IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2007 1735

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: GRANT ELLIOT PHILLIPS

Hearing Dates:	8, 9 & 10 November 2010
Appearances:	Mr R Appudurai of Counsel on behalf of Brian and Marion Phillips. Ms N Karapanagiotidis of Counsel on behalf of North Western Mental Health Service
Police Coronial Support Unit	Senior Sergeant J. Brumby, Assisting the Coroner
Findings of:	AUDREY JAMIESON, Coroner
Delivered On:	12 October 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000

I, AUDREY JAMIESON, Coroner having investigated the death of GRANT ELLIOT PHILLIPS

AND having held an inquest in relation to this death on 8, 9 and 10 November 2010

At MELBOURNE

find that the identity of the deceased was GRANT ELLIOT PHILLIPS

born on 19 March 1978

and the death occurred on 7 May 2007

on rail tracks near Glenroy Railway Station

from:

1 (a) MULTIPLE INJURIES IN A TRAIN INCIDENT

in the following summary of circumstances:

1. On 7 November 2007, Mr Grant Phillips[1] absconded from the Broadmeadows Inpatient Psychiatric Unit (BIPU) where he was an involuntary patient. He later attended at the level crossing at Glenroy Railway Station and took his own life by stepping in front of a Broadmeadows bound train.

BACKGROUND CIRCUMSTANCES

2. Grant was 29 years of age at the time of his death. He lived at 24 Lawrence Street, Hadfield with his parents and carers, Brian and Marian Phillips. He has three siblings, a brother and two sisters. Grant was in receipt of a Disability Support Pension.

3. Grant's medical history included a diagnosis of ADHD[2] at the age of 15 years for which he was commenced on dexamphetamine. In early 1999, Grant started displaying signs of mental ill health with his father reporting signs of paranoia.[3] Grant was diagnosed with schizophrenia in or around 2000 and from then on, he had regular contact with psychiatric services both as an inpatient and outpatient. He had been an involuntary patient on a Community Treatment Order (CTO) since 2002. Over the

[1] Brian and Marian Phillips requested that their son be referred to by his first name during the course of the Inquest. For consistence, I have attempted, where possible, to use only his first name throughout the Finding.

[2] ADHD = Attention Deficit Hyperactivity Disorder

[3] Exhibit 1 – Statement of Brian Phillips dated 18 June 2007

years he had been treated with various antipsychotic medications including depot medication on occasions.

4. In December 2001, Grant was seriously assaulted necessitating hospitalisation for treatment of facial injuries. He required multiple operations and subsequently became a heavy user of cannabis, escalating to heroin, ecstasy and other drugs to, according to his father, control his ongoing pain.[4] Over the years, Grant made a number of suicide attempts utilising a number of different modalities. He continued to "self-medicate" with illicit substances.[5]

5. Dandenong Psychiatric Services managed Grant's mental ill health until February 2006 when in moved to the Broadmeadows area. The NorthWestern Area Mental Health Service (NWAMHS) subsequently managed his care. Grant's history of schizophrenia was characterised by symptoms including auditory and visual hallucinations, disorganised and unpredictable behaviour, perplexity, significant suicide attempts and chronically poor insight.[6]

6. On 22 August 2006, Grant made another attempt on his life by hanging. At the time, he was living with his parents in Glenroy. Marian Phillips located her son and called out to Brian Phillips for assistance. Marian and Brian were able to release Grant from his hanging position with the assistance of a neighbour and they commenced cardio-pulmonary resuscitation while waiting for Ambulance paramedics to arrive. Grant was transported to the Royal Melbourne Hospital (RMH) and subsequently transferred to the BIPU where he remained for approximately one month. He was commenced on depot medication and discharged home on a CTO with the plan that he and his family would be seen weekly and that he would attend Broadmeadows Continuing Care Team (CCT) fortnightly for his depot injections. Grant was readmitted one week later after he stole and crashed his mother's car.

7. In October 2006, Grant was discharged from BIPU and returned to his parent's home. He remained subject to a CTO, supervised by Broadmeadows CCT, NWAMHS. He

---

[4] *ibid*

[5] T @ p 48 (Mr Phillips)

[6] Exhibit 4 – Statement of Dr Nicholas Owens dated 18 May 2007

was administered depot medication between September 2006 and December 2006 when it ceased due to complaints of severe side effects. He continued on oral antipsychotic medication.

SURROUNDING CIRCUMSTANCES

8. In or around April 2007, Grant's parents began to notice deterioration in Grant's condition. He was exhibiting bizarre behaviours, wearing his sunglasses 24 hours a day and refusing to take his oral medication. They had reported some of their concerns to Grant's case manager, Mr John Belanti.

