentation indicative of attempts by nursing staff following Daniel's admission to assess his need for or willingness to take PRN diazepam, or to explain the indication for its use, risks and benefits.

7. Dr Vella recorded that Daniel was to be nursed with a low threshold for recommendation as an involuntary patient under the Mental Health Act if he should try to leave. However, Daniel was placed in an unlocked ward, and I remain unclear as to who was advised about his 'low threshold' and how this approach was to be implemented. I note Associate Professor Burnett's evidence that at the time of Daniel's admission, OYH IPU operated as an unlocked unit, and that there was a discrete, secure section which could only house three clients. It is possible that it was impractical at the time to admit Daniel to a locked unit.

8. I also note that Professor Keks opined that Daniel was 'treated in the least restrictive environment possible, in accordance with the philosophy of the Mental Health Act'. But I also note that the object expressed in section 4 of the relevant Mental Health Act provides that 'people with a mental disorder are given the best possible care and treatment *appropriate to their needs* in the least possible restrictive environment and least possible intrusive manner *consistent with the effective giving of that care* and treatment'. It is unclear to me how placing Daniel in an unlocked ward, with 15 minutely observations availed staff with the opportunity to monitor his ability to leave and enact the 'low threshold' indicated by Dr Vella. While the importance of a minimally restrictive environment is clear, it does not supplant the need for one appropriate to the patient's needs. It is somewhat telling that I do not have evidence available to answer the Woodburn family's request for information about the specific information given to nursing staff as to the plan of management should Daniel try to leave OYH, or the systems in place at the time of his death for the monitoring of exits to the IPU.

9. I acknowledge the submissions that Melbourne Health accepted that the ability of Daniel to abscond from the OYH IPU was a factor directly related to his death. I also welcome the changes that have been implemented at OYH since Daniel's death to respond to the risks posed by an open unit, so that all OYH IPUs now operate as locked wards.

10. I also welcome the greater emphasis on meaningful patient engagement in the 2013 Clinical Risk Assessment and Management guidelines, which should mitigate the risk of head checks substituting staff engagement with patients. However, I note there remains an absence of specific articulation of how night duty staff should engage with and assess a patient's mental state to inform an assessment of current risk and to communicate that information at handover.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

1. I remain unpersuaded following this extensive investigation that there was effective communication between staff about Daniel's precarious position between voluntary and involuntary patient status. **I therefore recommend** that Orygen Youth Health provide specific periodic training on the use of the Clinical Risk and Management (CRAAM) guidelines, including but not limited to the expectations of night staff to engage with patients in circumstances such as Daniel's, where there is likely to be a significant delay between admission and assessment by a consultant psychiatrist.

2. With the aim of providing greater assistance, clarity and guidance to mental health clinicians, **I recommend** that the Chief Psychiatrist review whether there are or whether there should be guidelines issued by the Office of the Chief Psychiatrist, which provide guidance to clinicians on the appropriate engagement with clients in multifactorial situations, such as Daniel's, and in particular, but not limited to, on night shifts.

FINDINGS

The precise precipitating factors that led Daniel to adopt the course of action he ultimately chose on 20 January 2011 cannot be identified with any degree of certainty. However, on the evidence available to me, it appears as though his onset of acute mental illness, including depressed mood as well as auditory and command hallucinations was a contributing factor.

I accept and adopt the medical cause of death as identified by Dr Paul Bedford as multiple injuries secondary to a fall from a height, and find that Daniel John Woodburn intentionally took his own life.

AND I find that the investigation has identified a number of shortfalls in the management of Daniel by Orygen Youth Health. These short comings, some of which I acknowledge have been addressed, represent an opportunity lost to engage with, manage and monitor Daniel's acute onset of mental illness.

However, I am not persuaded that Daniel in fact warranted being admitted to the locked ward at Orygen Youth Health, as it was then, and in the circumstances, I cannot find with any degree of certainty that Daniel's death could have been prevented.

Pursuant to section 73(1A) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

I direct that a copy of this finding be provided to the following:

Mr Robert Woodburn

Ms Kathryn Booth, Maurice Blackburn Lawyers on behalf of Dianne and Robert Woodburn

Mr Peter Kelly, Director of Operations, Melbourne Health (NorthWestern Mental Health)

Ms Jess Bayly, K&L Gates Lawyers on behalf of Melbourne Health

The Chief Psychiatrist of Victoria

Sergeant Timothy Norton

Signature:

AUDREY JAMIESON
CORONER

Date: **1 June 2016**