IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 1142/07

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of LEE PATRICIA COLLINGS

Delivered On:	31 January 2012
Delivered At:	Coroners Court of Victoria Melbourne
Hearing Dates:	24, 25, 26 May 2010 29 November 2010
Findings of:	DR JANE HENDTLASS
Representation:	Leading Senior Constable King Taylor assisting the Coroner Dr Elizabeth Brophy appeared for Peninsula Health

I, JANE HENDTLASS, Coroner having investigated the death of LEE COLLINGS

AND having held an inquest in relation to this death on 24, 25, 26 May 2010 and 29 November 2010 at Melbourne

find that the identity of the deceased was LEE PATRICIA COLLINGS

and the death occurred on 25 March 2007

at Mornington Peninsula Freeway, Dromana, Victoria 3936

from:

1a. MULTIPLE INJURIES

in the following circumstances:

1. Lee Collings was 51 years old when she died. She lived alone in a caravan at the Ponderosa Caravan Park in Dromana. Ms Collings' medical history included depression, alcohol and prescription drug abuse, frequent incidents of attempted suicide, borderline personality disorder, generalised tonic seizures, ovarian cysts and endometriosis, osteoporosis and epilepsy. Her general practitioners were Dr Yasendri Arambepola in Bundoora and she remained under a Team Care arrangement managed through Bundoora Family Clinic. Ms Collings was prescribed sodium valproate, paroxetine, esomeprazole, mirtazapine and alendronate.

2. Ms Collings' husband developed a severe physical disability after they had been married five or six years. She cared for him full time but she felt guilty and inadequate because she was unable to maintain their relationship after he required institutional care. After this, Ms Collings worked as a carer at the Ivanhoe Diamond Valley Centre for Intellectually Disabled Adults. She enjoyed her work but told her family it sometimes imposed considerable responsibility on her and she was subject to assault by some of the clients. These stressors were associated with deterioration in Ms Collings' mental state and substance abuse.

3. Ms Collings' suicidal ideation increased further while she was living in Heidelberg Heights in 2005 and early 2006. Her family lived close by and she would ring them about every two weeks to say she had taken an overdose of medication or she was contemplating committing suicide. They would respond by arranging medical assistance or otherwise providing support. However, as Ms Collings became more desperate, these calls became less frequent.

4. Ms Collings was particularly affected after her de facto relationship broke down in November 2006. She was found sitting on the road saying she wanted to die and was admitted to the Austin Hospital. Ms Collings' family bought an on site van for her to live in and she moved to Dromana in November 2007.

5. After she moved to Dromana, Ms Collings tried to hide the severity of her depression and would talk to her family about once a month. Although she was still feeling life was hopeless, Ms Collings spoke more about current stressors rather than the historical issues that seemed to have been underlying

her earlier mental state. However, Ms Collings' drinking and substance abuse remained and she argued with other residents at the caravan park.

6. A case worker from the Peninsula Community Health Centre provided Ms Collings with support and financial advice. The Clinical Director of Psychiatry at Peninsula Health, Dr Richard Newton, formed the view that Ms Collings required long term rehabilitation to address her multiple social, mental health and physical problems including her alcohol abuse.

7. Peninsula Health is a metropolitan health service which includes the Frankston and Rosebud Hospitals and community mental health services. The Mental Health Triage Tool was operating in Peninsula Health in 2007 and is included as a 2½ hour session in two-day workshops for their Emergency Department triage staff. It is designed to be used in conjunction with the Australasian Triage Scale.

8. After Ms Collings moved to Rosebud, she presented at the Emergency Department at Frankston Hospital or Rosebud Hospital on six occasions prior to her presentation on 24 March 2007:

- At 9.56pm on 7 November 2006, Ms Collings presented to the Emergency Department at Frankston Hospital in an ambulance after a drug overdose. The Crisis Assessment Team clinician assessed her next day when she had no thoughts, plans or intent to kill herself. Ms Collings was booked to enter the Moreland Hall detoxification programme so she was discharged back to the Ponderosa Caravan Park. Her family say she was admitted to Moreland Hall as planned but discharged herself against medical advice.

- At 5.55am on 9 December 2006, Ms Collings presented to the Emergency Department at Rosebud Hospital in an ambulance when she was found wandering on the roadway with self inflicted lacerations after drinking a large amount of alcohol. At 3.50pm, the Crisis Assessment Team clinician assessed Ms Collings as safe to be discharged home when she denied current plan or intent to self harm but admitted she could be impulsive at times with alcohol. At 5.30pm, Ms Collings was discharged home. On 11 December, she was reviewed at home by the Crisis Assessment and Treatment Team clinician and diagnosed with alcohol abuse, borderline personality disorder and generalised tonic clonic seizures. Ms Collings assured the clinician she was safe and agreed to cut down on her alcohol use and to consult her general practitioner.

