IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 791 / 2007

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: PETER ROBIN TULLY

Delivered On:	17 May, 2012
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	18 February, 2011
Findings of:	DR JANE HENDTLASS, CORONER
Representation:	Mr Halley appeared for Austin Health Mr Kingsom appeared for Associate Professor Richard Newton and Dr Josephine Topp
Police Coronial Support Unit	Sergeant David Dimsey appeared to assist the Coroner

I, JANE HENDTLASS, Coroner having investigated the death of PETER ROBIN TULLY

AND having held an inquest in relation to this death on 18 February, 2011
at MELBOURNE
find that the identity of the deceased was PETER ROBIN TULLY
aged 55 years
and the death occurred on 25 February, 2007
at 185A Kangaroo Ground-Wattle Glen Road, Wattle Glen, Victoria 3096
from:

1 (a) HANGING

in the following circumstances:

1. Peter Robin Tully was 55 years old when he died. Mr Tully's family and friends usually called him Sam. He lived with a housemate and close friend, Jonathan Hicks, at 185A Kangaroo Ground-Wattle Ground Road in Wattle Glen. Mr Hicks' friend, Sue Ferguson, also stayed there frequently.
2. Mr Tully's medical history included bipolar disorder and depression as well as lowered mood, anxiety and insomnia. He also had whooping cough in 2001 and recurring pain in his right knee. His general practitioner was Dr Denise Chao.
3. Dr Chao referred Mr Tully to two psychiatrists, Dr Gaynor and Dr Arulanatham. In 2006, he also consulted Dr Virag and Dr Hucker. Dr Virag also referred him to a psychologist, Carl Schmidt, at Nillumbik Community Health Centre.
4. On 24 May 2005, Dr Chao referred Mr Tully to North East Community Mental Health Service following a two-week history of increasing suicidal ideation when Mr Schmidt was on leave.
5. In the year before he died, Mr Tully also experienced several stressful events, for example:
   - On 20 January 2006, he separated from his wife, Jennifer Tully, after an attempted reconciliation. Their three children went to live with Mrs Tully.
   - In November 2006, he started work as a building inspector in Frankston.
   - In December 2006, he moved into the share house with Mr Hicks.
   - In 2005, his mother had died and he seemed to continue to grieve for her.

6. At 9.50am on 13 January 2007, Mr Tully consulted Dr Chao after an 11-month absence. He told Dr Chao he was depressed and anxious about whether he could cope with the pace of learning in his new job. Dr Chao increased his reboxetine and sodium valproate doses and prescribed zolpidem as required to sleep.

7. On 1 February and 6 February 2007, Dr Chao reviewed Mr Tully, referred him to a different psychologist, Douglas McLeod, and advised him about a mental health treatment plan. This plan enables Medicare subsidy of his psychologist's services.

8. On 7 February 2007, Mr Tully kept his first appointment with Mr McLeod. However, Mr Tully did not disclose his suicidal thoughts or intentions to Mr McLeod. He made a further appointment for the following Thursday. Mr Tully later said he preferred Mr Schmidt.

9. On 8 and 9 February 2007, Mr Tully attempted to hang himself. No one was immediately aware of these attempts.

10. On 9 February 2007, Mr Tully spoke to his sister, Rosalie Ilgoutz, about his feelings of hopelessness and contacted the North East Crisis Assessment and Treatment (NECAT) team from her house.

11. At 10.15am on 9 February 2007, Mr Tully spoke to the NECAT triage nurse, Olga Pantazolpoulos, on the telephone. He told her he had attempted to commit suicide and agreed to assessment at noon.

12. At 12.30pm on 9 February 2007, the NECAT psychiatry registrar, Dr Monshat, and the NECAT clinician, C Parker, conducted an extensive assessment of Mr Tully. Mr Tully told them about his work-related stress which he found overwhelming, his unsuccessful attempts to re-negotiate his relationship with his wife, his loneliness, occasional panic attacks, suicide attempts and his rehearsal of hanging on the previous night.

13. Dr Monshat agreed to contact Dr Chao to discuss change in medication and arrange referral to a private psychiatrist. He also arranged for a NECAT clinician to contact Mr Tully next day.

14. Ms Parker also recorded that Mr Tully had no suicidal ideation, no plan to commit suicide and no intention of committing suicide. He was seeking help and agreed with the plan to change his medication, continue to see Mr McLeod, accept NECAT support and contact them if needed. Despite their current marital issues, she also registered Mrs Tully as Mr Tully's primary carer and wrote:

   "He agrees to seek support from family over weekend."

15. Accordingly, at 3.13pm on 9 February 2007, Dr Monshat contacted Dr Chao to tell her about Mr Tully's suicide attempt on the previous night and refer him back to her management. Dr Monshat advised Dr Chao to continue his zolpidem, cease the valproate and reboxetine and start another antidepressant, either mirtazepine or fluoxetine. Dr Chao agreed to manage Mr Tully in the meantime and to refer him to a private psychiatrist.

16. At about 12.00pm on 10 February 2007, Mr Tully presented at Dr Chao's surgery. He had walked there from Greensborough because he had time on his hands.

