IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 006039

FINDING INTO DEATH WITH INQUEST

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

Inquest into the death of Wieslaw Albin BERNACKI

Delivered on:	5 December 2014
Delivered at:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing dates:	5 and 6 August 2013
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr Michael REGOS from DLA Piper appeared on behalf of Mercy Mental Health Service
Assisting the Coroner:	Leading Senior Constable Tania CRISTIANO from the Police Coronial Support Unit

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of WIESLAW ALBIN BERNACKI
and having held an inquest in relation to this death on 5 and 6 August 2013
in the Coroners Court of Victoria at Melbourne:
find that the identity of the deceased was WIESLAW ALBIN BERNACKI
born on 16 December 1947
and that the death occurred on 30 December 2009
in the vicinity of the Western Ring Footpath, off Sunshine Avenue, St Albans, Victoria 3021
from:

I (a) HANGING

in the following circumstances:

BACKGROUND AND PERSONAL CIRCUMSTANCES[1]

1. Mr Bernacki was a 62-year-old man originally from Poland. He was the third youngest of his mother's six children, and was raised by her as a single parent. Mr Bernacki trained as a carpenter and served in the Polish army, before migrating to Australia more than 30 years ago.
2. He lived an itinerant lifestyle and had no family in Australia. However, Mr Bernacki maintained telephone contact with his siblings in Poland and enjoyed a number of enduring friendships within the Polish community in Victoria.[2]

PSYCHIATRIC HISTORY

3. Mr Bernacki had a long history of severe psychiatric illness, with the first documented Victorian contact with mental health services occurring in 1982. Most of Mr Bernacki's admissions to psychiatric units in Victoria involved contacts with police – sometimes precipitated by his erratic driving, or actual or threatened violence – during which he was detained and restrained before being transferred and admitted to inpatient psychiatric facilities as an involuntary patient.
4. Mr Bernacki was diagnosed with schizophrenia in the 1980s. His presentation, particularly at the time of involuntary admissions to psychiatric facilities, generally consisted of aggression, paranoid delusions involving police and mental health professionals, religious delusions and poor insight into his mental illness. He was resistant to treatment and frequently uncooperative with treating clinicians. Mr Bernacki was known to be abusive and threatening

[1] This section is a summary of facts that were uncontentious, and provide a context for those circumstances which were contentious and will be discussed in some detail below.

[2] Exhibits B and C.

towards staff, to refuse oral medications and nourishment, and attempt self-harm in protest. As a measure of the severity of his mental illness, between 2003 and 2009, Mr Bernacki was admitted to psychiatric inpatient facilities across regional and metropolitan Victoria, more than 10 times.

5. The severity of Mr Bernacki's mental illness made him a challenging patient. Although he had received electroconvulsive therapy during earlier admissions, the mainstay of his treatment more recently, was depot antipsychotic medication, both when he was an inpatient and when an involuntary patient in the community. Mr Bernacki's itinerant lifestyle, active avoidance of treatment, significant history of risk to himself, whether through neglect or deliberate self-harm, made it difficult for mental health services to provide continuity of care. Even when appropriately medicated, Mr Bernacki tended to be extremely guarded, with a chronic mistrust of law enforcement and mental health care professionals.[3]

ADMISSION TO WERRIBEE MERCY PSYCHIATRIC UNIT ON 1 DECEMBER 2009

6. On 1 December 2009, Mr Bernacki was driving erratically and was intercepted in Footscray by Victoria Police. According to the police, he displayed odd behaviour and attempted to flee. They deployed capsicum spray to subdue Mr Bernacki before arresting him pursuant to section 10 of the *Mental Health Act* 1986 [the MH Act], and transported him to Werribee Mercy Psychiatric Short Stay Unit [the Short Stay Unit]. Mr Bernacki was admitted to the Short Stay Unit and, later the same day, was transferred to the Werribee Mercy Inpatient Psychiatric Unit [WMPU], where he remained subject to an Involuntary Treatment Order under the MH Act. During transfer mechanical restraints were applied due to his agitation.[4]
7. On admission to WMPU, Mr Bernacki was dishevelled, irritable and verbalising religious delusions. He was assessed as being at high risk of self-neglect, impulsivity, violence towards others and non-compliance with treatment.[5] He demonstrated no insight into his mental illness and, given his demeanour, was nursed in seclusion for the first few days. On 2 December 2009, Mr Bernacki's status as an involuntary patient was confirmed by the consultant psychiatrist reviewing him as required by the MH Act.
8. The first fortnight of Mr Bernacki's admission at WMPU was characterised by resistance to all interventions including nourishment, animosity towards staff, unsettled and unpredictable behaviour and delusions with religious themes. Increasing doses of antipsychotics were

---

[3] See generally Exhibit E, the statement made by Mr Bernacki's treating psychiatrist, Dr T. Tawde, on 15 December 2010.

[4] See Exhibit E, page 2.

[5] Ibid.

administered by intramuscular injection as he refused to take oral medications.[6] Clinical staff conducted daily risk assessments, and regular and frequent mental state assessments.[7] Nursing staff performed half-hourly visual observations of Mr Bernacki throughout his admission. Staff also obtained collateral information about Mr Bernacki from his friends and other visitors who knew him well.