9. On 19 April 2007, Mrs Phillips accompanied Grant to a scheduled outpatient appointment. Community treating/Outpatient Psychiatrist, Dr Nick Owens had the impression that Grant was relapsing into psychosis and that the major risks were of further deterioration, risk to others and risk to self. Dr Owens considered the risks manageable with the assistance of the Crisis Assessment and Treatment Team (CATT) and he referred Grant's case to the CATT for daily visits and made some alterations to Grant's medication regime[7] including the commencement of Aminsulpride.

10. On 24 April 2007, Dr Owens reviewed Grant, again with his mother in attendance who reported some improvement in Grant's behaviour and compliance with his medication. Dr Owens did not identify any overt evidence of psychosis and Grant denied suicidal ideation. Dr Owens cancelled the CATT visits and scheduled a telephone appointment with Grant for 27 April 2007 and an in person review for 4 May 2007. Grant failed to call Dr Owens on 27 April 2007. Dr Owens made contact and following a discussion with Mrs Phillips, arranged for a triage phone call over the coming weekend and for the case manager to ring Grant on Monday 30 April 2007, in order to continually monitor Grant before his scheduled appointment on 4 May 2007.[8]

11. On 4 May 2007, Grant did not attend his scheduled appointment with his mental health team but Mr and Mrs Phillips did and reported Grant's deteriorating behaviour to Dr Owens and his case manager. Mr and Mrs Phillips told Dr Owens and Mr Belanti that

---

[7] *Op cit* & T @ p 107 (Dr Owens)

[8] *Op cit*

Grant needed to be readmitted to hospital and they knew that he would not go voluntarily.[9] Dr Owens and Mr Belanti assessed Grant, in his absence, as being at serious risk of self-harm. Dr Owens stated that:

> *At this stage my impression was that there was clear evidence of relapse of illness dating back at least two weeks, failed home treatment of this relapse including CAT involvement, clear evidence of at least recent noncompliance and evidence that the deceased's behaviour was becoming bizarre.*[10]

12. The decision was made to revoke Grant's CTO. Dr Owens referred the matter to the CATT so they could manage the revocation.

13. Later that day, the CATT attended at the family home and advised Grant that his CTO was revoked for non-compliance with medication. Grant would not co-operate with the CATT resulting in a request for assistance from the Police. Subsequently, Grant was transported to the RMH Emergency Department (ED) with the assistance of Police. He was admitted to the High Dependency Area at approximately 8.00pm following assessment by the admitting psychiatric registrar.

14. On 5 May 2007, following a review by Associate Professor John Fielding, Consultant Psychiatrist, Grant was transferred from the RMH High Dependency Area to the BIPU. At approximately 4.00pm, Grant was admitted to the Low Dependency Unit (LDU) at the BIPU as an involuntary patient. Nursing staff and the Psychiatric registrar, Dr Rani Ruben, assessed him on admission. Grant was observed at 15-minute intervals by nursing staff.

15. On 7 May 2007, at approximately 10.00am Dr Jianyl Zang, Consultant Psychiatrist, reviewed Grant who agreed to stay in hospital and continue with oral medication. As Grant had made no attempt to leave hospital over the weekend and had been compliant with his medication, Dr Zhang assessed him as suitable to remain in the LDU on 15-minute sight observations.

---

[9] T @ p 40 (Mr Phillips)

[10] Exhibit 4 (& see also p101 of paginated medical records)

16. At 1.30pm, Registered Nurse (RN) Edith Essibrah commenced duty and was allocated the role 'contact nurse' for Grant and four other patients. RN Essibrah was unsuccessful in her attempts to engage in conversation with Grant and found him to be guarded and suspicious of staff.[11]

17. At approximately 7.00pm, Mr Phillips visited Grant at the BIPU. When Mr Phillips was leaving, Grant said to his father, "Have a happy life".

18. At approximately 8.00pm, Grant packed his belongings into two shopping bags and absconded from the BIPU by jumping over the 1.4-metre fence in the common/exercise courtyard. At approximately 8.15pm, another patient informed RN Essibrah that Grant had climbed over the fence. RN Essibrah informed the nurse in-charge of the shift, Associate Nurse Unit Manager, Mr Tony Siddle. A search of the hospital grounds and adjacent parkland was initiated however, Grant was not found. RN Essibrah subsequently telephoned Mr Phillips to advise the family of the situation and the Broadmeadows Police Station to report Grant missing without leave.[12]

19. Grant later attended at the level crossing at the Glenroy Railway Station and at approximately 9.40pm, Grant stepped in front of a Broadmeadows bound train. Grant died on impact.