17. In the course of his consultation with Dr Chao, Mr Tully admitted attempting to commit suicide on a third occasion over night and could not guarantee his safety. At 12.40pm, Dr Chao contacted the NECAT service.

18. A NECAT clinician, Glenys Curry, assessed Mr Tully at the Hurstbridge Medical Clinic. Mr Tully told Ms Curry that he was feeling trapped in his current circumstances, hated his work and did not want to return there, wanted to reconcile with Mrs Tully and felt disconnected from all supports.

19. Mr Tully was hesitant and unsure and unable to make a definitive decision about admission to hospital but he was unable to guarantee his safety. Therefore, he agreed to Ms Curry's plan that he accompany her to the Emergency Department at the Austin Hospital.

20. According to Ms Curry's notes, Mrs Tully was also present at Dr Chao's surgery. Mrs Tully seemed very fragile and did not want to see Mr Tully because she felt guilty about his current circumstances.

21. At 2.45pm on 10 February 2007, Mr Tully presented at the Emergency Department at the Austin Hospital. At 2.55pm, the Emergency Department medical staff assessed him. At 3.30pm, an agency Division 1 nurse commenced 1:1 observations. At 4.00pm, a mental health clinician assessed him as requiring urgent voluntary admission. This was Mr Tully's first admission to a psychiatry unit.

22. There were no public mental health beds available in metropolitan Melbourne or in the Austin Psychiatry Unit so, at 4.20pm on 10 February 2007, the Emergency Department nurse at the Austin Hospital attempted to find Mr Tully a bed in a private hospital. However, this effort to place Mr Tully in an appropriate private hospital was unsuccessful because his private medical insurance did not cover allocations over weekends.

23. Therefore, when a bed became available in the Mood Disorders Clinic at the Austin Hospital at 4.50pm on 10 February 2007, Mr Tully was admitted as soon as possible. For the purpose of admission, his treating psychiatrist was Dr Peter Bosanac. However, Dr Bosanac had no documented involvement in Mr Tully's care.

24. Dr Josephine Topp was Mr Tully's psychiatric registrar and case manager. Dr Topp was in her first year at the Austin Hospital. She worked half time in the acute psychiatry unit and half time in the mother baby unit.

25. Dr Topp's previous relevant experience included ten years as a registrar with the Austin Child and Adolescent Mental Health Service. She had also worked as a general practitioner for ten years before that. Dr Topp does not cite experience as a case manager for first admission mental health patients discharged into the community.

26. From 3.30pm to 9.30pm on 10 February 2007, Mr Tully was nursed in the Mood Disorders Clinic at the Austin Hospital on 1:1 basis. At 8.00pm on 10 February 2007, a mental health clinician, Max Tan, assessed Mr Tully. Mr Tully was anxious and he told Mr Tan that he felt Mood Disorders Clinic at the Austin Hospital was the wrong place for him as he was not "a mental case". He looked and appeared low in mood but he was forthcoming with enquiries.

27. In the context of these feelings, Mr Tully denied any on-going suicidal ideation and said that he regretted his recent suicide attempts. He said he did not want to end his life because this was wrong and would not solve his problem.

28. Mr Tully's primary psychiatric diagnosis was Major Depressive Episode with an associated mood disorder. From 9.45pm on 10 February 2007, Mr Tully was placed on 30 minute observations. Dr Topp changed his antidepressant medication to venlafaxine.

29. At 6.00am on 11 February 2007, Mr Tully still presented as anxious and pre-occupied. He said he felt strange and lost in the ward and he required diazepam to sleep. However, by 2.00pm, Mr Tully's anxiety was decreasing: he was reactive and sociable. At 8.05pm, he denied suicidal thoughts and expressed concern about the possibility he would be certified next day. His continued to require observation every half hour.

30. On 12 and 13 February, Mr Tully remained flat in affect and isolative but he denied thoughts of self harm. Further, Dr Topp assessed Mr Tully as having no perceptual abnormalities and denying suicidal ideation. His treating team started to plan discharge.

31. On 14 February 2007, Mr Tully continued to seem quiet and flat in affect and requested increased sedation. Dr Topp assessed Mr Tully as having mild to moderate depression, continuing to deny suicidal ideation, wanting help and thinking about what to do in the future.

32. On 14 and 15 February 2007, Mr Tan went further than Dr Topp in assessing Mr Tully's improved mental state: at 9.20pm on 14 February 2007, he saw Mr Tully briefly and recorded that he remained cheerful reactive and pleasant, eating and drinking well. By 8.15pm on 15 February, Mr Tully said he was feeling much better and he was keen to have overnight home leave.

33. In contrast, Dr Topp also spoke to Mrs Tully on the telephone. She was very distressed and concerned about their children and the effect that Mr Tully's attempted suicide would have on them. Mrs Tully also told Dr Topp she could not live with Mr Tully.

34. At a subsequent meeting, Mrs Tully also told Dr Topp that she thought Mr Tully was playing the game because he wanted to get out of hospital. In court, Mrs Tully said:

   "... he told Gemma the day before, maybe the weekend, that he had to play the game and he would whisper to her because he believed the room was bugged and that if he didn't play their game they wouldn't let him out and he had to get out".