9. On or about 20 December 2009, Mr Bernacki remained uncooperative and non-compliant with medications, but presented as less angry and more readily engaged by staff. Given these signs of improvement, his treating team planned to maintain their reviews and reduce the dose of antipsychotics, with a view to referring him to Homeless Outreach Psychiatric Services [HOPS] to continue the administration of depot injections.[8]

10. During a mental state examination conducted on 23 December 2009, Mr Bernacki was attentive and engaged well, with speech that was spontaneous and normal in flow. Although he remained mildly irritable, Mr Bernacki expressed no persecutory beliefs about anyone on the ward and made no threatening or aggressive gestures. Mr Bernacki expressed no intentions to harm himself or others. Mr Bernacki's insight into his mental illness remained poor and his social judgement impaired, but the latter had improved from earlier in his admission.[9] Dr Tawde assessed Mr Bernacki as suitable for escorted day leave on 23 to 28 December 2009, pursuant to section 40 of the MH Act.[10]

11. On 24 December 2009, Mrs Ewa Wozniak contacted WMPU to ask whether her friend Mr Bernacki could stay with her and her husband for a couple of days. Mrs Wozniak stated that staff told her that Mr Bernacki could spend the day with her, provided he returned to WMPU each evening.[11] Accordingly, the Wozniaks collected Mr Bernacki from WMPU on the morning of 24 December 2009 and returned him to WMPU that evening after spending the day with him at their home. Mr Bernacki also spent 25 December 2009 with the Wozniaks, again being transported to and from WMPU by them. Both periods of escorted leave occurred without incident and without apparent adverse impact on Mr Bernacki's mental state.[12]

---

[6] See Exhibit E, page 3.

[7] See Exhibit E, page 5.

[8] See Exhibit E, page 4.

[9] Ibid.

[10] See "Leave of Absence for an Involuntary Patient" Form completed on 23 December 2009 by Dr T. Tawde.

[11] See Exhibit C and Transcript pages 32-3.

[12] See Exhibit E, page 4.

12. On 29 December 2009, Dr Tawde,[13] discussed Mr Bernacki's future management with the Director of Clinical Services, Associate Professor Dean Stevenson. Dr Tawde reported that Mr Bernacki's engagement and co-operation with staff was improving, although he still exhibited delusional beliefs and had poor insight into his condition. Administration of alternative antipsychotic medications was canvassed, but a change in medication was not regarded as an imminent consideration. Risk assessments were discussed, including the risk that Mr Bernacki would abscond, if his admission continued "too long".[14] The management plan adopted was to refer Mr Bernacki to the High Risk Panel, to continue to review his depot medication, and to continue on an inpatient basis for a few more weeks before discharging him on a Community Treatment Order.[15]

13. On the same date, Dr Tawde reviewed Mr Bernacki who presented as attentive, with good eye contact and appropriate demeanour. Mr Bernacki did not display aggression and reported no ongoing urge to hurt anyone, and no hallucinations. He reported good sleep and appetite, although he remained neglectful of self-care needs and complained of low energy and weakness, a possible side effect of his antipsychotic medications. Dr Tawde noted that Mr Bernacki's insight into his illness was poor but that his social judgment was improving. Overall, Dr Tawde assessed that Mr Bernacki's mental state was improving, although his delusions continued. He assessed the risks of Mr Bernacki absconding or failing to comply with treatment, causing harm to others and impulsivity as lower than they had been upon admission, that is "medium" rather than "high" risk.[16] Mr Bernacki's risk of suicide and deliberate self-harm had been consistently assessed as "low" throughout his admission.[17]

14. Mr Bernacki was informed of Dr Tawde's ongoing treatment plan; namely referral to the High Risk Panel and further discharge planning, including the continuation of escorted day leave. Dr Tawde authorised further escorted day leave for 29 December 2009 to 4 January 2010, pursuant to section 40 of the MH Act.[18]

15. At about 9am on 30 December 2009, Marian Marcinski attended WMPU to collect his friend, Mr Bernacki, for escorted day leave.[19] Shortly after leaving the hospital, Mr Bernacki asked

---

[13] Dr T. Tawde was Mr Bernacki's treating psychiatrist during his December 2009 admission to WPMU from 21/12/09 until his death, prior to that Mr Bernacki had been under the care of Consultant Psychiatrist Dr A. Singh during this admission.

[14] Exhibit E, page 5.

[15] Ibid.

[16] Ibid.

[17] Ibid.

[18] "Leave of Absence for an Involuntary Patient" Form completed on 29 December 2009 by Dr T. Tawde.

[19] Exhibit B.

Mr Marcinski to drive him to the Wozniak's home in St Albans. Mr Marcinski drove him there and offered to return at 5pm to drive Mr Bernacki back to WMPU. Mr Bernacki declined the offer, saying that he would like to stay at the Wozniak's later than 5pm.[20] Mr Marcinski left and Mr Bernacki spent the rest of the day with the Wozniaks.[21] After dinner, Mr Bernacki wished the Wozniaks a happy New Year and left on foot.

16. On 30 December 2009 at about 10.45pm, a member of the public who was walking along the Western Ring footpath observed a man, later identified as Mr Bernacki, hanging from high voltage electricity pylon.[22] Emergency services were called, and Mr Bernacki was pronounced deceased by responding paramedics. Police also attended and commenced investigation of Mr Bernacki's death on behalf of the coroner.

