FORM 37

Rule 60(1)

FINDING INTO DEATH WITH INQUEST

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

Court reference: 4013/09

Inquest into the Death of MARK RONALD CONNOLLY

Delivered On: 2nd December, 2011

Delivered At: Melbourne

Hearing Dates: 10th March and 12th September 2011

Findings of: Deputy State Coroner, Iain Treloar West

Representation: Ms A. Magee for Melbourne Health, North West Mental Health and Mid West Area Mental Health Services

Place of death: Furlong Road Overpass, Sunshine, Victoria 3020

PCSU: Leading Senior Constable Antolini

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

Court reference: 4013/09

In the Coroners Court of Victoria at Melbourne

I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: CONNOLLY
First name: MARK
Address: 8 Hewson Street, Melton, Victoria 3337

AND having held an inquest in relation to this death on 10th March and the 12th September, 2011 at Melbourne

find that the identity of the deceased was MARK RONALD CONNOLLY
and death occurred on the 17th August, 2009

at Furlong Road Overpass, Sunshine, Victoria 3020

from
1a. HEAD INJURY SUSTAINED IN A MOTOR VEHICLE COLLISION (PEDESTRIAN)

In the following circumstances:

1. Mark Connolly, aged 27 years, was a single male residing with his parents at 8 Hewson Street, Melton. After completing his VCE, he successfully undertook a diploma in software design, however, at the time of his death he was unemployed. Mr Connolly had a history of depressive illness, having been diagnosed with paranoid schizophrenia and having had multiple hospital admissions in a setting of poor compliance to medication regimes. He had suffered his first mental health incident in June 2007 and in the period leading up to his death, he had been on a Community Treatment Order and had been daily monitored by his regional Crisis Assessment Treatment Team (CAT team).

2. On the 15th August 2009 at approximately 7:15pm, Mr Connolly had a home visit by the CAT team during which time he told the attending psychiatric nurse that he had taken his medication earlier and that he had done so in the presence of his father. He presented well with no sign of agitation or restlessness, nor was there evidence of formal thought disorder, nor overt

psychotic symptoms. However, at approximately 9:00pm, Mr Connolly attended at the Melton Police Station in a highly agitated state, which resulted in his father, Peter Connolly, being contacted, collecting him and taking him home. After returning home and realizing that his son needed hospitalization and medication, Peter Connolly contacted the CAT team who advised him to take his son to the Sunshine Hospital Emergency Department (Northwest Mental Health).

3. Whilst at the Emergency Department awaiting assessment, Mr Connolly asked his father to stand guard making sure he didn't run out, as he reported hearing voices telling him to do so and to self harm. The nature of his illness was characterized by perceptual disturbances with auditory hallucinations which were at times commanding him to remove his clothes in public, or to engage in self harming behaviour. On subsequent assessment he presented as agitated +++ resulting in him being sedated and remaining at the Emergency Department, pending placement at the Sunshine Adult Acute Psychiatric Unit (SAAPU).

4. On the 17th August a bed became available in the Low Dependency Unit of the SAAPU, with Mr Connolly being transferred there at approximately 2:40pm. Following his arrival he was assessed by Dr Karunaweera and during the course of assessment, he reported hearing voices commanding him to disrobe in public and to kill himself. He stated that he had attempted to jump out of his father's moving car and that he wanted to be nursed in the High Dependency Unit, as he was worried clients would not tolerated him disrobing elsewhere. Despite a bed not being immediately available in the High Dependency Unit he was reassured that appropriate enquiries would be made and at 3:45pm he was offered and accepted, medication (PRN medication 10mg olanzapine and 5mg diazepam) that was prescribed by the assessing doctor. Mr Connolly was noted to be polite, pleasant and cooperative and after being given an orientation to the Low Dependency Unit, was asked to stay in front of the nurse's station, whilst discussions took place regarding the possibility of transfer to the High Dependency Unit. This he agreed to do and he was commenced on 15 minute visual observations.