35. Mrs Tully stated that she told Dr Topp:

   "I'm so scared that he's going to come out. He just wants to get out just so he can do it'. She sat there and said 'Oh, we're very pleased with his progress. We can never be 100 per cent sure with things but we don't think you need to worry about that'".

36. Despite the time between his death and the Inquest, Dr Topp told the Court she remembered Mr Tully. She told the Court:

   "You always remember someone who's died. "

37. However, Dr Topp said she did not remember these conversations with Mrs Tully. She also said they would have made her concerned and that her normal reaction would be to confront the patient with those concerns. She also did not remember having any discussion with Mr Tully about his family's reports that he was deliberately misleading his clinical team about his mental state.

38. In the circumstances of Mrs Tully's statement made on 1 March 2007 and her relationship with Mr Tully, I accept the substance of her evidence that Dr Topp was aware that Mr Tully had said that he was fabricating his presentation in order to avoid extending his admission

time. I am uncertain as to whether or not Dr Topp confronted Mr Tully with his family's concerns.

39. On 16 February 2007, Mr Tully also saw a probationary clinical psychologist, Felicity Locklett. Ms Locklett's assessment also differed from that of Dr Topp and Mr Tan. She recorded that Mr Tully's mood remained low although it had improved since admission, his affect was flat but he reported no suicidal ideation.

40. On 16 February 2007, despite the family concerns about Mr Tully's presentation and the opinion expressed by the clinical psychologist, Mr Tully was approved to take overnight leave at home and the frequency of his ward observations was reduced to hourly. Dr Topp told the Court that overnight leave was a very important pre-discharge procedure.

41. Mr Hicks visited Mr Tully in hospital nearly every day of his admission. However, there is no record that any of Mr Tully's treating team spoke to Mr Hicks about the reasons for the over night leave or its implications for his discharge planning or at all. Further, there is discussion in Mr Tully's medical record about his refusing permission for the treating team to disclose his circumstances to some specific people including his employer but there is no suggestion that he refused consent for discussions with Mr Hicks.

42. Ms Ilgoutz also visited Mr Tully three times in hospital. In her statement prepared for the coronial investigation, she said that Mr Tully spoke to her about discharging himself but she discouraged this action. Conversely, on 17 February 2007, treating staff recorded that Ms Ilgoutz 's visit went quite well.

43. At 6.00pm on 17 February 2007, Mr Hicks and Ms Ferguson took Mr Tully out for dinner. The medical record indicates that staff were aware that he was going out for only four hours and he returned to the ward at 10.30pm that night.

44. Mr Tully was inconsistent in his reporting of the success of his leave. He told the nursing staff he did not want to stay out overnight because there was no air conditioning in their house. However, in group sessions he said he enjoyed his leave and felt more hopeful about the future. Dr Topp also recorded that he had enjoyed the dinner with his friends.

45. Further, Dr Topp recorded that Mr Hicks and Ms Ferguson reported that Mr Tully had managed his outing well. However, in her statement prepared for the coronial investigation, Ms Ferguson said that he was extremely uncomfortable and anxious and they were too concerned about his presentation to allow him to stay with them overnight.

46. On 18 February 2007, Mr Tully's mood and mental state became noticeably better and discharge planning commenced. As an outside visitor, Mr Hicks also stated that Mr Tully's mood went up and down but generally it improved over time.

47. However, Mr Tully remained very anxious about discharge. On 19 February 2007, he told Dr Topp he was worried about how he will cope in the community and that he would become suicidal again. After further discussion, Dr Topp confirmed her assessment that Mr Tully's mental state was improving and she discussed discharge arrangements including referral back to Dr Chao and Mr Schmidt. He did not want a referral to a psychiatrist.

48. On 20 February 2007, Mr Tully had a meeting with Dr Topp and Mrs Tully. Mrs Tully was clear that Mr Tully could not move back with her yet. She understood that he would be discharged back to the house he shared with Mr Hicks.

49. Afterwards, Mrs Tully took Mr Tully out for an hour with her. When he returned to the ward, he remained low in mood and flat in affect. Mr Tully was anxious about the future, anxious about going back to work and anxious about having to be independent. He was seeking clear discharge planning.

50. Mr Tully also rang Ms Ferguson to say he was being discharged the following day. He did not know where he was going to go or what he was going to do but he did not want to return to the share house in Wattle Glen.

51. On 21 February 2007, Dr Topp contacted Dr Chao about Mr Tully's pending discharge. She made arrangements for him to consult Dr Chao at 11.15am on 27 February and told her that Mr Tully was now prescribed venlafaxine and zolpidem.

52. Dr Topp relied on Mr Tully to contact Mr Schmidt. On 20 February, he followed up this referral and reported a three-week wait for an appointment. Mr Tully also spoke to Ms Ilgoutz but she doubted his report because he had previously threatened to discharge himself.

53. No one from Mr Tully's treating team contacted Ms Ilgoutz or Mr Hicks and Ms Ferguson about Mr Tully's discharge arrangements. They knew that Mr Tully had private health insurance but no one considered transfer to a private health facility.

