IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 / 1406

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, JOHN OLLE, Coroner having investigated the death of KATHY TRANTER

without holding an inquest:
find that the identity of the deceased was KATHY LOUISE TRANTER
born on 4 February 1961
and the death occurred on 4 March 2009
at 4 Pentland Street, Ascot Vale, 3032

from:

1 (a) HEAD INJURIES

Pursuant to section 67(2) of the *Coroners Act 2008*, I make findings with respect to the following circumstances:

SUMMARY

1. Ms Kathy Tranter was 48 years of age when she died. She had four children with her former husband.

2. Ms Tranter was residing at 4 Pentland Street, Ascot Vale with her daughter and her son-in-law.

3. At approximately 6.00pm on 4 March 2009, Ms Tranter was located by her daughter deceased in the shed of 4 Pentland Street, Ascot Vale.

4. At the time of the index offence Mr A was in his mother's care on overnight leave from Orygen Youth Health,[1] where he was being detained as an involuntary psychiatric patient. He was experiencing an episode of acute paranoid schizophrenia, and harboured the belief that his mother posed a threat and endangered his family. Mr A inflicted

[1] Hereafter referred to as 'OYH'.

extreme head injuries occasioned by multiple blows of blunt force, by way of punching, elbowing and kneeing Ms Tranter.

5. The forensic pathologist at the Victorian Institute of Forensic Medicine determined that Ms Tranter's medical cause of death was head injuries.

6. Although Ms Tranter's death resulted from a homicide, this matter was not subject to a mandatory inquest. Justice Coghlan directed that the defence of mental impairment had been made out and that a verdict of not guilty by reason of mental impairment be recorded.[2] On 21 September 2009, Justice Coghlan sentenced Mr A. His Honour made a custodial supervision order committing Mr A into custody at Thomas Embling Hospital for a nominal period of 25 years.

7. Due to the circumstances surrounding Ms Tranter's death, I deem it imperative to review the appropriateness of Mr A's mental health treatment, including the risk assessments conducted, medication regime and the decision of OYH to grant Mr A overnight leave on 3 March 2009.

BACKGROUND

8. Mr A was 20 years of age at the time of the index offence. He did not hold any formal qualifications and had previously worked in low-skilled occupations. He had no prior criminal history but had a history of poly-substance use including cannabis, ecstasy, hallucinogens and benzodiazepines.[3]

9. Mr A's mental illness was first brought to the attention of mental health services in November 2008.[4] He was diagnosed with first episode psychosis, and was later diagnosed with schizophreniform disorder.[5]

10. On 26 November 2008 an acquaintance made contact with OYH triage to discuss her concerns regarding Mr A's behaviour. At this time, Mr A believed that he was psychic and could control others thoughts. He was also expressing thoughts of self-harm and physically assaulted his flatmate in the setting of persecutional delusions. Telephone contact between OYH and Mr A occurred that same day.

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2 Order made by the Honourable Justice Coghlan on 21 September 2009.
3 Coronial Inquest Brief of Evidence, 256.
4 Ibid 237.
5 Coronial inquest brief of evidence, above n 3, 257.

OYH established that Mr A had psychotic symptomology. He was referred to the Bendigo Area Mental Health Service.

11. On 31 December 2008, Mr A was admitted to Bendigo Hospital following an outburst of verbal and physical aggression towards his father. He was subsequently detained as an involuntary patient under the *Mental Health Act 1986* (Vic). Mr A was examined by a psychiatric nurse. He was identified as being at low risk of suicide and self-harm, with moderate risk of aggression. In the 24 hours that followed, his risk of aggression was downgraded to low.[6]

12. Mr A's medical records from this admission stated that Ms Tranter requested for her son to receive mental health treatment from OYH, as he had strong family support in Melbourne. Following his transfer to OYH, it was determined that Mr A required 15 minutely observations. Risk assessments were conducted which focused on his risk of self-harm and vulnerability. Overall he was considered to be at low risk of harm to others.[7] On 8 January 2009, he was admitted as an involuntary patient to the OYH inpatient Unit in the Western Hospital, West Footscray.

13. A risk assessment completed on 10 January 2009 recorded Mr A's risk of harm to self or others as low and noted that no aggressive behaviour had been observed on the ward.[8] His observation category was reduced to 15 minutely observations during the day and hourly overnight.

14. A risk assessment completed on 14 January 2009 noted that Mr A was psychotic and had marked formal thought disorder. His risk to self was upgraded to significant however while he was noted to be irritable at times, his risk to others was still regarded as low.[9] He was observed 15 minutely, including at night.

15. On 20 January 2009, a risk assessment noted Mr A's delusions and hallucinations continued, but his risk to self was low. Although he continued to be described as irritable, his risk to others was also assessed as low. However, he was thought to be at risk of absconding and remained on 15 minutely observations.[10]

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6 Ibid 363.
7 Coronial Inquest Brief of Evidence, above n 3, 564.
8 Ibid 562.
9 Coronial Inquest Brief of Evidence, above n 3, 560.
10 Ibid 558.

16. On 23 January 2009, Mr A kicked a patient in the groin. A medical review by psychiatrist, Dr Conrad Newman, noted him to be psychotic and a significant risk to self and others. At a family meeting held at OYH on 27 January 2009, Mr A's family said that Mr A had assaulted friends on two occasions prior to his admission.