- At 1.55pm on 17 December 2006, Ms Collings re-presented to the Emergency Department at Frankston Hospital in an ambulance after a further drug overdose. She was admitted for drug withdrawal and a psychiatric review next day. Ms Collings was diagnosed with adjustment disorder/borderline personality disorder prone to depressive and suicidal features. On 20 December, she was discharged home with referral to the Peninsula Drug and Alcohol Program.

- At 2.38am on 17 February 2007, Ms Collings presented again to the Emergency Department at Frankston Hospital following a phone call to Lifeline threatening to commit suicide and subsequent transfer under section 10 of the *Mental Health Act* 1986. She was intoxicated and absconded before

she could be assessed by the Crisis Assessment Team clinician. The Crisis Assessment and Treatment Team subsequently made phone contact with and assessed Ms Collings. She was apologetic, the situational crisis had resolved and she will continue to see the Peninsula Drug and Alcohol Program for support with reducing her alcohol use.

- On 21 March 2007, Ms Collings called an ambulance to transport her friend from the caravan park to the Emergency Department at Frankston Hospital with depression and suicidal thoughts. Then, at 12.17am on 22 March 2007, Ms Collings jumped into the water from the Dromana Pier wearing a backpack containing gym weights and cans of beer. She told fishermen she intended to kill herself. Police pulled Ms Collings out of the water. She was transported voluntarily by ambulance to the Emergency Department at Frankston Hospital. The Crisis Assessment Team clinician recorded that she was unable to assess Ms Collings because she was too busy and Ms Collings was sleeping. At 11.00am, Ms Collings had no plans, thoughts or intent to self harm. She was discharged home with referrals to detoxification at Peninsula Drug and Alcohol Programs, her carer and her general practitioner.

- At 2.10am on 23 March 2007, police found Ms Collings with self-inflicted wounds to her wrist in her caravan at the Ponderosa Caravan Park. Again, she was transported to the Emergency Department at Frankston Hospital by ambulance under threat of involuntary transport if she failed to comply. Ms Collings was intoxicated so her assessment was delayed until 2.50pm when she was alert and cooperative. She denied further thought, plan or intent to self harm so she was discharged with her parents and referred for detoxification to the Peninsula Drug and Alcohol Programme and Dr Forbes Smith in Rosebud.

9. At 4.15pm on 24 March 2007, Ms Collings telephoned Suicide Helpline stating she was going to kill herself with an electric knife and that she had presented at the Emergency Department at Frankston Hospital twice in the last two days following suicide attempts. Suicide Helpline contacted the Peninsula Health Community Mental Health Telephone Triage. At 4.20pm, the mental health clinician at Peninsula Health Community Mental Health Telephone Triage rang "000" to request an urgent welfare check and feedback from police following the check. She also completed a Peninsula Health Psychiatric Service Screening Triage/Referral Form. This Form was sent for filing on Ms Collings' Frankston Hospital out-patient records.

10. At 4.21pm on 24 March 2007, Constable Robert Burton and Senior Constable Anita Parnell responded to the phone call from Psychiatry Triage. At 4.27pm, Constable Robert Burton found Ms Collings in bed with a vegetable knife next to her in her caravan at the Ponderosa Caravan Park. She said she had been thinking about killing herself and admitted to drinking two beers and taking some medication but she did not appear intoxicated or under the influence of drugs. Mr Burton was not aware of Ms Collings' interaction with police and Rosebud and Frankston Hospitals on the previous two days.

11. At 4.43pm on 24 March 2007, police called an ambulance to transport her to Frankston Hospital for the third time in consecutive days. Mr Burton gave Ms Collings the choice of transfer by ambulance or divisional van. She chose the ambulance and Sergeant Steve Atkins authorised Ms Collings' transfer

by ambulance to Frankston Hospital for assessment by the Crisis Assessment Team. At 5.12pm, ambulance officer, Glen Pattrick, assessed Ms Collings as depressed, attempting self-harm and having thoughts of self-harm.