INVESTIGATION – SOURCES OF EVIDENCE

17. This finding is based on the totality of the material the product of the coronial investigation of Mr Bernacki's death. That is the brief of evidence compiled by Constable Brendan Higgs from Sunshine Police, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[23] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

PURPOSE OF A CORONIAL INVESTIGATION

18. The purpose of a coronial investigation of a *reportable death*[24] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[25] The *cause* of death refers to the *medical* cause of death, incorporating where

---

[20] Ibid.

[21] Exhibit C.

[22] Coronial Brief of Evidence, page 11.

[23] From the commencement of the *Coroners Act 2008* [the Act], that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.

[24] The *Coroners Act 2008,* like its predecessor the *Coroners Act 1985*, requires certain deaths to be reported to the Coroner for investigation. Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes deaths that appear *to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury* and the *death of a person who immediately before death was a patient within the meaning of the Mental Health Act 1986".*

[25] Section 67(1) of the *Coroners Act 2008.* All references which follow are to the provisions of this Act, unless otherwise stipulated.

possible the *mode* or *mechanism* of death. For coronial purposes, the *circumstances* in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[26]

19. The broader purpose of any coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the *prevention* role.[27] Coroners are also empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[28] These are effectively the vehicles by which the prevention role may be advanced.[29]

FINDINGS AS TO UNCONTENTIOUS MATTERS

20. In relation to Mr Bernacki's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. His identity[30] and the date and place of death were not at issue. I find, as a matter of formality, that Wieslaw Albin Bernacki born on 16 December 1947, aged 62, of no fixed abode, died in the vicinity of the Western Ring Footpath, off Sunshine Avenue, St Albans, Victoria 3021 on 30 December 2009.

21. I further find that immediately before his death Mr Bernacki was a "person placed in custody or care" as defined in section 3[31] of the *Coroners Act* 2008 because he was a patient in an approved mental health service within the meaning of the MH Act, namely at WMPU.

---

[26] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[27] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[28] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[29] See also sections 73(1) and 72(5) which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

[30] Identity was established by Fingerprint Identification Report [FPB Identification Number: 2392/910] on 31 December 2009.

[31] See section 3(i) of the Act.

22. The medical cause of Mr Bernacki's death was similarly uncontentious. In light of his family's objection, no autopsy was performed. However, on 31 December 2009, (then) Senior Forensic Pathologist Dr Noel Woodford from the Victorian Institute of Forensic Medicine (VIFM) conducted a preliminary examination of Mr Bernacki's body, including review of post-mortem CT scaning of the whole body (PMCT) and the circumstances of the death as reported by the police to the coroner, and advised that it would be reasonable to attribute death to hanging, without the need for an autopsy. As a matter of formality, I find that Mr Bernacki's death was caused by hanging.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

23. In common with many coronial investigations, the primary focus of the coronial investigation and inquest into Mr Bernacki's death was on the circumstances in which he died. Specifically, the investigation and inquest examined the following issues, and whether or not they caused or contributed to Mr Bernacki's death:
    a. whether it was reasonable and appropriate to allow Mr Bernacki to have escorted leave from WMPU on 30 December 2009;
    b. whether communication between WMPU staff and Mr Bernacki's leave escorts were sufficient to establish the nature and extent of supervision required, including arrangements for managing crises by both the escorts and WMPU; and
    c. whether WMPU staff responded in an appropriate and timely manner to Mr Bernacki's failure to return from escorted leave.

    It is convenient to deal with the evidence in relation to each of these issues in turn.

MR BERNACKI'S SUITABILITY FOR LEAVE ON 30 DECEMBER 2009

24. The decision to allow Mr Bernacki to take day leave from WMPU on 30 December 2009 was governed by sections 40 and 41 of the MH Act and the procedures in operation at WMPU at that time, namely the Mercy Health procedure entitled 'Client Leave' (version 2) created in September 2009 [Leave Procedure].[32] Pursuant to both of these documents, Mr Bernacki's treating psychiatrist, Dr Tawde, completed a 'MHA21 Form' on 29 December 2009 permitting leave between 29 December 2009 and 4 January 2010 for "up to 6-8 hours" per

[32] Coronial Brief of Evidence, pages 51 and 52.

day, provided Mr Bernacki was "escorted" and did not drive a vehicle or use illicit drugs.[33] Dr Tawde discussed the leave of absence, and the conditions attached to it, with Mr Bernacki on the date he signed the MHA21 Form.[34]

25. The Leave Procedure provided that notwithstanding the existence of a current MHA21 Form, the nurse-in-charge could withhold leave if necessary. That is, leave could be cancelled due to "change" in a patient's circumstances, his or her risk profile or because his or her mental status had deteriorated such that a grant of leave may be detrimental, or pose a risk to the patient or the community. Accordingly, both mental state and risk assessments of the patient were to be undertaken on the day of proposed leave day and the outcomes considered when determining whether to allow leave that day.[35]