54. On 21 February 2007, Dr Topp also completed Mr Tully's discharge summary. In contrast to Mr Tully's understanding of his discharge plan, she noted that:

- Mr Tully's mood had lifted noticeably a few days after admission and he consistently denied suicidal ideation;

- He was keen to be discharged;
- He did not want to see a psychiatrist but he planned to continue to see Mr Schmidt; and
- He would stay with his sister who could monitor his mental health.

55. Dr Topp also stated:

    "However Peter was clearly quite anxious at the prospect of discharge and his sister and Peter were given the phone number for CAT as a precaution."

56. Dr Topp also provided Mr Tully with a medical certificate that he was unfit for work until 28 February 2007.

57. On 21 February 2007, Mr Tully rang Ms Ilgoutz to ask her to pick him up from the hospital. She arrived at about 3.30pm but she had to wait while Dr Topp reviewed him. No one is recorded as having spoken to her about Mr Tully's discharge plan during this time.

58. At 6.00pm on 21 February 2007, Mr Tully was discharged from the Austin Mood Disorders Clinic with Ms Ilgoutz and one week's supply of venlafaxine and zolpidem. Mr Tully's clinical team also provided him with contact details for Berry Street financial counselling service and for NECATT.

59. On 22 February 2007, Mr Tully faxed a letter and his medical certificate to his employer. In the afternoon of 22 February 2007, Ms Ilgoutz drove Mr Tully to an appointment with Mr Schmidt. On the way home they discussed his return to his shared home.

60. On 23 February 2007, Mr Tully rang Ms Ferguson to say he was coming home to their house. He believed he had no choice. Mr Hicks was shocked that Mr Tully came home because he thought Mr Tully would continue to stay at his sister's place as he would have been haunted by his actions there.

61. Early on Saturday 24 February 2007, Ms Ilgoutz dropped Mr Tully at the Wattle Glen unit and he did his washing. When Ms Ferguson got home at 3.00pm, Mr Tully told her he planned to stay overnight and to go back to work on 28 February 2008 when his medical certificate expired but he was not looking forward to it. They had dinner and talked socially until Mr Tully abruptly got up and went to his room.

62. Mr Hicks and Ms Ferguson heard him moving furniture around in his room until about 12.45am on 25 February 2007 when Mr Hicks asked if he was alright. There was no response. In retrospect, they believe he was preparing for or practising his suicide.

63. At breakfast on 25 February 2007, Mr Tully seemed very low and withdrawn. At 11.00am, Mr Hicks and Ms Ferguson left home for the day. They told Mr Tully they expected to be home later that evening.

64. Mr Tully spent the rest of 25 February 2007 with Mrs Tully and two of their children at the horse show at Hurstbridge. At 3.10pm, Mr Tully dropped Mrs Tully at her home in Warrandyte. No one is known to have seen him alive after this time.

65. At 8.50pm on 25 February 2007, Mr Hicks and Ms Ferguson returned home and found Mr Tully unresponsive hanging in his bedroom. He was unable to be resuscitated.

66. Police found medication packets in the bedroom including three 10mg tablets from a packet of zolpidem prescribed by Dr Topp and dispensed by Austin Health on 21 February 2007, three 150mg tablets from a packet of seven venlafaxine prescribed by Dr Topp and dispensed by Austin Health on 21 February 2007, one 10mg tablet from a packet of 20 zolpidem prescribed by Dr Denise Chao and dispensed by Priceline Pharmacy in Diamond Creek on 4 February 2007.

67. An application for no autopsy to be performed was granted by the Coroner. The forensic pathologist who inspected the body formed the opinion that in the circumstances a reasonable cause of death was hanging. Toxicological analysis detected venlafaxine at a concentration consistent with therapeutic use.

68. Accordingly, I find that Peter Tully intentionally died from hanging.

COMMENTS

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

1. The Austin & Repatriation Medical Centre is an approved mental health service under section of the *Mental Heath Act* 1986.

2. On Saturday 10 February 2007, Peter Tully presented at the Emergency Department of the Austin Hospital following referral by his general practitioner, Dr Denise Chao, and assessment by a North East Crisis Assessment & Treatment mental health clinician.

3. Mr Tully preferred to be called Sam but I note this name was not used at all in records of his medical management at the Austin Hospital.

4. This was Mr Tully's first psychiatric admission to hospital. There were no adult acute mental health beds available in metropolitan Melbourne. Further, Mr Tully's private medical insurance did not cover private bed allocation over weekends. Therefore, Mr Tully was admitted as a voluntary patient to the Austin Hospital Mood Disorders Unit.

3. Dr Josephine Topp was Mr Tully's case manager and psychiatry registrar during his admission to the Austin Hospital Mood Disorders Unit.

4. Mr Tully was diagnosed with Major Depressive Disorder with associated mood disorder. He had attempted suicide at least three times in the last week. His marriage had collapsed and he was struggling with his new job. Accordingly, Dr Topp also assessed Mr Tully as low risk of deliberate self harm, low risk of accidental self harm and medium to high risk of suicidality. She prescribed venlafaxine with continuing prescription of zolpidem for sleep.

5. Although Mr Tully's mental state appeared to improve over the next 11 days and he repeatedly denied any risk of self harm and suicidality, his mood remained low and his affect was mainly flat.