5. Whilst arrangements were being undertaken for a bed to be made available in the High Dependency Unit, Mr Connolly was observed at 4:00pm in the east wing corridor of the Low Dependency Unit and at 4:15pm, in the communal lounge area standing near the courtyard door. At 4:30pm when the arrangements for transfer to the High Dependency Unit were finalized, Mr Connolly could not be located. A full ward and ground search was undertaken to no avail, resulting in the decision being made to notify Keilor Downs Police Station that he had absconded. Before this occurred, however, Senior Constable Loveday contacted the ward at 5:10pm, enquiring if they had recently discharged a young male client, or if a client was missing. The purpose of the enquiry was to attempt to identify a deceased male who had run onto the Western Ring Road, into the path of an oncoming truck.

6. Investigations into the circumstances surrounding the death, revealed that after leaving the SAAPU, Mr Connolly proceed north along a grass verge, adjacent to the south bound lanes of

the Western Ring Road, Sunshine North. He then climbed over a 2 metre high metal fence and entered onto the emergency lane, walking on the eastern side, against the flow of traffic. At approximately 4.30pm he commenced running in the emergency lane, before suddenly veering into the path of an Australia Post truck. This vehicle was a 22 tonne truck that was proceeding in the left hand lane at approximately 90 km/h. Due to the speed at which the vehicle was travelling, the density of traffic at the time and the suddenness of the movement, the truck driver was unable to avoid colliding with Mr Connolly, who sustained fatal injuries as a result and died at the scene.

CLINICAL ASSESSMENT AND MANAGEMENT

7. The Inquest heard that Mr Connolly was attended by two registered nurses whilst in the Emergency Department, with these nurses being Nurse Colbourne and Nurse Plinius-Weise. Both nurses had previous contact with Mr Connolly, with Nurse Colbourne last attending him at his home on the 15th August 2009. They told the Inquest that they found Mr Connolly co-operative whilst in the Emergency Department and that he had made no attempt to abscond, nor did he appear agitated, or aggressive, or exhibit any behaviour that would have raised concerns about self harming behaviour. Both nurses stated that Mr Connolly requested being placed in the High Dependency Unit because of his concerns regarding the fact that he might disrobe in front of other clients in the unit. Neither nurse had concerns about Mr Connolly being admitted to the Low Dependency Unit.

8. Dr Karunaweera was the admitting psychiatrist on the 17th August 2009 at the SAAPU. Dr Karunaweera undertook an assessment of Mr Connolly with the assistance of Registered Psychiatric Nurse Chikwinya. Nurse Chikwinya's role in the assessment process was to be a witness and to contribute in the assessment, if required. Dr Karunaweera stated that at the times she undertook the assessment she was aware of Mr Connolly's history that brought him to the hospital and on assessment, found him displaying paranoid delusions with elevated levels of anxiety and distress. She was concerned about him hearing voices and that he might abscond (he had previously absconded from the unit), and in her opinion, he required placement in the High Dependency Unit. She ordered 15 minute observations and following the assessment, Nurse Chikwinya accompanied Mr Connolly to the area of the nurse's station where Nurse Chikwinya relayed the observation direction to Nurse Shepherd. Nurse Chikwinya then attended inside the nurse's station to partake in a formal handover to the nurse in charge of the unit. Nurse Trinh was the nurse in charge on the 17th August 2009, however, she had no direct contact with Mr Connolly.

9. Nurse Shepherd was the visual observations nurse on the Ward and observed Mr Connolly on three occasions; first when he was identified for her by Nurse Chikwinya and then at 4:00pm and 4:15pm, as per the visual observations chart. Mr Connolly was also observed by Nurse Anderson at these times, with Nurse Anderson being the medications nurse who had given Mr Connolly his medication at 3:45pm. Whilst she was not the visual observations nurse on

duty, she nevertheless monitored him, as she wished to check that he was all right and that there was no adverse reaction to the medications. Nurse Shepherd told the Inquest that there was no change in Mr Connolly's demeanour whilst under her observation and that he did not appear to be agitated, or distressed.