12. Mr Burton's notes indicate they imposed section 10 of the *Mental Health Act* 1986 which means that Ms Collings was an involuntary patient. This report is not otherwise referred to in the ambulance notes or statements from ambulance or police officers. There is no copy of the Victoria Police Mental Health Disorder Transfer Form[1] in the medical record or the ambulance record. Accordingly, there is no indication that hospital staff were aware that section 10 of the *Mental Health Act* 1986 had been invoked to require transport or that she was therefore an involuntary patient until assessed by a mental health clinician.

13. On the contrary, Mr Pattrick says Ms Collings asked him to take her to Frankston Hospital and she was co-operative in making arrangements for the care of her dog and her keys. He also says that Ms Collings was uncommunicative during the journey. Therefore, I presume that section 10 of the *Mental Health Act* 1986 was not invoked to require Ms Collings' presentation to ambulance or the Emergency Department at Frankston Hospital.

14. At 5.49pm on 24 March 2007, the triage nurse in the Emergency Department recorded the information provided by Mr Pattrick to indicate that Ms Collings was threatening suicide and asking for the Crisis Assessment Team clinician. She did not assess Ms Collings' vital signs and there was no way that the triage nurse could know about Ms Collings' two presentations to Frankston and Rosebud Hospitals in the last three days unless, by coincidence, he or she had been working at the time of these presentations.

15. Ms Collings was assessed as Mental Health Triage Category 4. Mental Health Triage Category 4 indicates that she had a *'semi urgent mental health problem'* but was no immediate risk to herself or others. According to the Australasian Triage Scale and the Victorian Emergency Department Mental Health Triage Tool, Category 4 mental health patients must be seen regularly at least every 30 minutes with assessment and treatment commenced within one hour.

16. The only Crisis Assessment Team clinician on duty, Edward Robinson, also spoke briefly to Ms Collings in the corridor beside the triage desk. He stood within two metres of her and explained that there would be a delay because he was already managing three other patients. Mr Robinson told the Court that Ms Collings understood what was going on and accepted the delay. He did not smell alcohol. He did not become involved in the triage process.

17. The statewide Mental Health Client Management Interface computer service was unavailable on that weekend due to a malfunction. Further, consistent with Ms Collings' triage Category 4,[2] the triage registration clerk ordered her medical record from storage through the non-urgent retrieval system at

[1] Victoria Police VP Form L42 which requires the "Agency Copy" to be handed to the person to whom they transfer care.
[2] Peninsula Health, Policy & Procedures, Health Information Services, Electronic Requesting & Retrieval of Medical Records, September 2005; Peninsula Health, Policy & Procedures, Health Information Services, Collection and Delivery of Medical Records, September 2005.

5.49pm on 24 March 2007. It was retrieved at 6.23pm ready for delivery to the Emergency Department within the next hour. Therefore, there was no information immediately available to the triage nurse or Mr Robinson about Ms Collings' recent presentations to the Emergency Departments at Frankston and Rosebud Hospitals.

18. At 6.24pm on 24 March 2007, Mr Pattrick handed Ms Collings' care to an Emergency Department contact nurse in the private interview room at the Emergency Department at Frankston Hospital. The private interview room has glass windows which look out on to the corridor near the nurses' station. There is also a camera which monitors the room but there is no consistent direct line of sight to the entire triage desk. However, in order to leave the emergency department a patient must walk past the triage desk.

19. The triage nurse repeated the ambulance note that Ms Collings was still threatening self harm and requesting the Crisis Assessment Team clinician. Ms Collings also said that she had spoken to Mental Health Telephone Triage earlier in the day expressing thoughts of self harm and wanting to slash her wrists.

20. However, the contact nurse responsible for completing observations at least every hour recorded that she was calm and wanted a cigarette. He did not mention alcohol in his observations and he did not perform vital signs.

21. When Ms Collings presented on a Saturday evening, Mr Robinson was working alone in the Emergency Department assessing another patient. He asked the contact nurse caring for Ms Collings to wait for the cigarette until he had reviewed her. However, Ms Collings was insistent so the contact nurse arranged for a security guard to accompany her outside and to have her cigarette.

22. At 6.20pm on 24 March 2007, Ms Collings returned to the private interview room at the Emergency Department. In the meantime, Mr Robinson had read the ambulance records indicating Ms Collings was threatening self harm and seeking a Crisis Assessment Team assessment. He also checked with the contact nurse and other Emergency Department staff. They said nothing had changed and there were no management issues.