6. Further, Mr Tully quickly learned how to dissemble in reporting his thoughts and intentions. For example, at first Mr Tully told his treatment team that he felt the Austin Hospital Mood Disorders Unit was the wrong place for him as he was not "a mental case". After that, he told family and friends that he dared not say anything to staff or he would be there forever. He was concerned about being made an involuntary patient.

7. As another example, on 17 February 2007, Mr Tully went out with his friends for four hours. Mr Tully told staff he did not stay overnight because there was no air conditioning at home. He also told Dr Topp and his co-patients that the leave was very successful. On the contrary, his friend told the Court that Mr Tully was extremely uncomfortable and anxious and they would not allow him to stay with them overnight.

8. Mrs Tully also told Dr Topp that Mr Tully had told family and friends that he was "playing their game" because he wanted to get out of hospital. Dr Topp does not remember this part of their conversation.

9. The Head of the Psychiatry Unit at the Austin Hospital, Associate Professor Richard Newton, told the Court:

   ".... it's the norm for all of us as people to put on facades with other people and in an inpatient unit it's very common for people to feel that they should behave in a particular way

in order to get whatever they want out of the interview and for them to talk about that amongst themselves as patients beforehand and so all of these things happen all the time and at the same time people also put on a facade in order to hide their feelings because they're afraid of what might happen if they reveal their feelings so some of this is normal and understandable and people being people and some of it is deliberate putting on an act in order to hide things that they don't want us to know and that constantly occurs."

10. This knowledge about patients' motives for misrepresenting their current mental state emphasises how important it is for clinicians to obtain and take into account all available collateral evidence to inform their clinical decisions about discharge readiness and planning.

11. Mr Tully's friends and relatives were aware of Mr Tully's procrastination with his clinical team and ready to share their knowledge but they were not asked. Even when Mrs Tully volunteered the information, it was not recorded and not taken into account.

12. Coroners frequently make recommendations about the way in which mental health clinicians communicate with patients' families and friends. For example, in the course of an Inquest in the State Coroner's investigation of the death of Anne Marie Cameron in 2002, Dr Peter Doherty, Director of Psychiatry at The Alfred hospital said:

    "Carers have a fundamental interest in the welfare if their loved ones and have information to pass on to treating staff which may not be given by the patients themselves but it may be available only through the carers, with regard to the patient's mental state and other matters to do with the patient's past history and even how they may be feeling at any particular point in time."

13. Similarly, in the course of his investigation of the death of Glenn Bernard Furey, the Deputy State Coroner also stated:

    "An important issue for the deceased's family was the fact that they felt excluded by not being sufficiently involved in his management and care, a common complaint raised by families in this jurisdiction... Family members and carers of the mentally ill frequently have knowledge of a loved one's pattern of behaviour and thinking that should be incorporated into the management and treatment decision making process. They have a fundamental interest in the welfare of their loved one..."

14. In my Findings in relation to the death of Sarah Ellen Cuffley in 2007, I adopted the Deputy State Coroner's recommendation:

"That clinicians remain attentive to the contribution able to be made by the family and incorporate into their decision making process the family's knowledge of the their loved one's behaviour and thinking."

15. This recommendation remains relevant to this investigation of Mr Tully's death. **(Recommendation 1).**

16. Accordingly, Mr Tully's treating team arranged to discharge Mr Tully on 21 February 2007 and Dr Topp contacted Dr Chao to transfer responsibility for his support and make an appointment for 27 February.

17. Mr Tully was anxious about his discharge but he agreed to comply with the discharge plan which required him to live with his sister, consult his psychologist and his general practitioner and take his medication. He was not placed on a Community Treatment Order because he accepted treatment voluntarily.

18. However, no one from Mr Tully's treating team communicated this discharge decision with the people who needed to provide Mr Tully with his immediate post-discharge, day to day care: his sister, his housemates or his psychologist.

19. On 21 February 2007, Mr Tully was discharged into the care of his older sister with continuing use of venlafaxine and zolpidem, an appointment to consult his general practitioner on 27 February 2007, and a medical certificate for one week's sick leave from work.

20. On 24 February 2007, Mr Tully returned to the house he shared with friends. They were unaware of his discharge from hospital and shocked that he would return to the house where he had previously attempted to commit suicide.

21. Four days after his discharge from the Austin Hospital, Mr Tully intentionally died from hanging after spending the day with his wife and children.

22. Mr Tully's death raises a number of issues in relation to suicide of mental health patients including:
    - Management of first admissions to an approved mental health service;
    - Discharge Planning for first admissions to an approved mental health service; and
    - Discharge of mental health patients following their first admission to an approved mental health service.

23. Under the Mental Health Act 1986, people with a mental disorder must be given the best possible care and treatment appropriate to their needs in the least possible restrictive

environment and least possible intrusive manner consistent with the effective giving of that care and treatment. Accordingly, a patient's decision to accept treatment is interpreted as an indicator of their insight into their condition and their likely compliance. Under these circumstances, it is difficult for mental health clinicians to legally impose an involuntary treatment order or discharge them on a Community Treatment Order.