JURISDICTION

20. At the time of Grant's death, the *Coroners Act* 1985 (the Old Act) applied. From 1 November 2009, the *Coroners Act 2008* (the new Act) has applied to the finalisation of investigations into deaths that occurred prior to the new Act commencement.[13]

21. In the preamble to the new Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for the purpose of finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference

---

[11] Exhibit 8 – Statement of Edith Essibrah dated 3 May 2010

[12] Exhibit 8 – *op cit*

[13] Section 119 and Schedule 1 - *Coroners Act 2008*

to preventable deaths and public health and safety are referred to in other sections of the Act.[14]

22. Section 67 of the new Act describes the ambit of the coroners' findings in relation to a death investigation. A Coroner is required to find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.[15] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

23. A Coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.[16] A Coroner may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death which the Coroner has investigated including recommendations relating to public health and safety or the administration of justice.[17]

Identification

24. The identity of Grant Elliot Phillips was confirmed by fingerprinting performed by the Forensic Services Department of Victoria Police.

INVESTIGATION

Medical investigation

25. Mr Brian Phillips lodged an Objection to Autopsy.[18]

26. Dr Michael Burke, Forensic Pathologist, at the Victorian Institute of Forensic Medicine (VIFM) performed an external examination, reviewed a post morten CT scan, and reported to the Coroner that in the absence of a full post mortem examination, and in

---

[14] See for example, sections 67(3) & 72 (1) & (2)

[15] Section 67(1)

[16] Section 67(3)

[17] Section 72(1) & (2)

[18] Section 29 *Coroners Act 1985*

the circumstances, a reasonable cause of death could be attributed to multiple injuries sustained in a train incident.

27. The objection to autopsy was upheld.

28. Toxicological analysis was negative for alcohol, common drugs or poisons. At the time, the Toxicology Department of VIFM did not have the technology to test for a wide range of antipsychotic medications including Amisulpride.

Police Investigation

29. The Police investigation and preparation of the coronial brief was undertaken by leading Senior Constable Brad Gray from Fawkner Police Station.

INQUEST

30. Direction Hearings were held on 21 April 2010 and 20 May 2010.

31. An Inquest was held pursuant to section 52(2)(b) *Coroners Act 2008* because at the time of his death, Grant was *a person placed in custody or care* as it is defined in the Act.[19] The issues identified as requiring further examination through a public hearing included:

- The risk assessment undertaken by staff at the BIPU when he was an involuntary patient on 5 May 2007 and the appropriateness and accuracy of this.
- The decision to accommodate Grant in the Low Dependency Unit (LDU) at the BIPU as opposed to a High Dependency Unit (HDU) and reason why this course was adopted.
- The decision to place Grant on 15-minute visual observations and the sufficiency of this.
- The issue of fencing in the patient outdoor area at the BIPU in the LDU and the sufficiency of this and the reasons for alterations to the fencing at the unit since the time of Grant's death.

[19] Section 3 *Coroners Act 2008*

- The issue of the communication to police by BIPU staff regarding Grant's absence from the unit and whether sufficient information was communicated to police to reflect the level of suicide risk which Grant presented.

Viva voce evidence was obtained from the following witnesses:

- Mr Brian PHILLIPS – Grant's father
- Mr John BELANTI – Social Worker/Case Manager, North Western Mental Health
- Dr Nicholas OWENS – Consultant Psychiatrist, North Western Mental Health
- Dr David MUIRHEAD – Consultant Psychiatrist and Director of Clinical Services, North Western Mental Health
- Dr Jianyl ZHANG – Consultant Psychiatrist, Alfred Hospital (previously of North Western Mental Health)
- Ms Edith ESSIBRAH – Registered Nurse, North Western Mental Health
- Mr Mark BESTER – Registered Psychiatric Nurse, North Western Mental Health
- Acting Sergeant Bradley GRAY – Investigating Officer

FINDINGS AND COMMENTS

Risk assessments

32. Dr Owens agreed with the proposition that Mr and Mrs Phillips were very engaged with the people involved in Grant's treatment and that because of their engagement, their input about his mental state could be trusted *absolutely.*[20] According to Mr Belanti, the risk assessment of Grant undertaken on 4 May 2007 reflected that there were *significant risks* and that Grant *would need a contained environment.*[21] Mr Belanti played a part, with Dr Owens, in making the decision, based greatly on information provided by Mr and Mrs Phillips, that Grant could no longer be managed in the community – that is, that his CTO should be revoked.