23. Mr Robinson also spoke to Peninsula Health Community Mental Health Telephone Triage to establish the validity of Ms Collings' claim she had spoken to them earlier in the day. Despite their contact with the Suicide Helpline and the police, the Peninsula Health Community Mental Health Telephone Triage clinician was not aware that there had been phone contact with Ms Collings that day: the notes of these phone calls were already filed in Ms Collings' out patient records and Ms Collings' medical file was still not available in the Emergency Department.

24. Between 6.30pm and 7.00pm on 24 March 2007, Mr Robinson undertook a seven or eight minute preliminary assessment of Ms Collings with the security staff present. Mr Robinson told the Court this was a review or re-triaging assessment to see if anything had changed. By then, her speech was slurred and she was drowsy and unbalanced on her feet. Mr Robinson incorrectly recorded that the

Metropolitan Ambulance Service had assessed Ms Collings as "non violent and non-suicidal".[3] Ms Collings also told Mr Robinson she might hurt herself if she returned home.

25. Mr Robinson still had not smelt any alcohol but he was was concerned enough to undertake a breath test to determine her blood alcohol concentration. It was also an issue if admission was considered because the ward would not accept patients with a blood alcohol concentration over 0.05g/100mL. The breath test apparatus recorded a reading of 0.23/100mL but there is some doubt about its accuracy because it had not been recalibrated for some time. Mr Robinson used it as a "ball park" assessment.

26. In the context of a very busy work load, Mr Robinson planned to perform a formal risk assessment when he had more time and he had seen Ms Collings' medical history and when she was less drowsy and less affected by alcohol. Ms Collings agreed to wait. Therefore, Mr Robinson stood down the security staff and left Ms Collings in the private interview room at the Emergency Department.

27. At 7.10pm on 24 March 2007, while Mr Robinson was still dealing with other patients, Ms Collings was unaccompanied when she left the private interview room for another cigarette. The contact nurse recorded that she returned at 7.30pm.

28. At 7.40pm on 24 March 2007, Mr Robinson returned but Ms Collings was not in the private interview room in the Emergency Department at Frankston Hospital. A nursing note comments that:

*"Obs(*ervations*) unable to be done because patient was always out smoking."*

29. By then, Mr Robinson had read her file and become aware of her history over the last few days:

"By the time I'd realised Lee was missing I actually had the file and when I'd seen that she had been assessed over the previous few days and what the plan was and the diifferent presentations that was when my concerns were understandably a lot higher."

30. No one saw Ms Collings leave the Emergency Department and, when she did not return by 8.10pm, a search was initiated. At 8.00pm, Mr Robinson notified Rosebud Police that Ms Collings had absconded. He told police that he had insufficient grounds to detain Ms Collings on presentation because she was a voluntary patient and she was non-violent and non-suicidal. There is no record of Ms Collings being seen alive again or how she got home to the Ponderosa Caravan Park.

31. At 12.25am on 25 March 2007, the driver of a car exiting the freeway outside the Ponderosa Caravan Park saw something on the road. It was very dark and the road was dry. Although he swerved and braked, he was unable to avoid running over Ms Collings who was lying on the ramp of the Mornington Peninsula Freeway. She was immediately unresponsive and unable to be revived. Police found suicide letters in Ms Collings' caravan but their age is unknown.

[3] Paul Bean from the Metropolitan Ambulance Service has explained that this error may be attributable to the call taker's use of the drop down to allocate services because the operator seems to have manually written suicide under the patient behaviour category of "Threatening" rather than locating "suicidal" under drop down box for "patient thought content".

32. An application for no autopsy to be performed was granted by the Coroner. The forensic pathologist who inspected the body is of the view that a reasonable cause of death was multiple injuries. Toxicological analysis detected a blood alcohol concentration of 0.12g/100mL as well as diazepam and paroxetine at therapeutic levels. Therefore, in the context of her previous history, there is no reason to believe that Ms Collings was so intoxicated as to be unable to move from the road before the car hit her.

33. Accordingly, I find that Lee Collings intentionally died from multiple injuries sustained when she lay on the road and was hit by a car.

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

1. Lee Collings had an extensive medical history in the northern suburbs of Melbourne and her family lived in Melbourne. However, she had been living in Rosebud for about four months when she died. In that time, she had presented to the Emergency Department at Frankston or Rosebud Hospitals on six occasions after attempting to commit suicide, including twice in the three days before she died. On each occasion, Ms Collings was intoxicated and her mental state and risk assessment was delayed. On all but the last presentation, she was assessed when she was sober and discharged home to her caravan at the Ponderosa Caravan Park in Rosebud.