24. This means that the legal status of a person with a mental disorder is not necessarily or usually related to the severity of their illness or risk or the treatment that is appropriate to their needs. Associate Professor Richard Newton told the Court that the patient's voluntary or involuntary status should be no difference to their management and discharge. I agree.

25. All these factors applied to Mr Tully's voluntary admission to and discharge from the Austin Hospital. Therefore, I do not discriminate between the voluntary nature of Mr Tully's admission and discharge plan and those that should apply to all first admissions to a mental health facility.

Management of first admissions to mental health facilities

26. First admission to a public mental health facility can be frightening, challenging and very confronting. The ward is frequently chaotic and hectic. The other patients have their own reasons for forming opinions about appropriate care. Patients find themselves living closely with people with whom they feel little affiliation and do not want to associate. All this is unlike the facilities provided by private hospitals and also differs from medical or surgical wards in public hospitals.

27. Dr Topp told the Court:

"I think first admissions particularly for people with mood disorders are very, very, frightening because admission into acute psych units is a very frightening experience and I do think that often private hospitals provide a much more appropriate care for people such as this."

28. Mr Tully confirmed that he experienced these concerns about his first admission to the Austin Hospital. He said it was the wrong place for him as he was not "a mental case". He worried that he would be made an involuntary patient. He also said he could not be honest with staff because he would never get out of there.

29. In Court, Mrs Tully confirmed:

"I think he was extremely shocked to find out he ended up where he was. He, on many, many times, said to me and to people that visited him, I don't belong here. That was like the first - I don't belong here. I don't belong here and he couldn't even tell me what he'd done. He had to write it in a note and he just kept saying, I have to get out of here. I have to get out of here."

30. In 2007, I investigated the death of Sarah Ellen Cuffley who intentionally died during her first admission as a voluntary patient in the Alexander Bayne Centre in Bendigo. In the course of that investigation, I was provided with pamphlets intended to help patients and their carers understand their new environment. I found these documents to be confusing and they had not been provided to Ms Cuffley's family. I was assured that improved pamphlets were forthcoming. It seems not.

31. Associate Professor Newton has made statewide enquiries and determined that there is no tailored information package for patients and their families on first admission to psychiatric services. Accordingly, Austin Health submits that a tailored information package for patients and their families on first voluntary admission would be an invaluable improvement to services. I agree.

32. Austin Health has formed the belief that providing a tailored information package to patients and their family members on first admission to psychiatric services would be an invaluable improvement to services. I agree.

33. Austin Health limited their comments about providing information to first voluntary admissions but, consistent with Associate Professor Newton's opinion, I do not agree with their implied distinction between services provided to voluntary and involuntary patients. **(Recommendation 2)**

34. Austin Health also has a number of specific opinions about the content, medium and distribution of the information package to patients and their family members on first admission to psychiatric services. I do not have sufficient expertise to comment on their suggestions.

35. Rather, it is important for consumers and carers to identify how best to communicate with them about what they can expect to experience during and after their first admission to an approved mental health service and for them to trial the product before it is finalised. **(Recommendation 3).**

Discharge planning for first admissions to mental health facilities

36. In 2002, the Chief Psychiatrist published clinical practice guidelines to assist approved mental health services concerning practice in relation to case management and discharge planning in community settings (the "Chief Psychiatrist's Guideline").[1]

37. As relevant to Mr Tully's management, the Chief Psychiatrist's Guideline adopts the following Key Principles:

   - *"Consumers and their carers as appropriate should be made aware at the point of entry that services will be provided for the period clinically indicated.*
   - *Active Case Management and case load monitoring requires the input of all levels of staff – this includes members of the treating team, Community Mental Health Service managers and consultant psychiatrists.*
   - *Relevant discussions and clear communication between clinician, consumer, family/carer and the service/person who is to provide ongoing treatment is vital."*

38. Except for providing advice about patients who have not presented to an Area Mental Health Service in the previous three months, the advice to clinicians in this Chief Psychiatrist's Guideline does not discriminate between first and repeat admissions.

39. Therefore, it is important for the Chief Psychiatrist's Guideline to also address the special circumstances experienced by all patients on their first admission to an approved mental health agency. **(Recommendation 4).**

40. Mr Tully's discharge planning involved:

   - Overnight leave on the night of 17 February 2007.
   - Accommodation arrangements.
   - Referral back to his general practitioner.
   - Return to work.
   - An appointment with his preferred psychologist.
   - Contact details for Berry Street financial counselling service.
   - Contact details for NECATT.
   - Arrangements for transport.

---

[1] Office of the Chief Psychiatrist, Chief Psychiatrist's Guideline, "Discharge Planning for Adult Community Mental Health Services," August 2002.

41. I will deal with each of these issues individually.

Overnight leave

42. Dr Topp told the Court that overnight leave was a very important pre-discharge procedure. I agree. However, before he left the ward on 17 February 2007, Mr Tully had changed his arrangement to only stay out for four hours. Therefore, Mr Tully did not experience the overnight leave that was planned to prepare him for discharge.