[20] T @ p 90 (Dr Owens)

[21] T @ p 68 (Mr Belanti)

33. The decision to revoke Grant's CTO and facilitate his involuntary admission to hospital was appropriate in the circumstances. The risk assessment completed by Dr Owens and Mr Belanti had appropriate and respectful regard to the information provided by his parents - his carers - but also took into account their own knowledge and observations of Grant in the preceding few weeks.[22]

34. The often-heard complaint from family and loved ones of people with mental ill health is that the mental health team does not heed their concerns so it was enlightening to hear the evidence of Mr Phillips in conjunction with the evidence of Dr Owens and Mr Belanti that this was not the case in Grant's circumstances.

35. However, it was conceded by both Mr Belanti and Dr Owens that risk can change and according to Dr Muirhead, Grant was assessed suitable for the LDU on the basis of a number of factors including that he had not demonstrated *any positive evidence that he was depressed or had intention to harm himself.*[23] In addition, he had previously been managed in the LDU on two occasions without incident and had talked positively about the future as late as the day of his death. Dr Muirhead stated that a further factor in the consideration for managing Grant within the LDU was the requirements of the *Mental Health Act 1986*, which stipulates that all patients be managed in the least restrictive setting possible.

36. Dr Muirhead also commented that the patient's risk assessment is an ongoing process with assessment of Grant being done at the different facilities but in general terms, would also be undertaken each day or if required.[24] He agreed with the proposition that a patient's risk is an ongoing process, which can fluctuate from day to day, and within any one day.[25]

37. The decision to accommodate Grant in the LDU at the BIPU is linked to a contemporaneous assessment of risk. When Grant arrived from RMH, nursing staff performed the initial assessment of risk, according to Dr Muirhead. In addition, the

---

[22] T @ pp 91-92 (Dr Owens)

[23] Exhibit 5

[24] T @ p 125 (Dr Muirhead)

[25] T @ p 126 (Dr Muirhead)

admitting registrar, Dr Ruha, made his own assessment of Grant's risk.[26] However, the fact that Professor Fielding had assessed Grant at the RMH as being suitable for Broadmeadows LDU *would have been given some weight in terms of weighing all of the evidence available in terms of making their assessment.*[27] Dr Muirhead was able to reconcile the risk assessment performed on 4 May 2007, that Grant was of significant risk of self-harm on the basis that:

> *When he was assessed in the community he was assessed in terms of what the risk would be if he is in the community…*[28]

Low Dependency Unit v. High Dependency Unit

38. The HDU is locked at all times with access in and out of the Unit for a patient achieved only with a staff member. Patients within the HDU are involuntary patients.[29] The HDU equates to a high level of confinement and observations and it is anticipated that such a level of containment and observation will occur for only a short period.[30] The fence in the HDU courtyard was *significantly higher*[31] than the LDU and is under direct observation by nursing staff. The LDU on the other hand has patients that are both involuntary and voluntary and access to and from the Unit is less restrictive. The door is often opened/left open to enable patients to leave the building for example to smoke outside. Observation of patients in the LDU courtyard is periodic.

39. Dr Owens' role with Grant effectively ended once the CTO was revoked and Grant was admitted as an in-patient. Any subsequent decisions regarding which Unit in which to accommodate Grant was not at the behest of Dr Owens or indeed, done in consultation with him. He conceded that he was not the one assessing Grant on 5 May 2007 when he was being transferred back to BIPU from RMH but he did state:

---

[26] *Op cit* &.T @ p 137 (Dr Muirhead) & pp 234-236 paginated medical records

[27] T @ p 131 (Dr Muirhead)

[28] T @ p 131 (Dr Muirhead)

[29] However, Dr Muirhead did say it was not inconceivable that a patient might volunteer to be placed in HDU but the qualifications he then placed on this statement made it seem unlikely that would ever occur. T @ pp127-128

[30] T @ p192 (Dr Muirhead)

[31] T @ p 128 (Dr Muirhead)

..based on my knowledge of him in the community, my understanding of what his parents were telling me on the Friday when I revoked his CTO and my assessment of the risks, I felt that he should have been in HD.[32]

40. However, according to Dr Muirhead, the decision as to whether a patient should be admitted to the HDU or LDU is based on the perceived level of risk *at the time.* Any decision to place a patient in the HDU would be guided by whether the assessor of risk considered the patient *was a significant risk of absconding,* or *likely to try to (sic) harm themselves or others*. The patient's vulnerability[33] is also taken into account. Dr Muirhead said that he could not say that the decision to place Grant in the LDU was *actually wrong.* He stated:

I mean it is wrong in retrospect but on the basis of the information available and the knowledge of the patient and how he had been when he had been in LD previously it was a reasonable decision.[34]

41. In the event that Grant had been placed in the HDU on his admission to the BIPU on 5 May 2007, it is likely, according to Dr Muirhead, that he would have remained in the HDU over the weekend *because of the practicalities of having staff available who know the person.*[35] A review of his risk and suitability to be moved in the LDU would have occurred on the Monday – 7 May 2007, which in fact did occur.