2. At 5.49pm on 24 March 2007, Ms Collings presented to the Emergency Department at Frankston Hospital in an ambulance. The ambulance officers told the triage nurse she was threatening self harm and asking for the Crisis Assessment Team clinician. Ms Collings was assessed as Mental Health Triage Category 4. She was placed in the interview room usually used for mental health presentations and the nurse responsible for her care recorded seeing her every 15 minutes. Mental Health Triage Category 4 indicates that Ms Collings had a *'semi urgent mental health problem'* but was no immediate risk to herself or others.

3. The Crisis Assessment Team clinician on duty, Edward Robinson, was working alone on Saturday afternoon shift in the Emergency Department at Frankston Hospital on 24 March 2007. He already had three mental health patients to assess when Ms Collings arrived. Therefore, Mr Robinson was under pressure to assess and admit or discharge all these patients as quickly as possible. Although this issue was not raised in the Peninsula Health reviews of Ms Collings' death, the Court heard that rostering of Crisis Assessment Team clinicians has changed so that there are now two Emergency Department Crisis Assessment Team clinicians rostered to work on Saturdays and at other busy times.

4. Mr Robinson also had a short conversation with Ms Collings in the corridor beside the triage desk. The triage nurse and Mr Robinson did not know that Ms Collings had presented to the Emergency Departments at Frankston and Rosebud Hospitals on six occasions after attempting to commit suicide, including twice in the previous three days.

5. At 6.20pm on 24 March 2007, Mr Robinson undertook a preliminary or re-assessment of Ms Collings. He decided to delay his formal assessment until she was sober and he had access to her

medical records. Mr Robinson also decided that Ms Collings was still unlikely to abscond or harm herself and, accordingly, he stood down the security person required to supervise her when she went outside for a cigarette.

6. At about 7.40pm on 24 March 2007, Ms Collings absconded from the Emergency Department at Frankston Hospital. In the meantime, Ms Collings had been allowed to go out unsupervised for a cigarette. She returned to the interview room but was missing five minutes later. No one is known to have seen her leave. To the extent that her absence was noted in the medical record, it was explained by Mr Robinson's approval of her unsupervised smoking arrangement.

7. At 12.25am on 25 March 2007, Ms Collings died when she was hit by a car as she lay on the road near the Ponderosa Caravan Park. She had absconded from the Emergency Department at Frankston Hospital while the Crisis Assessment Team clinician was obtaining further information about her and waiting for her blood alcohol level to decline.

8. Accordingly, I find that Ms Collings may not have died when she did if Mr Robinson had been able to access her records before he undertook his preliminary re-assessment and had been able to perform her full risk assessessment immediately despite her elevated blood alcohol level.

Risk and Mental State Assessment

9. Management of patients who present at the Emergency Department of public hospitals with symptoms consistent with mental illness must be triaged to determine their immediate management plan. Triage clinicians' assessment of mental health symptoms and perception of risk of harm are the main 'patient factors' contributing to the triage outcome[4] and diagnosing mental illness is not part of the triage role.[5]

> *"**Risk assessment**: is the process by which an estimation of the likelihood of particular adverse events occurring within a specified time period is made. The process defines the level of risk the assessing clinician has determined to be present at the time of the clinical assessment."*

10. Alcohol abuse, depression and other psychiatric disorders frequently occur together but assessment of their separate diagnoses and associated risk factors can be difficult and unreliable when substance abuse and psychiatric symptoms are present.

12. Further, alcohol and other drugs may mask symptoms of mental illness and some hospitals will not authorise admission to a mental health ward until a patient's blood alcohol level is below 0.05g/100mL. Therefore, understandably, mental health clinicians usually prefer to perform mental state assessments on patients who are not intoxicated or drug affected. Factors influencing escalation of underlying chronic risk may also be difficult to identify in patients under the influence of alcohol or other drugs.

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4 Department of Health, Statewide mental health triage scale: Guidelines, Victorian Government, May 2010, p.19.
5 Department of Health, Statewide mental health triage scale: Guidelines, Victorian Government, May 2010.

13. In the four months between November 2010 and January 2011, 90.2% of mental health presentations to the Emergency Department at Frankston Hospital were assessed for substance use issues and 95% underwent a risk assessment. Further, about half were referred to other organisations including other mental health service providers and alcohol and drug agencies.