26. Notably, one aspect of Mr Bernacki's presentation changed overtly prior to his leave on 30 December 2009. Night shift notes for the week prior to 30 December 2009 demonstrate that Mr Bernacki had slept soundly.[36] In contrast, overnight on 29-30 December 2009, the nursing note of Nurse Gwynn documents that Mr Bernacki had been awake throughout the night shift and had paced the ward all night.[37] At inquest, Nurse Davies testified that this sort of information would ordinarily form part of a "verbal handover" between nursing staff at each change of shift, as nurses may not have an opportunity to read notes made by staff on an earlier shift.[38] Nurse Davies, who had worked the afternoon shift on 30 December 2009, not Nurse Gwynn's night shift, nor Nurse Mnkandla's morning shift, stated that he could not comment on whether the information about the change in Mr Bernacki's sleep pattern had been handed over verbally.[39]

27. Both Dr Tawde and an independent psychiatric expert, Associate Professor Richard Newton, gave evidence at inquest that the reason behind Mr Bernacki's sleeplessness on the night

---

[33] Coronial Brief of Evidence, page 45. Note that the MHA21 Form relevant to the leave taken by Mr Bernacki on 24 and 25 December 2009 appears in the Brief at page 45-1. Dr Tawde explained his clinical decision to authorise Mr Bernacki's escorted leave in his statement, Exhibit E, and when giving evidence at inquest: see Transcript pages 48-51 and 56 in which Dr Tawde emphasised Mr Bernakci's progress during the WMPU admission, the collateral information provided by his friends, the low(ering) risk assessment results and the desirability of transitioning back into the community.

[34] This discussion between physician and patient is a requirement of completion of the MHA21 Form (and the Leave Procedure). Dr Tawde marked the MHA21 Form indicating that agreed leave of absence requirements had been discussed with Mr Bernacki; similarly, the clinical notes maintained WMPU reflect the content of that discussion. Neither MHA21 Form completed in respect of Mr Bernacki's leave contains crisis information. The Leave Procedure required that all sections of the MHA21 Form be completed. Moreover, it is unclear whether Mr Bernacki received a copy of either MHA21 Form.

[35] Coronial Brief of Evidence, pages 51 and 52.

[36] Mercy Mental Health Clinical notes dated 23 December 2009 and forward.

[37] Mercy Mental Health Clinical notes dated 30 December 2009.

[38] Transcript page 18.

[39] Transcript, page 18.

before leave ought to have been "explored" and was one of the factors to consider during the pre-leave mental state assessment.[40]

28. In accordance with the Leave Procedure, Nurse Mnkandla considered Mr Bernacki's mental state prior to leave and her brief notes of this appear in the patient progress notes. According to her note, Mr Bernacki appeared dishevelled, was poorly motivated and his insight into his illness remained poor. Although his judgement was improving, he remained "guarded about his mental state" and refused all nursing interventions because he was "not ill".[41] Mr Bernacki did approach the nurses' station for brief conversations.

29. As required, Nurse Mnkandla also completed a "Visual Observations/Risk Assessment Form" in relation to Mr Bernacki at 8.05am on 30 December 2009. In this document, Mr Bernacki's risk of suicide, deliberate self-harm, violence to others and use of drugs or alcohol was assessed as zero/nil, demonstrating no change in risk level from the previous day. Mr Bernacki's risk of self neglect was again scored as three (on a scale of zero to four where four indicates the highest level of risk). The only risk that had changed, according to Nurse Mnkandla's assessment , indeed increased, was the 'risk of absconding/non-compliance with intervention', which Nurse Mnkandla assessed as three. The Nurse noted that this elevated score was due to Mr Bernacki's refusal of nursing interventions that morning.[42]

30. It is not clear from the documents created by Nurse Mnkandla whether and/or what extent, Mr Bernacki's sleepless night was considered in the mental state assessment. Nor is it apparent whether and/or to what extent, Nurse Mnkandla endeavoured to ascertain the cause of Mr Bernacki's sleeplessness. What is clear is that Nurse Mnkandla allowed Mr Bernacki to take escorted leave on the basis of her assessments. Unfortunately, Nurse Mndandla did not give evidence at inquest.

31. Associate Professor Newton testified at inquest that, in the absence of evidence from the assessing nurse as to the content of her risk and mental state assessments, he could not conclude that Mr Bernacki's leave should have been withdrawn.[43]

32. Dr Tawde's evidence was that on the basis of the clinical and nursing progress notes and the risk assessment completed on 30 December 2009, he considered it "reasonable" to allow Mr Bernacki's leave on that date.[44] Dr Tawde noted that had Nurse Mnkandla been concerned

---

[40] See generally, Associate Professor Newton's statement, Exhibit F, and Transcript page 76-78; Dr Tawde's evidence on this point appears on Transcript pages 57-8, 62 and 69.

[41] Mercy Mental Health Clinical notes dated 30 December 2009 at 1430 hours.

[42] See generally the Visual Observations/Risk Assessment Form completed on the morning of 30 December 2009.

[43] Transcript page 78.