42. Dr Zhang reviewed Grant at approximately 10.00am on 7 May 2007, and assessed him as suitable to remain in the LDU. Dr Zhang was familiar with Grant, having been his treating/in patient consulting psychiatrist during Grant's long admission to the Unit in 2006. Dr Zhang had regard to his own background knowledge of Grant, Dr Owens' notes and the risk assessment he undertook[36] in deciding to continue to manage Grant in the LDU. He also spoke to the nursing staff to find out how Grant had been presenting in the previous two days.[37] Dr Zhang was cognisant of Grant's significant

---

[32] T @ p 102 (Dr Owens)

[33] T @ pp 126-127 (Dr Muirhead)

[34] T @ p 196 (Dr Muirhead)

[35] T @ P 201 (Dr Muirhead)

[36] See pp 237(rear) – 238 paginated medical records

[37] T @ pp210-211 (Dr Zhang)

risk of self-harm but following his assessment, he did not believe it to be an imminent acute risk[38] but a chronic risk because of his previous suicide attempts.[39] Dr Zhang believed Grant's *risk to self was containable in the (sic) hospital environment and he did not need to go into the high lock-up ward.*[40]

Fifteen-minute nursing observations

43. Dr Owen stated that:

> *The decision as to which level of observation someone should be on in the inpatient unit is made continuously based on how they are presenting, their state of mind and their behaviour on not just a daily basis but more frequently than that.*[41]

44. A member of the nursing staff is allocated the responsibility of "observation nurse" on each shift. The role requires the nurse to locate and record the whereabouts of each patient at the allocated interval. The role does not require that nurse to engage with the patient, merely to sight the patient.[42]

45. Dr Muirhead stated that in retrospect it had to be conceded that 15-minute observations did not work in Grant's case[43] - Grant was able to leave the Unit with two shopping bags without being seen by a member of the nursing staff. There was an expectation that 15-minute observations in the LDU would be sufficient to keep Grant in the hospital which Dr Muirhead opined was reasonable given Grant's two previous admissions to the BIPU.[44]

---

[38] T @ p 213 (Dr Zhang)

[39] T @ pp 218-219 (Dr Zhang)

[40] T @ p 221 & p 225 (Dr Zhang).

[41] T @ pp 97-98 (Dr Owens)

[42] T @ pp 132-134 (Dr Muirhead)

[43] T @ p 157 (Dr Muirhead)

[44] T @ p 191 (Dr Muirhead)

Communication to Police

46. Dr Muirhead believed that the nursing staff had proceeded to advise Mr Phillips and ascertain if Grant was at the family home and inform the Police of Grant's absence from the Unit, *as quickly as reasonably possible.* They had made these calls after a search of the immediate grounds of the hospital and adjoining parkland subsequent to discovering that Grant was missing. An "absent without leave" notification form was faxed to Broadmeadows Police at 9.00pm after nursing staff telephoned them at approximately 8.30pm.[45] RN Essibrah also contacted the CATT about Grant's absence without leave.[46]

47. Dr Muirhead was confident that the process for dealing with an "absent without leave" patient was followed as per the hospital's policy. He was confident that the on call consultant psychiatrist would have been notified, as is required by the policy, but conceded that *ideally...that would have been documented*[47]. He later offered that it was entirely possible that the nurses proceeded to contact police before ringing the on call psychiatrist. Similarly, there is no recording of a risk assessment performed by the on call consultant psychiatrist as the policy requires however, this could also be explained by the fact that it would be very uncommon, according to Dr Muirhead, for a psychiatrist who did not personally know the patient to vary from the practice of reporting to Police.[48]

48. I find that the hospital's policy on how to respond when a patient is absent without leave was not strictly complied with. It was complied with in part and of significance, the notification to Police of Grant's absence was, I find, done in a timely manner after the nursing staff had completed a search of the immediate grounds of the hospital. Whether the on call psychiatrist was notified beforehand or after notification to Police is not known because the nursing documentation is deficient in this regard. If the on call psychiatrist was notified and did communicate his/her own risk assessment this too is unknown because there is no documentation to support that it occurred either by

---

[45] Exhibit 5 - statement of Dr David Muirhead dated 11 September 2008

[46] T @ p 244 (RN Essibrah)

[47] T @ p 169 (Dr Muirhead)

[48] T @ p 175 (Dr Muirhead)

nursing staff or retrospectively by the psychiatrist in question. However, despite the deficient documentation and lack of adherence to their own policy, I accept the comments of Dr Muirhead that the on call psychiatrist with no personal knowledge of Grant would be unlikely to order the nursing staff to do anything other than report his absence, to the Police. There was little scope for any effective input from the on call psychiatrist - Grant was not physically present to be personally assessed and nursing staff knew by their phone call to Mr Phillips, that Grant had not returned to the family home. It is also worthy of commendation that RN Essibrah was so concerned for Grant's welfare that she returned to the immediate surrounding parkland to search for Grant after her shift had finished.