12. In 2007, Associate Professor Richard Newton was the Clinical Director of Psychiatry at Peninsula Health based at Frankston Hospital. He says Peninsula Health applied the Victorian Emergency Department Mental Health Triage Tool in 2007.[6] This is an assessment tool for general triage nurses when a patient presents with diagnosed or suspected mental health issues. The Mental Health Triage Tool states:

> *"Intoxication by drugs and alcohol may cause an escalation in behaviour that requires management.".*

13. However, the Victorian Emergency Department Mental Health Triage Tool does not provide specific advice that triage nurses should allocate mental health patients to a higher triage category when alcohol may influence risk associated with other symptoms of mental health such as suicidality.

14. Dr Sean Jepherson took over as Director of Clinical Services in Mental Health at Peninsula Health on 31 August 2009. In his statement, Dr Jepherson says that a Joint Clinical Practice Guideline entitled *"Assessment of the Mental Health Consumer in the Emergency Department"* was approved by the Mental Health Executive on 18 August 2010. The Peninsula Health Joint Clinical Practice Guideline states:

> *"Voluntary consumers who have been triaged as category 1, 2 or 3 (according to the Mental Health Triage Tool) where significant risk has been identified, require continuous visual supervision until they have been assessed by a mental health clinician or medical officer.*
>
> *Following assessment their triage category will be reassessed and the level of observation required will be determined by the mental health clinician and/or medical officer..."*

15. I find that these requirements would have made no difference to Ms Collings because she was triaged category 4 and, at least to the knowledge of her clinical team, she was a voluntary patient. She also absconded after she had been assessed by the mental health clinician with no significant risk of absconding or self harm.

16. Further, in 2010, the Department of Health introduced the Statewide Mental Health Triage Scale guidelines.[7] This document applies to presentation at an Emergency Department, assessments by Crisis Assessment and Treatment teams and telephone assessments by a mental health triage clinician. These Statewide Mental Health Triage Scale guidelines classify the outcome of a triage assessment according to the person's eligibility and priority for mental health services and the response required by mental

6 Victorian emergency department, mental health triage tool, August 2006.
7 Department of Health, Statewide mental health triage scale: Guidelines, Victorian Government, May 2010.

health and other services. The reasons for implementing the Statewide Mental Health Triage Scale Guidelines include:

- *"to promote greater consistency in the response of consumers, carers and referrers seeking entry to mental health services*

- *to help ensure that initial service responses are appropriate to the person's level of clinical acuity and risk...."*

17. Therefore, according to the Statewide Mental Health Triage Scale Guidelines, one role of mental health triage is to ensure that the triage clinician responds to the patient's immediate level of risk. In the circumstances of Ms Collings' presentation, this risk is expressed as absconding or self harm. There is no provision for assessment of longer term or chronic risk or changes in risk which can easily occur spontaneously or opportunistically or with changes in environment such as intoxication or detoxification.

18. In relation to alcohol, many clinicians routinely perform mental state and risk assessments together or at the same time. Further, Associate Professor Newton says that intoxication usually interferes with risk assessment. Sometimes, the risk assessment of a suicidal patient declines with their drug-induced state. In these circumstances, the risk assessment is not a useful tool because it does not purport or actually relate to the likelihood of self harm when the patient drinks again.

19. Therefore, patients with high blood alcohol levels and/or drug overdose associated with possible suicidal intention may have to undergo a number of risk assessments as their intoxication declines or, alternatively, be required to wait until their alcohol level has declined before their clinicians perform their risk assessment. When the mental health clinician is over committed and the patient denies suicidal ideation, there must be considerable temptation to take the less work intensive latter path.

20. In particular, Ms Collings' blood alcohol concentration had declined from about 0.23g/100mL at 7.00pm to 0.12g/100mL when she died. Therefore, her blood alcohol concentration when she died suggests any alcohol-related suicidal ideation would have continued despite five hours in which to metabolise alcohol. There is no reason to believe that her state of mind or suicidal intention was influenced by further drinking after she left the hospital or waiting for her blood alcohol level to decline.

21. In other words, if Ms Collings had not absconded and Mr Robinson had formally assessed her at 7.30pm as planned, he would probably have determined the same risk as he did in his preliminary re-assessment. However, in the context of her prior presentations, he may have kept her under greater surveillance over night until her blood alcohol level had subsided. The outcome may have been different.

22. In 2006, I investigated the death of Roy Pulley (3535/04). Mr Pulley died after he was transferred to Frankston Hospital under section 10 of the *Mental Health Act* 1986. Police and ambulance officers had found Mr Pulley drinking red wine after taking four temazepam tablets and he

had had already been assessed as suicidal by the Crisis Assessment and Treatment Team. Within one hour of presentation, a consultant psychiatrist had assessed Mr Pulley and confirmed his involuntary status. He was subsequently admitted to the psychiatry unit for 16 days and died nine days after discharge. No inquest was held.