[44] Transcript pages 59 and 61.

about allowing Mr Bernacki leave, as a matter of practice, she could have raised the issue with the charge nurse, medical officer or treating psychiatrist.[45] Dr Tawde confirmed that he had not been contacted by Nurse Mnkandla on that date.[46]

SUFFICIENCY OF COMMUNICATIONS BETWEEN WMPU AND ESCORTS

33. WMPU's Leave Procedure does not include a section regarding communication between staff and leave escorts prior to, during or after leave, other than there being a requirement that a patient's "primary carer" be informed prior to leave being taken.[47]

34. In his evidence at inquest, Mercy Mental Health's Clinical Services Director, Associate Professor Dean Stevenson, conceded that at the time of Mr Bernacki's death, the Leave Procedure "wasn't fully compliant" with the Chief Psychiatrist's Guideline [the Guideline], issued and distributed in September 2009.[48] Indeed, despite the Leave Procedure being updated in December 2009 and explicitly referring to the Guideline, Associate Professor Stevenson acknowledged the Leave Procedure was "not fully reflective"[49] of the Guideline which emphasised "communication with patients and carers regarding leave arrangements" and "documentation of leave approval and arrangements".[50] Moreover, Associate Professor Stevenson confirmed that, as at the date of the inquest in August 2013, an updated Leave Procedure that accorded with the Guideline had not been finalised.[51]

35. I have already referred to Dr Tawde's discussion with Mr Bernacki about the conditions attached to his leave.[52] At inquest, Dr Tawde stated that other than conversations he may have with a patient's family or carers about treatment and discharge planning, including leave arrangements, he was not ordinarily involved in communications with a patient's escort on leave days.[53] It is not evident from Mr Bernacki's patient notes that any conversations of this

---

[45] Transcript page 63.

[46] Transcript page 70.

[47] Coronial Brief of Evidence, pages 51 and 52; see also the Statement of Associate Professor Richard Newton, Exhibit F, pages 3-4.

[48] Transcript page 85; see also Transcript page 72 regarding the timing of distribution of new Chief Psychiatrist's Guidelines.

[49] See Exhibit G.

[50] The Chief Psychiatrist's Guideline entitled, "Inpatient leave of absence" is extracted in the Coronial Brief of Evidence at pages 47-50.

[51] Transcript page 88.

[52] Paragraph 24 above.

[53] Transcript page 52.

type occurred between Dr Tawde and Mr Bernacki's friends.[54] Instead, Dr Tawde gave evidence of his expectation that the "contact nurse would communicate the conditions of leave to the escort upon arrival on the ward to collect the patient".[55] He also expected that the individual acting as an escort for leave purposes would be identified in the patient's notes.[56]

36. In the absence of oral evidence at inquest from the contact nurse, Nurse Mndandla, about the content of the communications that occurred between her and Mr Bernacki's day leave escorts, I can only rely on other sources of evidence. Relevantly, Mr Bernacki's patient notes and explanations of this documentation from clinical and expert witnesses, and the evidence of Mr Bernacki's day leave escorts.

37. There is no documented communication with the Wozniaks, Mr Bernacki's escorts, prior to the leave that occurred on 24 and 25 December 2009, and no documentation even of their names or contact details.[57]

38. Similarly, there is no documented communication with Marian Marcinski, who collected Mr Bernacki from WMPU on 30 December 2009.[58] Nor is it documented in the patient notes that Mr Marcinski was Mr Bernacki's escort for the day. Indeed, the only information documented in relation to this period of leave is that Mr Bernacki "left for day leave at 0900 with a friend. Due at 1700".[59] However, Nurse Mnkandla did note that Mr Bernacki was wearing (presumably among other items) a "yellow t-shirt" and a "brown head band".[60]

39. On the face of the documentation, then, it is not clear whether or to what extent the role of 'escort' was communicated to either the Wozniaks or Mr Marcinski, including the significance of leave being "escorted" rather than "unescorted" and what that entailed. The documentation is also silent as to whether any other conditions attached to Mr Bernacki's day leave were communicated to his escorts.[61]

40. In both his expert report, and at inquest, Associate Professor Newton was critical of the Leave Procedure and commented that "good clinical practice ... requires communication with carers

---

[54] See generally the Mercy Mental Health Clinical notes maintained in relation to Mr Bernacki's December 2009 admission.

[55] Transcript pages 52 and 54. It was implicit in Dr Tawde's evidence that instructions to escorts on the day of leave would include emphasising the 'importance of the leave being escorted' and that if concerns arose, the escort would contact the hospital or return the patient to the hospital, particularly if the escort had not had the benefit of a treatment/planning meeting with treating staff (see Transcript page 53-55).

[56] Transcript page 70.

[57] Mercy Mental Health Clinical notes maintained in relation to Mr Bernacki's December 2009 admission.

[58] Ibid.

[59] Mercy Mental Health Clinical notes dated 30 December 2009 at 1430 hours.

[60] Visual Observations/Risk Assessment Form completed on the morning of 30 December 2009.

[61] See generally Exhibit F page 3.

about leave expectations and crisis management. These standards of communication were not met in this case".[62]

41. Mrs Wozniak gave evidence at inquest that when she and her husband collected Mr Bernacki from WMPU on 24 and 25 December 2009, they were told that he must return each evening by 8pm.[63] She testified that on 24 December 2009, a nurse gave her a business card with the hospital's telephone number, to be used if "something was to happen".[64] Mrs Wozniak did not recall being given any other instructions about Mr Bernacki's care or supervision on either date when he spent day leave with her.[65] In relation to 25 December 2009, Mrs Wozniak testified that WMPU staff gave no instructions to her or her husband. They "just simply went to pick him up".[66]