43. Further, Mr Tully reported the success of this venture and the reasons for his early return to the ward differently from the way in which his friends reported it in their statements for the coronial investigation. Dr Topp admitted that she would not know about these inconsistencies unless she spoke to the patient's carers and there is no evidence that this occurred.

44. The Austin Hospital has now changed the way in which overnight leave is reviewed. Inpatient staff now routinely contact the patient or his family while he is on leave to enquire how the leave is progressing. Further, when the patient returns from leave a more robust assessment is carried out. In particular, an assessment of the patient is carried out followed by corroborated evidence from the carer.

45. If this practice had been followed after Mr Tully's four hour leave on 17 February 2007, I presume his discharge planning would have required a successful overnight leave before discharge. This may have prevented his death.

Accommodation arrangements

46. Mr Tully's treatment team knew that Mr Tully could not live with Mrs Tully even though she was his designated long term carer. Further, it seems they had had no communication with his sister, Rosalie Ilgoutz, or housemate and friend, Jonathan Hicks, and there was no long term plan about where he would live.

47. Mr Hicks had refused to have him stay overnight during Mr Tully's admission and was shocked when Mr Tully returned to his house only two nights after discharge from the Austin Hospital.

48. This failure to ensure appropriate short to medium term accommodation arrangements contributed to Mr Tully's death. **(Recommendation 5).**

Referral back to his general practitioner

49. Dr Topp contacted Mr Tully's general practitioner and they talked about his current mental health and his medication requirements. However, she made his first appointment five days after discharge.

50. In many ways the general practitioner plays the role of case manager for patients discharged back into their community. Therefore, it is crucial that discharge plans include immediate transfer back to their known stable support systems including their general practitioners.

51. In the circumstances facing Mr Tully, five days was too long. An appointment on the day of or after discharge may have changed the outcome for Mr Tully. **(Recommendation 6).**

Return to work

52. Mr Tully consistently expressed concern about his employment, his capacity to do the work and his anxiety about returning to and explaining his absence from work. Dr Topp was also very concerned about his employment situation,

53. Accordingly, the social worker associated with the Austin Hospital acute adult psychiatry unit contacted Mr Tully's employer and told him that Mr Tully had a certificate for further one week after discharge. She also committed Mr Tully to making further contact with his employer his employer a "few days" after discharge.

54. Further, Mr Tully's medical certificate to allow him to avoid going back to his workplace expired on 28 February 2007.

55. To his credit and inconsistently with his capacity to manage other issues, Mr Tully was able to follow up the social worker's contact with his employer to facilitate a further week of leave. He did not live long enough to execute his plan.

An appointment with his preferred psychologist

56. Mr Tully was responsible for contacting his preferred psychologist. He was unable to make an appointment for three weeks so he did not make one at all.

57. An appointment with his psychologist may have prevented Mr Tully's death.

Contact details for Berry Street financial counselling service

58. Mr Tully was advised to but did not follow up with the financial advisor recommended by the Austin Hospital social worker. I am unable to say whether or to what degree this failure affected Mr Tully's death.

Contact details for NECATT

59. Dr Topp provided Mr Tully with the contact details for NECATT and he had previously used this service.

60. In evidence, Dr Topp accepted that Mr Tully could have been provided with more assertive post discharge follow-up. In particular, she could have notified NECATT that there were concerns so that they would have contacted Mr Tully rather than waiting for him to contact them.

61. If NECATT had contacted Mr Tully and/or his sister, they would have been aware of his planned return to his shared house accommodation and his concerns about managing in the community.

62. However, Dr Topp's admission is predicated on her having concerns about his safety when she authorised his discharge. She did not hold these concerns because she did not consult his family and friends and she was unaware of the degree to which he fabricated his mental state.

Arrangements for transport

63. No arrangements were made for Mr Tully's transport after discharge.

64. On 21 February 2007, Mr Tully rang his sister to arrange to be picked up. She was unaware of the organisational issues that were associated with discharge. She was also unaware of the responsibility imposed on her as his carer and presumed provider of stable accommodation.

65. Failure to discuss these issues may have contributed to Mr Tully's early return to his share house accommodation and his death.

Summary

66. Dr Topp accepted the role of case manager during Mr Tully's admission to the Austin Hospital. In that role, she arranged his review by a social worker to address his work issues and his conference with Mrs Tully to clarify her capacity to continue her role as his carer. She also made an appointment with his general practitioner for five days after discharge.

67. Dr Topp also told the Court that she was confident that Mr Tully did not present as an immediate suicide risk at the time of discharge. This does no explain her failure to make any arrangements for further overnight leave, stable accommodation or transport from the hospital on discharge. Dr Topp also required Mr Tully to initiate contact with his preferred psychologist, the financial advisor and with NECATT. He made none of these appointments.

68. In the absence of accurate assessment, adequate discharge planning and continuity of care into the community environment, Mr Tully was unlikely to cope with the stressors which predisposed his admission and continued after discharge.

Discharge of mental health patients following their first mental health admission

69. Associate Professor Richard Newton has introduced new follow up arrangements for all patients who are discharged from the Austin Health mental health facilities. These include daily NECATT contact until the NECAT team considers the patient's risks have decreased adequately to be managed through less intensive monitoring in the community and appointment of a discharge co-ordinator who contacts patients within seven days of discharge to ensure they have followed up their discharge plan and do not require further assistance.