23. On the other hand, in 2008, I investigated the death of Walter Bradic (2201/06). Mr Bradic died after he was transferred to Western Hospital under section 10 of the *Mental Health Act* 1986. His assessment was delayed because his blood alcohol concentration was 0.286g/100mL. After six hours, he was further assessed and diagnosed with simple intoxication of alcohol and secondary diagnoses of isolation and suicidal ideation. Mr Bradic said he had no plans or intent to self harm but the clinician commented that he remained at risk to himself in future due to poor judgement when under the effects of alcohol. Mr Bradic was discharged home. He was found dead next morning. His blood alcohol concentration was 0.12g/100mL.

24. In the circumstances of Mr Bradic's death, I recommended that:

> *"Mid West Emergency Crisis Assessment and Treatment clinicians develop policies and practices which enable risk assessment of alcohol affected clients who present expressing suicidal intention in order to take into account this known, important factor which is known to increase risk."*

25. In 2007, the Department of Human Services introduced a dual diagnosis policy which favours an integrated approach to assessment and treatment.[8] Further, the Victorian Mental Health Reform Strategy 2009-2019, Implementation plan 2009-2011 includes on-going support for the Victorian Dual Diagnosis Initiative. Under this policy, mental health services must universally screen for substance abuse and provide a full dual diagnosis assessment when co-morbidities are identified.

26. However, the Joint Clinical Practice Guideline states:

> *"The provision of mental health services is not dependent on sobriety ....*
> *The presence of alcohol and/or drugs does not preclude early assessment as intoxication may exacerbate symptoms of a mental illness. Conversely, it may mask symptoms of a mental illness and may indicate, based on past history and/or current events, the need for further assessment when the consumer is no longer intoxicated.*
>
> *When a request for assessment is received, it is not appropriate to insist that the consumer be free of the effects of alcohol and/or other drugs ....*
>
> *A Blood Alcohol concentration is to be established and this is to be discussed with the treating team. The fact that a consumer is under the influence of alcohol or drugs does not prevent recommendation under the Mental Health Act as long as the criteria in section 8(1) are met ...."*

[8] Gary Croton (2007), Screening for and assessment of co-occurring substance use and mental health disorders by Alcohol & Other Drug and Mental Health Services, Victorian Dual Diagnosis Initiative Advisory Group, Victoria.

27. These provisions do not support relaxation of Ms Collings' supervision in the Emergency Department at Frankston Hospital as occurred on 24 March 2007. If they had already been implemented and if Mr Robinson had been aware of her recent history, she may not have died in the way she did.

Access to records

28. The Statewide Mental Health Triage Scale Guidelines state:

> *"The person's history - for example, the severity, frequency, patterns and dates of self harm - is critical to effective risk assessment."*[9]

29. Accordingly, professional witnesses accepted that immediate prior history of attempted suicide increases the current risk and that Ms Collings would have been triaged into category 2 or 3 if the triage nurse had been aware of her three presentations to an Emergency Department in Peninsula Health in the last three days following suicide attempts. For example, in his statement, Associate Professor Newton said:

> *"There is one change that might lend itself to the reduction in a similar occurrence happening in the future. That is around continuity of information. The clinician that night, in his preliminary assessment of the patient, was not aware of her presentation on the previous two nights and the file had not yet arrived from medical records."*

That is, he inferred that better access to clinical information prior to Mr Robinson's preliminary re-assessment may have changed the outcome for Ms Collings.

30. Mr Robinson also says that he would have acted differently if he had known about Ms Collings' previous attempts to self harm and her psychiatric history when he spoke to Ms Collings in the corridor before returning to his other work. In particular, he says he would have contacted the on-call consultant psychiatrist and the Clinical Director of the Peninsula Drug and Alcohol Programme.

31. Mr Robinson remained unaware of Ms Collings' recent history when he undertook her preliminary assessment in the Emergency Department at Frankston Hospital on 24 March 2007 and approved her leaving the Emergency Department unsupervised to have a cigarette. There were a number of system failures contributing to Mr Robinson's ignorance:

- He was unaware that there was a misinterpretation of the ambulance call so that her suicide attempt was not recorded.
- He was not told that she had contacted Suicide Helpline.
- He was told she had not contacted psychiatry triage.
- He was not told that psychiatry triage had contacted police and she was transported on their recommendation.