42. Mr Marcinski gave evidence that he had escorted Mr Bernacki on day leave before 30 December 2009.[67] It was clear that Mr Marcinski appreciated that his friend was unwell and "under treatment".[68] When he arrived to collect Mr Bernacki on 30 December 2009, a nurse told him to return Mr Bernacki to WMPU by 8pm and "just look after him because, you know, he's not well".[69] Mr Marcinski testified that the nurse did not give him any other instructions about Mr Bernacki's leave,[70] nor was he given any contact number for the hospital,[71] or advice about what to do if he became concerned about Mr Bernacki.[72] Moreoever, Mr Marcinski was not asked to provide his contact number, but he believed WMPU already had that information.[73]

43. As regards his observations of Mr Bernacki during leve on 30 December 2009, Mr Marcinski felt he was behaving uncharacteristically in that he "didn't want to talk" and was "very tense".[74] While they were in his car, Mr Bernacki told Mr Marcinski that he had "changed his mind" about spending the day with him and wanted to see the Wozniaks in St Albans

---

[62] Exhibit F, page 4.

[63] Transcript page 32.

[64] Transcript page 33.

[65] Transcript pages 30-40 and Exhibit C.

[66] Transcript page 32.

[67] Transcript page 23.

[68] Transcript page 22.

[69] Transcript pages 22 and 24, 25 and 26.

[70] Transcript page 25.

[71] Transcript page 26.

[72] Transcript page 23.

[73] Transcript page 22.

[74] Ibid.

instead.[75] Mr Marcinski drove Mr Bernacki to the Wozniak's house and offered to return at 5pm (a time convenient to Mr Marcinski) to take him back to the hospital.[76] Mr Bernacki declined the offer, stating that he intended to remain with the Wozniak's later than 5pm. Mr Marcinski gave evidence that he knew Mr Bernacki was supposed to be with him and that it was his "duty"[77] to return Mr Bernacki to the hospital, but "when he changed his mind, what could I have done?"[78] Mr Marcinski left once Mr Bernacki was safely inside the Wozniak's gate, assuming that they would drive him back to WMPU.[79]

44. Mrs Wozniak gave evidence that she observed Mr Bernacki's arrival and that Mr Marcinski dropped him off at her house. She "understood" that Mr Bernacki was still a patient of the hospital.[80] Mr Bernacki spent the day at the Wozniak's home and after dinner, perhaps around 8pm, they offered to drive Mr Bernacki back to WMPU.[81] He declined saying that Mr Marcinski would take him back to the hospital.[82] Mr Bernacki appeared "impatient" and left on foot, telling the Wozniaks that he was going to meet up with Mr Marcinski.[83] Mrs Wozniak testified that she did not contact the WMPU as she was not worried when Mr Bernacki left.[84]

APPROPRIATENESS OF WMPU'S RESPONSE TO MR BERNACKI'S NON-RETURN

45. Mr Bernacki left WMPU at 9am on 30 December 2009 and, pursuant to the MHA21 Form completed by Dr Tawde, he was to have up to eight hours of escorted leave per day. Thus, he was due to return to WMPU at 5pm[85] and Nurse Mnkandla had made a note to this effect.[86]

46. Involuntary patients are considered absent without leave when they have absconded from an acute mental health unit, or failed to return from an agreed leave period. WMPU's 'Absconded Psychiatric Patients Protocol' [the Protocol], created in 2005, was applicable at

---

[75] Transcript page 23.

[76] Transcript page 24 and Exhibit B.

[77] Transcript page 27.

[78] Ibid.

[79] Transcript page 27-8.

[80] Transcript page 35, although there is no reason that Mrs Wozniak should have this belief.

[81] Transcript page 35.

[82] Ibid.

[83] Ibid.

[84] Transcript page 36.

[85] Coronial Brief of Evidence page 45.

[86] Mercy Mental Health Clinical notes dated 30 December 2009 at 1430 hours.

the time of Mr Bernacki's death and prescribed the response required when a patient is absent without leave.[87]

47. Nurse Davies worked the afternoon shift at WMPU on 30 December 2009 and gave evidence at inquest. Among his other duties on shift, Nurse Davies updated Mr Bernacki's Visual Observations/Risk Assessment Form with the entry "D/L", indicating that Mr Bernacki was on day leave, each half-hour between 6.30pm and 8pm, other nurses having made like notes since 9.30am.[88]

48. Nurse Davies gave evidence that when he realised that Mr Bernacki had not returned from leave at 5pm, he notified his supervisor "straight away".[89] The supervisor instructed him to start making inquiries as to Mr Bernacki's whereabouts.[90] When asked about the timing of his inquiries, Nurse Davies said that although the inquiry (and notification) processes commenced around 5pm if the patient had not returned from leave, it was "quite reasonable not to expect the person to arrive [back until] eight o'clock".[91]

49. Nurse Davies testified that he "spent some time searching the patient's file for contact details". He was looking for "something that would help me identify where Mr Bernacki was, someone I could speak to".[92] Although he could not be specific about how long he spent looking through the file, he conceded that "it took a bit of time,"[93] and added that "it would have been easier for me to locate [Mr Bernacki] if I had... the name of the person that took him out".[94] In the end, Nurse Davies was not sure how he determined that he should contact Mr Marcinski or how he found his telephone number.[95]

50. Nurse Davies endeavoured to call Mr Marcinski on the number he found, and a note of this attempt was made by him at 7.50pm.[96] It is not clear who Nurse Davies spoke to when he called the Marcinski's landline telephone number.[97] Nurse Davies believed he spoke to Mr Marcinski, whereas Mr Marcinski, in evidence, indicated that he was not at home at the

---

[87] Coronial Brief of Evidence, pages 58 and 59.