49. The quality of the information conveyed to the Police by nursing staff was also identified as an issue requiring examination as the original notification to Police failed to stipulate that Grant was an immediate risk of suicide although they were advised that he had attempted suicide in the past. This is critical information to a Police response but specifically, the question for this investigation is whether it would have made any difference to how the Police did respond to the information that Grant was an involuntary patient absent without leave from the BIPU. If the response by Police had been different by virtue of that additional knowledge the question that logically follows is, would it have in fact, made any difference to the outcome.

50. RN Mark Bester commenced the night shift on 7 May 2007 at 9.30pm. He was informed of Grant's disappearance and that Mr Phillips, the CATT and the Police had been notified. He spoke with Police between the hours of 10.00 – 11.00pm and informed them, from his reading of Dr Zhang's notes made that morning that the doctor had found no evidence of suicidal or homicidal ideation.[49] At approximately 1.30am on 8 May 2007, RN Bester telephoned Broadmeadows Police Station to correct his initial advice to them in so much as he advised Police that Grant in fact had a history of suicide attempts[50] and should be considered a suicide risk.

51. The Investigating Officer, Acting Sergeant Gray, stated that Grant's absence without leave was not given the highest of priority status because the risk of suicide did not

[49] Exhibit 8 – Statement of Mark Bester dated 13 May 2010 & T @ pp 260-261

[50] T @ p 267 (RN Bester)

appear imminent from the information they received from the BIPU. At 10.38pm, Senior Constable Harris from the Broadmeadows Police Station telephoned a request to the Police Communications Centre for a "keep a look out for" broadcast to all police units after she obtained/retrieved the faxed forms from the BIPU at 10.00pm.

52. I am satisfied that the level of information conveyed to Police by the BIPU was conveyed both in a timely manner and sufficiently appropriate in its content. There was delay in the Police actioning the report of Grant's absence without leave, which was in part explained however, the Police were sufficiently aware of a history of suicide attempts to appreciate a level of risk. I find that the additional information about the immediacy of the risk conveyed by RN Bester, unlikely to have made a difference to the Police response in this instance, because they had no information about his actual whereabouts/destination or the means that Grant would utilise to take his own life. His past attempts were by different modalities and Grant had given no indication of his intentions prior to absconding from the Unit. Nevertheless, although there were no identifiable consequences in Grant's case, the circumstances do serve as a reminder of the importance of thorough documentation and accurate communication between agencies who interact in caring for people with mental ill health.

53. I make no adverse comment about the content of the information provided to the police by BIPU or of the Police response. The timeframe between Grant leaving the BIPU and his death was only approximately 90 minutes. He had taken his own life before the request to Police Communications occurred.

The fencing in the common/exercise courtyard

54. Grant left the LDU at the BIPU by scaling the 1.4 metre fence in the common/exercise courtyard. At the time, the courtyard was also used for smoking and patients were permitted to move freely in and out of the courtyard between 7.00am and 11.00pm when it was then locked.[51] Evidence was given of the relative ease at which a patient in the LDU could leave the hospital given the "open door policy". Questions were put to medical witnesses about the appropriateness of such a policy particularly given the mixing of both voluntary and involuntary patients in the same Unit. Managing security

[51] T @ p 239 (RN Essibrah)

and the safety of patients while balancing the requirements of the *Mental Health Act* to manage/care for patients therapeutically in the least restrictive possible environment is a challenge for the service providers however, I make no further comment in this respect in this investigation, as Grant did not abscond through the front door but over the fence effectively at the rear of the Unit.

55. The fence enclosing the common/exercise courtyard in the LDU was approximately 1.4 metres high. It was *a capped metal paling fence*[52] - of a type commonly associated with domestic swimming pools.