10. The hearing highlighted a conflict in the evidence of witnesses as to whether there was a practice in place at the SAAPU, for the admitting nurse to remain with an High Dependency Unit patient at all times. A view was expressed that there was a expectation that the admitting nurse, in this instance Nurse Chikwinya, would stay with the patient whilst waiting for an High Dependency Unit bed. This expectation, however, appears inconsistent with the admission process and inconsistent with the direction given by Dr Karunaweera. It is inconsistent with the need for the admitting nurse to participate in the handover process, which was required to be done in privacy in the nurse's station. It is also inconsistent with the specific direction by the doctor to place Mr Connolly under 15 minute observations, and inconsistent with the role played by Nurse Shepherd as the visual observation nurse. It was further inconsistent with Nurse Chikwinya being required to accompany Dr Karunaweera to the High Dependency Unit, in order to assist in assessing another patient, as to whether that patient could be transferred to the Low Dependency Unit, thereby making a bed available for Mr Connolly. In these circumstances I am not satisfied that there was a policy within the unit requiring Nurse Chikwinya, being the admissions nurse, to remain with Mr Connolly at all times prior to his admission into the High Dependency Unit.

11. How Mr Connolly left the unit was a key issue addressed during the course of the inquest. It was submitted by Ms Magee, who appeared on behalf of the hospital, that there is insufficient evidence to form a view as to how he absconded. I do not agree with this submission. The only tenable means of exit was via the door in which he had entered the premises, or by jumping the courtyard fence. All exit doors to the unit were locked and hence in order for Mr Connolly to have left via a door, a staff member would have had to unlock it. Although Mr Connolly may not have been known to all staff members, I find it improbable that he left by having a door opened for him. The courtyard, which was open to patients within the unit, had an approximate two metre high fence around it. The last observation made of Mr Connolly was at 4:15pm, when he was positioned in the communal lounge area standing near the courtyard door. After Mr Connolly was found to have absconded from the unit, a search of the premises revealed a chair placed beside the courtyard fence. On the balance of probability I am satisfied that Mr Connolly left the unit by going over the courtyard fence, using a chair to provide sufficient elevation to enable him to do so.

12. Northwest Mental Health has made a number of structural and clinical changes, which address issues arising out of this incident. The changes include:

a. An increase in acute services beds;

b. The development of an online daily access and bed co-ordination system;
c. Protocols for the local area and local area access to acute beds;
d. Local and network wide escalation plans;
e. Review of clinical documentation
f. Improvement in clinical documentation;
g. Improvement in clinical observations with an enhanced and management improvement project (CRAAM);
h. New risk assessment forms;
i. New observations guidelines and
j. Improved guidelines for admission to SAAPU.

COMMENT:

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

1. Mr Connolly was visited by the CAT team on the evening of the 15th August. On arrival, he told the attending psychiatric nurse that he had already taken his medication and that his father had watched him do it. Although the nurse was aware of his non-compliance with medication, she made no attempt to verify the veracity of the statement, despite it being indicated that Peter Connolly was at home. The explanation offered for this failure to enquire, was that the team were at the stage of disengaging from him and had to trust him. I do not accept that this explanation is reasonable, given that the team attended in order to supervise the taking of his oral medication and knowing of his non-compliance history.

2. A number of matters of concern were highlighted during the inquest:

- the Risk Assessment Sheet filled out by Dr Karunaweera recorded constant observations, however, the verbal direction was for 15 minute observations
- the observation level was not recorded in Mr Connolly's file
- the nurse who was requested to undertake the observations did not know the nature of risk for which the observations were required.

3. These anomalies are indicative of suboptimal care, as they fall outside the parameters of reasonable health care management.

RECOMMENDATIONS:

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

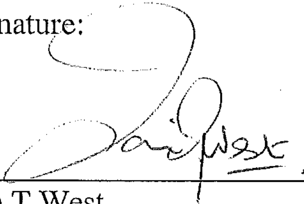
1. As previously indicated, I am satisfied that Mr Connolly absconded by climbing over the courtyard wall. It is recommended that the wall be modified in such a way as to prevent climbing over it and/or to secure any courtyard furniture so that it cannot be used as a climbing aid.

DISTRIBUTION:

1. Family of Mark Connolly

2. Melbourne Health, North West Mental Health and Mid West Area Mental Health Services

Signature:



Iain T West
Deputy State Coroner
2nd December, 2011