[88] Visual Observations/Risk Assessment Form dated 30 December 2009.

[89] Exhibit A.

[90] Ibid.

[91] Transcript pages 12-13.

[92] Transcript page 3.

[93] Transcript page 4.

[94] Transcript page 4.

[95] Nurse Davies initially appeared reasonably confident that someone on the ward had told him that Mr Bernacki had been escorted by Mr Marcinski on day leave. However, after being examined by Mr Regos, for the Mercy Mental Health Service, he indicated that he could not be certain about the source of the information: see Transcript pages 8ff.

[96] Mercy Mental Health Clinical notes dated 30 December 2009 at 1950 hours.

[97] Exhibit A.

relevant time but was told of the call from WMPU by his wife later.[98] Nonetheless, Nurse Davies spoke to someone who informed him that s/he had not seen Mr Bernacki and provided a number for "Wally" who might know Mr Bernacki's whereabouts. The Nurse asked that s/he contact WMPU if s/he heard from Mr Bernacki and provided a contact telephone number. Nurse Davies conceded that due to the heavily accented English used by the individual with whom he spoke miscommunication between them was possible.[99] Nurse Davies tried unsuccessfully to reach Wally on the number provided.

51. Between about 8pm and 10pm a number of telephone calls were made between Mrs Marcinski and her husband who was at a friend's house, Mr Marcinski and WMPU, and between the Marcinskis and Wozniaks.[100] There is evidence that by about 9pm, Mr Marcinski had informed WMPU that he had left Mr Bernacki with the Wozniaks in St Albans that morning[101] and that Mrs Wozniak had informed Mr Marcinski that Mr Bernacki had left their home after dinner.[102] On learning that Mr Bernacki was missing from the hospital, Mr Wozniak searched for him in the streets near his home.[103]

52. At 10.05pm, Nurse Davies telephoned Werribee Police Station and formally reported Mr Bernacki as a missing person.[104] He completed the 'Mercy Mental Health Unit – Absconder Form' on which he recorded Mr Bernacki missing as at 8pm on 30 December 2009,[105] and faxed this document, a 'Missing Persons Form' and a 'Person Physical Description Form' to police. These documents were received at the police station by 10.10pm.[106] Of note, the physical description of Mr Bernacki provided to police was lacking in detail and, in particular, that contained no information about the clothing Mr Bernacki was wearing that day.[107]

53. A Missing Person Report was promptly initiated by Victoria Police. Constable Marshall, who received the report, took appropriate steps to verify details provided by WMPU, attempted to

---

[98] Compare Exhibits A and B, and Transcript pages 14-15 and Transcript pages 28-29.

[99] Transcript pages 14-15.

[100] See Exhibits B and C and Transcript pages 28-29.

[101] Transcript pages 28-29. I note that any conversation between Mr Marcinski on the evening of 30 December 2009 is not documented in Mercy Mental Health Clinical notes relating to Mr Bernacki.

[102] Transcript page 28.

[103] Exhibit C.

[104] Exhibit D.

[105] Mercy Mental Health Clinical notes relating to Mr Bernacki's December 2009 admission (see Correspondence section).

[106] Exhibit D.

[107] See generally the Person Physical Description Form forming part of the Mercy Mental Health notes relating to Mr Bernacki's December 2009 admission. I note that Nurse Davies ability to complete the required paperwork was limited by the fact that he had not been on shift at the time Mr Bernacki left WMPU on day leave but that a rudimentary description of his clothing was contained in the Visual Observations/Risk Assessment Form dated 30 December 2009.

make telephone contact with the Marcinskis and Wozniaks and reported fresh information to WMPU.[108] However, I note in passing that the case narrative entered into the Police LEAP system contained inaccurate information about Mr Bernacki's most recent risk and mental state assessments, that may have impacted Victoria Police's prioritisation of a response.[109]

54. An entry made in Mr Bernacki's patient notes by Nurse Berry at 11pm recorded that the After Hours Coordinator, Mental Health Triage Service and On-call psychiatrist had been informed, that he had not returned from day leave, in compliance with the Protocol.[110] All other requirements of the Protocol appear to have been followed.[111]

55. When evaluating WMPU's response to Mr Bernacki's failure to return from day leave, Associate Professor Newton noted the dearth of identifying and contact information regarding Mr Bernacki's leave escorts, and the lack of specific information about Mr Bernack's likely whereabouts whilst on leave. These omissions were impediments to WMPU's ability to institute a meaningful search for Mr Bernacki. Associate Professor Newton noted that WMPU had complied, in large part, with its Protocol by 11pm, that is, within a few hours of recognising that Mr Bernacki had not returned from leave.[112] Notwithstanding Mr Bernacki's chronic risk of self-neglect, Associate Professor Newton concluded that it was "reasonable" to wait to see if Mr Bernacki would return before involving the Police and the Crisis Assessment and Treatment Team.[113]

CONCLUSIONS

56. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[114] The effect of the authorities is that Coroners should not make adverse findings against or comments about institutions or individuals, unless the evidence provides a comfortable level of satisfaction that they breached

---

[108] Exhibit D and Transcript pages 40-44.