56. Since Grant's death, the fence in the men's common/exercise courtyard has been replaced with a solid metal fence, approximately 2.2 metres in height. According to Dr Muirhead, this was *part of a previously planned capital rollout occurring across all inpatient units within NorthWest mental health*[53] and *was as much about wanting to prevent drug deals occurring over the fence as about the problem of absconding.*[54]

Other changes

57. Dr Muirhead stated that none of changes implemented by the North Western Mental Health Service since Grant's death are directly related to his death. The change to the fence over which Grant made his escape was already a planned procedure. Similarly, a move to electronic recording of notes, which was raised in the course of evidence, occurred because of a file storage problem at Northern Hospital rather than any identification of a need for improved clinical practice communication. Furthermore, a review of the adequacy of the Risk Assessment Form as a clinical tool has arisen out of various incidents and not due to any specifically identified circumstances in respect of Grant's management at the BIPU.[55]

---

[52] Exhibit 5

[53] *Op cit* and T @ p136 (Dr Muirhead)

[54] T @ pp134-135 (Dr Muirhead)

[55] T @ pp 200-204 (Dr Muirhead)

CONCLUDING COMMENTS

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

1. Dr Owens was critical about the demarcation of responsibility for the care of patients between the community treatment team, the CATT and the inpatient units stating that he was of the opinion that this situation fostered a lack of communication between the community and the inpatient units. On the other hand, when there is continuity of care by a psychiatrist across the levels of delivery of care, engagement with the patient and assessment of clinical risk are improved upon[56] as is the psychiatrist's *sense of accountability to the patient, which* ensures a better delivery of care in the long term.[57] According to Dr Owens, the current model at NWAMHS *splits the patient's trajectory through the service too much.*[58]

2. I accept Dr Owens views about the model for a better delivery of mental health services. His views are based on his experiences both here in Australia and in Ireland. His preferred model is not unique to Ireland but is also apparently adopted by other services in Victoria. His evidence was compelling. (See Recommendation 1) A model of delivery of care that provides continuity of care by a psychiatrist should be encouraged and ideally should be adopted statewide across all of the mental health services. A single statewide model for the delivery of mental health services would add to the continuity, certainty to those needing the services as well as to those working within the services.

3. I find that the lack of continuity of care by Dr Owens in all probability influenced Grant's admission to the LDU rather than the HDU on 5 May 2007. Dr Owens considered it would have been more appropriate to have Grant admitted to the HDU given the level of risk to self that was apparent to Dr Owens on 4 May 2007. It would have been prudent and logical to transfer Grant from the HDU at RMH to the HDU at the BIPU given the reasons for the revocation of his CTO. It would have been prudent and logical to transfer Grant to the HDU at the BIPU because of his history of suicide

---

[56] T @ pp 109-110 (Dr Owens)

[57] T @ p111 (Dr Owens)

[58] T @ p 112 (Dr Owens)

attempts when in a state of psychosis. It would have been prudent and logical to admit Grant to the HDU at the BIPU because it was the weekend and it was known that a consultant psychiatrist, who was familiar with him, would not see him until the Monday – 7 May 2007.

4. However, the opportunity for Grant to abscond over the weekend was not realised. He was on 15-minute sight observations throughout those two days and into Monday 7 May 2007, including up to immediately before the time Grant absconded that evening.

5. If Grant had spent the weekend in the HDU, it remains probable that Dr Zhang would have authorised his transfer to the LDU on the Monday after his assessment of Grant that morning. If this had been the background scenario, Grant would have been in the same position as he was when he absconded – that is, in the LDU on 15-minute sight observations.

6. There is no evidence that Grant's state of mind would have been any different on the Monday had he spent the weekend in the HDU such that I can definitively find that the course of events would have been different. I accept that Dr Owens would have admitted Grant to the HDU on 4 May and 5 May 2007 however, it is merely speculative and not based on any evidence, that Dr Owens would have adopted the same position about Grant's level of risk on the Monday, such that I can find that the course of events would have been different. In this regard I accept the evidence of all the medical witnesses that risk is a constantly evolving feature in the acutely mentally ill.

7. Furthermore, there is no evidence, only proposition that the reason to transfer Grant from an HDU at RMH into the LDU at the BIPU was related to resources. I did not direct that the facility provide me with statistics of occupancy rates in the HDU on 5 May 2007 and I have no reason not to accept the evidence of Dr Zhang who was of the belief that the decision was based on *clinical judgement at the time.*[59]

[59] T @ p 228 (Dr Zhang)

Family support

8. Mr and Mrs Phillips were committed to looking after their son despite the lability of his illness and his ongoing polysubstance abuse.