[9] Department of Health, Statewide mental health triage scale: Guidelines, Victorian Government, May 2010, p. 21.

- Her file was not immediately available in the Emergency Department because Ms Collings had been triaged category 4 so her records did not get priority.
- The Mental Health Client Management Interface service was unavailable on that weekend due to a malfunction.

32. However, Mr Robinson does not say that this knowledge of Ms Collings' prior history would have changed his decision to stand down the security officer charged with supervising Ms Collings in the Emergency Department and while she had a cigarette. The Acting Director of the Emergency Department at Frankston Hospital, Dr Choo Leong Goh, also says and I accept that the decision about whether or not to allow a patient to leave the Emergency Department unsupervised to have a cigarette was and remains linked to their assessed likelihood they will abscond. In the absence of any declared threat to abscond, the decision is likely to remain the same.

33. The Frequent Presenters Group at Peninsula Health has identified overdoses and mental health patients to be among the 20 treatment codes most likely to present more than three times within six months. Ms Collings would have easily met this definition of frequently presenting patient.

34. The new Peninsula Health Joint Clinical Practice Guideline also acknowledges the increased risk associated with frequently presenting mental health patients:

> *"ESCALATION*
> *When to call the consultant psychiatrist on duty/on call:*
> ....
> *Repeat self harm presentations within a relatively short period where clinical management is unclear...."*

35. Therefore, Peninsula Health has developed a computer generated alert in connection with frequently presenting patients. This service generates a message to a hand held Blackberry device retained by the Rapid Assessment and Discharge Officer in the Emergency Department when a patient presents more than three times within six months. In the context of an operating internal computer system, this function would have assisted Mr Robertson in identifying Ms Collings as a Frequent Presenter.

36. However, there are two separate sets of paperbased records of Peninsula Health patient presentations: the physical health file and the mental health file. This means that mental health clinicians sometimes had difficulty accessing a patient's mental health file in order to assist assessment of a frequent presenter.

37. Mr Robinson told the Court that paper-based triage records have now been replicated by electronic records at Frankston Hospital. Associate Professor Newton confirmed that mental health clinicians in the Emergency Department at Frankston Hospital now have access to patient's internal electronic Emergency Department records which would at least provide the frequency of Ms Collings'

recent presentations and may have alerted Mr Robinson to her risk of absconding which was not otherwise obvious.

38. However, an audit of presentations to the Emergency Department at Frankston Hospital in the six months from July 2010 to January 2011 indicated there were 1280 mental health presentations and, of these, 60% were unknown to Peninsula Health. Therefore, although they would have assisted Mr Robinson in assessing Ms Collings, the internal files of Peninsula Health are unlikely to provide information about the recent history of two thirds of mental health patients.

39. The Department of Mental Health has acknowledged and overcome this problem of patient mobility by providing mental health clinicians with access to the statewide Mental Health Client Management Interface computer service patient summary. However, only the clinical assessment summary is uploaded into the statewide Mental Health Client Management Interface computer service and no clinical assessment summaries were completed for Ms Collings on 22 and 23 March 2007. Even if they had been, they would not have been coded into the database within the short time frame, taking into account the weekend presentation. And, on 24 March 2007, this computer was not operating.

40. Therefore, in the context of increasing awareness of the importance of dual diagnosis and of the risk associated with inappropriate triage and assessment in the Emergency Department, acute risk assessment should always take into account the patient's recent history of presentations with self harm.

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

1. The Chief Psychiatrist advise Emergency Department mental health clinicians to routinely and regularly re-assess patients who present with a history of self harm and with a high blood alcohol concentration in order to more accurately determine the factors likely to predict risk of absconding and suicide.

2. The Minister for Health acknowledge that mental health and overdose patients are over represented in Emergency Department Frequent Presenter populations and accordingly ensure that all Emergency Department mental health and overdose presentations are recorded electronicially in databases accessible to subequent treating mental health clinicians.

3. The Australasian College of Emergency Medicine and the Royal Australian College of Nursing advise Emergency Department triage staff to maintain and access the electronic record of patients presenting with mental health issues as part of their triage assessment.

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

The Attorney General
The Minister for Mental Health
The Minister for Health
The Royal Australian College of Nursing
The Australian College of Mental Health Nurses
The Royal Australian and New Zealand College of Psychiatry
The Australasian College of Emergency Medicine
The Chief Psychiatrist

Signature:

DR JANE HENDTLASS
CORONER

31 January 2012