70. These new arrangements would not have changed the outcome for Mr Tully because they do not cover the early post-discharge period when Mr Tully died.

71. Therefore, in circumstances where the post-discharge appointment with the general practitioner is delayed by more than 24 hours from discharge, it is appropriate for NECATT to contact all first admissions daily to assess their transfer into the community and consult with their carers. **(Recommendation 7)**

72. In 2003, the *Mental Health Act* 1986 was amended to require the authorised psychiatrist in an approved mental health service to include appointment of a case manager in the treatment plans of involuntary community-based mental health clients. The Chief Psychiatrist's Guideline also advocates allocation of a case manager to patients engaged in ongoing treatment with community-based mental health services.

73. In practice, the level of case management provided to involuntary patients depends on their clinical needs. There is no reason for voluntary patients discharged from an approved mental health service to be less needy than involuntary patients.

74. Further, voluntary patients frequently access non-government services including private hospitals, private psychiatrists and psychologists and general practitioners. Therefore, it is important for all adult mental health patients to have a case manager to take responsibility for coordinating their service delivery.

75. Mr Tully was discharged to continuing support from his sister, his housemate, his wife, his general practitioner and his psychologist.

76. However, other than Mr Tully's sister's crucial offer of short term accommodation, these supports were unlikely to help him in circumstances where :

- His housemate had already refused to allow him to stay overnight because of his concerns about risk;
- His wife was unwilling to live with him;
- His psychologist was unavailable for three weeks;
- His general practitioner's appointment was in five days time;
- He was expected to contact his employer about returning to work in "a couple of days".

77. Further, although Dr Topp accepted the role of case manager and he had seen a social worker during his admission, Mr Tully did not have a designated case manager in the community. This failure suggests there is a practical as well as a legal distinction between the services provided to voluntary and involuntary patients. This difference is inconsistent with the Chief Psychiatrist's Clinical Guideline which do not otherwise discriminate on the basis of patients' legal status. **(Recommendation 8)**

78. A designated case manager for first admissions would reduce their anxiety and take responsibility for maintaining continuity during the admission and contact in the crucial post-discharge period or co-ordinating his post-discharge supports. **(Recommendation 9)**

79. Designated case managers for first admissions could also take responsibility for ensuring that the clinical team maintains contact in the early post discharge period until patients have consulted their general practitioner and their management has been transferred back to them and co-ordinate post discharge supports. **(Recommendation 10)**

RECOMMENDATIONS

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

1. That clinicians remain attentive to the contribution able to be made by the patient's family and carers and incorporate into their decision making process their knowledge of his or her behaviour and thinking.

2. That the Chief Psychiatrist facilitate development of a tailored information package to all patients, their family members and carers on first admission to an approved mental health service.

3. That the Chief Psychiatrist inform herself about the preferences of clients, families and carers before she determines how best to communicate with them about what they can expect to experience during and after their first admission to an approved mental health service.

4. That the Chief Psychiatrist publish clinical practice guidelines to assist approved mental health services concerning practice in relation to case management and discharge planning for all first admissions to acute adult mental health services.

5. That the Austin Hospital adult psychiatry unit ensure that discharge plans for first admission patients always include appropriate short to medium term accommodation arrangements and that cohabitants agree to these arrangements before discharge.

6. The Austin Hospital adult psychiatry unit ensure that discharge plans for first admissions always include immediate transfer back to and communication with their known general practitioner.

7. That the Austin Hospital amends its new discharge arrangements to include daily contact by NECATT until patients have consulted their general practitioner and their management has been transferred back to them.

8. That the Chief Psychiatrist amend clinical practice guidelines to advise that the same or similar practices apply to discharge of voluntary patients as already apply to involuntary patients.

9. In the alternative, that the Austin Hospital acute adult psychiatry unit appoint case managers for voluntary first admission patients to help them manage their discharge arrangements and follow them into the immediate post discharge phase of their therapy.

10. That the designated case managers take responsibility for ensuring that the clinical team maintains contact with first admissions in the early post discharge period until patients have consulted their general practitioner and their management has been transferred back to them and co-ordinate post discharge supports.

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

Attorney General

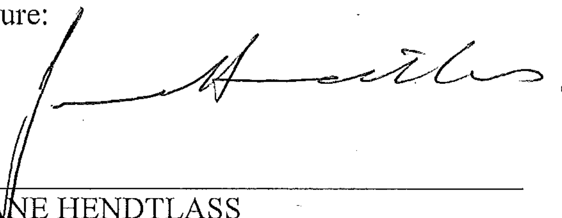
Minister for Mental Health

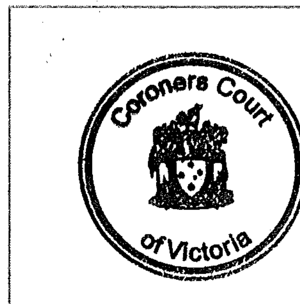
Minister for Health

Chief Psychiatrist

Director of Psychiatric Services, Austin Hospital

Signature:





DR JANE HENDTLASS
CORONER
Date: 17 May, 2012