[109] Coronial Brief of Evidence, pages 41-43. The LEAP text also contained inappropriate 'stigma-driven' language.

[110] Mercy Mental Health Clinical notes dated 30 December 2009 at 2300 hours.

[111] However, it is not clear whether a search of WMPU or its grounds were conducted and whether Security were notified of Mr Bernacki's failure to return.

[112] Ibid.

[113] Exhibit F.

[114] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

the prevailing standards of their profession, and in so doing they caused or contributed to the death.

57. The available evidence supports a finding that it was reasonable and appropriate for Mr Bernacki to be granted leave on 30 December 2009, in the terms stipulated by his treating psychiatrist, Dr Tawde.

58. Consistent with the concession made at the inquest, the evidence also supports a finding that at the time of Mr Bernacki's death, WMPU's Client Leave Procedure was inadequate, by reference to the standards expected in good clinical practice, and failed to comply with the Chief Psychiatrist's Guideline on Inpatient leave of absence, distributed three months earlier.

59. I further find that communications between WMPU staff and leave escorts were not in accordance with good clinical practice in that they failed to address or establish:

    a. the nature and purpose of escorted leave;

    b. the necessity for and extent to which patient supervision was required;

    c. leave arrangements including expected destinations while on leave and the agreed time of return;

    d. agreed strategies for crisis management;

    e. the identity of an escort and the means through which she or he could be reliably contacted during a period of leave.

60. On the evidence before me, I am satisfied that if the nature and purpose of escorted leave had been properly explained to them, neither Mr Marcinski nor the Wozniaks would have disregarded their obligations as escorts of their friend. I am also satisfied that they would have contacted WMPU as soon as they apprehended that a breach of the escorted leave regime was imminent on Mr Bernacki's part. Mr Bernacki was effectively left without any escort for part of 30 December 2009, due to WMPU's suboptimal practice and inadequate communications about escorted leave.

61. Furthermore, at the time of Mr Bernacki's death, WMPU's documentation of leave arrangements, particularly on the day of leave, was poor and that this impeded its staff's ability to respond efficiently, and in a timely manner, to Mr Bernacki's failure to return to the ward by 5pm.

62. The available evidence does not support a finding that staff at WMPU responded in a timely manner to Mr Bernacki's failure to return from leave. While some flexibility with leave arrangements is reasonable, it is not reasonable in my view, to delay meaningful inquiries or search efforts when an involuntary patient is nearly three hours late in returning from escorted day leave. Nor is a five hour delay reasonable, before reporting Mr Bernacki as a missing person to Victoria Police and other authorities.

63. Nonetheless, delay in implementation aside, I am satisfied that WMPU's Absconded Psychiatric Patients Protocol was adequate in itself, and that staff complied with the Protocol when finally responding to Mr Bernacki's failure to return from escorted leave.

64. Between leaving the Wozniak's home at about 8pm and the discovery of his body at about 10.45pm, there was a window of opportunity of almost three hours for mr Bernacki to take his own life. I am unable to ascertain with any more precision, the time when Mr Bernacki is likely to have died. WMPU staff could have initiated a search for Mr Bernacki from as early as 5pm, when he failed to return. A search of almost three hours, could have been initiated by the Wozniaks calling WMPU before or immediately after Mr Bernacki left their home, had they appreciated the need. Mr Marcinski could have notifed WMPU that he was not escorting Mr Bernacki, shortly after he dropped him off at the Wozniaks' home, had he appreciated the need. These are hypothetical scenarios that demonstrate that, as beleaguered as Mr Bernacki was by his illness, his death was potentially preventable.

65. I find that Mr Bernacki intentionally took his own life by hanging. I further find that, in combination, the inadequacy of the communications between WMPU staff and Mr Bernacki's escorts and the WMPU staff's delay in initiating its Protocol, indirectly contributed to Mr Bernacki's death by providing him with the opportunity to take his own life.

RECOMMENDATIONS

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

1. That Mercy Mental Health review its Client Leave Procedure to ensure that it complies with the Chief Psychiatrist's September 2009 Guideline on Inpatient Leave of Absence, with particular emphasis on the inclusion of requirements for communicating responsibilities to leave escorts and recording crisis information. I note that as at the time of inquest in August 2013, Mercy Mental Health had almost completed a significant revision of its leave policy and anticipated that the new policy would be finalised by the end of 2013.

2. That Mercy Mental Health review its Absconded Psychiatric Clients Protocol to ensure it contains a clear process and mandates a timely response to a patient's failure to return from an approved leave of absence.

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

Mr Bernacki's family

Mr and Mrs Wozniak

Mr and Mrs Marcinski

Associate Professor Dean Stevenson, Clinical Services Director (Mercy Mental Health), Mercy Health

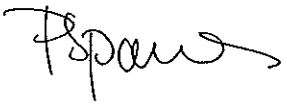
Dr Tejraj Tawde, Goulburn Valley Area Mental Health Service, Shepparton

Assoc Prof J. R. Newton, Medical Director, Mental Health Clinical Service Unit, Austin Health

The Chief Psychiatrist

Constable Brendan Higgs 36841 of Sunshine Police Station

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: 5 December 2014