9. Mr Phillips stated that life for Grant was up and down, with no real progression/improvement in his condition over the years. He and his wife did not like the conditions at the BPIU and believed that they were *not very conducive to someone trying to be healed because it was so depressing.*[60]

10. Mr Phillips stated that he and his wife never fully understood the nature of Grant's illness while he was alive but according to Mr Belanti, *they really got that sense about when Grant was not Grant and when it was more the illness.*[61] According to Mr Phillips, information about Grant's illness had not been forthcoming from Grant's mental health team but similarly, they had not sought out the information themselves until after Grant's death. Nevertheless, they had recognised deterioration in Grant's condition, which prompted them to seek out his readmission when they met with Dr Owens and Mr Belanti on 4 May 2007. They were aware that Grant had never engaged with his mental health team[62] and that he was resistant to admission[63] but they also saw admission at that time as being in his best interests.[64] Mr and Mrs Phillips were concerned about Grant harming himself.[65]

11. On 7 May 2007 when Grant told his father to "have a happy life", he had also been asking for his wallet and his mobile telephone. It did cross Mr Phillips mind that Grant may be planning to abscond but he thought:

---

[60] Transcript (T) @ p 17 (Mr Phillips)

[61] T @ p 73 (Mr Belanti)

[62] Mr Belanti on the other hand felt that he had developed a rapport with Grant in 12 months he had worked with him as his case manager – T @ p 70.

[63] T @ p 40 (Mr Phillips)

[64] T @ p 22 (Mr Phillips)

[65] T @ p 23 (Mr Phillips)

...well, he can't get out of here, he's being watched but I (sic) didn't report it because I thought well, there's no need to because he can't go anywhere. My strong belief was that he was under their care and he can't go anywhere.[66]

12. Mr Phillips could not recall Grant's previous attempts at his life being preceded by remarks[67] like the one he made on the evening of 7 May 2007, or of other signs[68] of his intentions.

13. The contemporaneous medical record entries however reflect that on 4 May 2007, Mr and Mrs Phillips reported to Dr Owens and Mr Belanti that there were certain behaviours that had precipitated Grant's suicide attempt by hanging. Mr Belanti recorded in the *MH - Risk Assessment*:

Parents extremely concerned that Grant has been behaving in a similar fashion as to his previous presentation which led Grant to hang himself.[69]

14. Following Grant's death, Marian and Brian were contacted by Dr Muirhead and asked to attend the BIPU for a meeting. On 15 May 2007, the Phillips met with Drs Muirhead, Owens and Zhang. Mr Phillips was unable to recollect the length of meeting but he did recall that the doctors advised them that they had wrongly assessed Grant. They told the Phillips that Grant should not have been placed in the LDU but in the HDU as he had been at the RMH,[70] because he was a high risk of absconding and a high risk of suicide.

FINDING AS TO CAUSE OF DEATH

Grant had a tortured illness but he was loved and supported by his parents and siblings. The support and involvement of Brian and Marian Phillips in caring for their son Grant ensured that his mental health team were able to promptly respond to his deteriorating condition. Grant was appropriately detained and monitored however, because he was detained in an

---

[66] T @ p 21 (Mr Phillips)

[67] T @ p 46 (Mr Phillips)

[68] T @ p 47 (Mr Phillips)

[69] MH- Risk Assessment @ p 51 of paginated medical records

[70] T @ pp 26-29 (Mr Phillips)

environment which aims to be the least restrictive setting - both supportive and conducive to treatment and recovery, he was able to abscond. Mr and Mrs Phillips were entitled to feel that Grant was safe at the BIPU and entitled to feel aggrieved and disappointed that he was able to abscond however, I find that Grant's ability to abscond does not equate to nor is it a reflection of any derogation of the provision of care that he received.

I find that Grant Elliot Phillips, an involuntary psychiatric patient at the Broadmeadows Inpatient Psychiatric Unit, was capable of forming an intention to take his own life.

AND I find that Grant Elliot Phillips died from multiple injuries sustained when he intentionally placed himself in the path of an oncoming train.

RECOMMENDATIONS

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

1. With a view to consistency with the National Mental Health Care Plan 2009-2014, "Priority area 3: Service access, coordination and continuity of care" - I recommend that North Western Mental Health Services review its model of delivery of psychiatric care with a view to implementing one that provides greater continuity of care by the psychiatrists, such as described by Dr Owens in his evidence. The review should incorporate a comparison of other regions/jurisdictions that have adopted similar models.

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

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

- Mr Brian and Mrs Marion Phillips
- Mr Ragu Appuduri, Special Counsel, Russell Kennedy Pty Ltd
- Ms Jan Moffatt, Donaldson Trumble Lawyers
- Office of Chief Psychiatrist
- Secretary to the Department of Health
- Mr Grant Armstrong, Department of Infrastructure

Signature:

AUDREY JAMIESON
CORONER
Date: 12 October 2012