17. On 30 January 2009, a risk assessment documented that Mr A was still experiencing 'significant psychosis, some improvement' with no apparent risk to others and low risk to self.[11]

18. From early February it was thought Mr A was developing insight into his condition. A trial of escorted leave was approved and he was moved to 30 minutely observations. On 6 February 2009 his leave was uneventful. On 9 February 2009 he had escorted leave with his father, but was reported as sullen upon his return. He stated he and his father had a fight.[12]

19. Documentation from a risk assessment completed on 12 February 2009 records Mr A's belief that he was being poisoned. The record states, 'does not trust anybody esp his [mother].[13] His risk to self was upgraded to significant but he continued to be considered a low risk to others.

20. On 13 February 2009, while in the low dependency area on 15 minute observations, Mr A assaulted his brother and was transferred to the intensive care area.[14] Mr A's brother told staff that his brother believed his family were not his real family and that Mr A's brother was trying to control or interfere with him through eye contact. He denied homicidal or suicidal ideations, but his persecutory thoughts remained constant.

21. On 15 February 2009, Dr Newman noted Mr A had stated to him that if anyone gets in his way he will assault them and that the reason he assaulted his brother was a secret. Dr Newman noted that he remains a 'significant risk'.[15] He was seen again by Dr Newman on 18 February 2009. He reported that his 'thinking is clearer' and that he no longer believed his mother was trying to poison him.[16]

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11 Coronial Inquest Brief of Evidence, above n 3, 556.
12 Ibid 490.
13 Coronial Inquest Brief of Evidence, above n 3, 554.
14 Ibid 502.
15 Coronial Inquest Brief of Evidence, above n 3, 504
16 Ibid 508.

22. On 20 February 2009, during a visit by his mother and brother, he became agitated and refused to allow them to leave. His progress notes indicate increasing agitation. A nursing entry recorded:

> It is the writer's impression that any assaultative behaviour by Mr A is most likely to be with friends or family due to prolonged and intimate nature of engagement with him.[17]

23. On 21 February 2009, following a visit from his mother and father (separately), Mr A was described as being irritable.[18] The following day, following another visit from his parents, the nurse suggested restricting Mr A's visitors to two at a time, for a maximum period of 2 hours.

24. On 24 February 2009 it was noted during a ward round that Mr A had deteriorated following a change in his medication from Risperidone to Quetiapine. No further assaults were recorded at that time. He was seen by the Psychiatric Registrar. He 'denied persecutory delusions' and recognised that 'his thinking was quite unclear when he came in'.[19]

25. On 25 February 2009, Consultant Psychiatrist, Dr Erasmus, documented in Mr A's progress notes that nursing staff reported that he had 'no behavioural problems recently'.[20] It was noted that he had 'no acute risks' and his category of observation was 15 minutely. That day, Mr A went on escorted leave with staff and was described as 'preoccupied' but 'showing signs of improvement'. However, later in the day, following a visit from his family, he became agitated and mildly hostile toward staff.[21]

26. On 1 March 2009, Mr A was reported as 'pleasant and polite on approach, bright and reactive'.[22] His mother visited and requested to take him out to dinner. Leave was discussed with the on-call consultant psychiatrist. The following day, progress notes record that Mr A was staring through the window at nursing staff. He remained on 15 minutely visual observations.[23]

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17 Coronial Inquest Brief of Evidence, above n 3, 511.
18 Ibid 512.
19 Coronial Inquest Brief of Evidence, above n 3, 517.
20 Ibid 519.
21 Coronial Inquest Brief of Evidence, above n 3, 519.
22 Ibid 521.
23 Coronial Inquest Brief of Evidence, above n 3, 522.

27. On 2 March 2009, Ms Tranter telephoned OYH to request that her son be permitted to take overnight leave the following day so that he could celebrate her son-in-law's birthday at a family dinner.

FATAL INCIDENT

28. On 3 March 2009, Mr A was said to have 'minimal engagement with nursing staff and co-patients' and a 'reactive but guarded mental state.' He remained on 15 minutely observations.[24]

29. Mr A was assessed by Consultant Psychiatrist, Dr Mark Phelan, on 3 March 2009. Dr Phelan had previously reviewed Mr A at various intervals throughout his admission and was covering the duties of Dr Newman for one day, while he was on annual leave.

30. Dr Phelan reviewed the most recent entries by doctors in Mr A's file from 18 February 2009, and formed the impression that there had been an overall improvement in his mental state in the preceding fortnight. Mr A had been expressing a wish to stay at his mother's house for overnight leave. Dr Phelan noted that Mr A had been out with his mother on two prior occasions during the period of his admission, and that there had been 'no behaviour of concern during those periods'.[25]

31. During this assessment, he noted that Mr A appeared preoccupied, but without 'delusional or perceptual abnormalities'.[26] Dr Phelan questioned him about his earlier belief that his mother had wanted to poison him. In response, Mr A stated that he had been 'messed up in his head',[27] which Dr Phelan stated suggested a degree of insight into the delusional nature of his prior belief.[28] Dr Phelan downgraded Mr A's level of observation to 60 minutely. He was noted as compliant with his medication. On this basis, overnight leave was determined to be reasonable and was approved. This was the first time that overnight leave had been arranged since his admission in January.

32. A nursing entry at 4.55pm that day described Mr A as being 'pleasant on approach, settled in behaviour'. It noted that Mr A left the hospital in

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24 Ibid 523.
25 Coronial Inquest Brief of Evidence, above n 80.
26 Ibid 523.
27 Coronial Inquest Brief of Evidence, above n 3, 523.
28 Ibid 80.

the company of his mother at 3:45pm, and it recorded that Ms Tranter was advised to contact the ward if there were any issues.[29]

33. At approximately 6.10pm, Ms Tranter's son-in-law arrived home to 4 Pentland Street. When he entered the house, Ms Tranter and Mr A were seated at the kitchen table. Mr A had a large kitchen knife in his lap. Mr A stated he 'felt like he needed to protect us'.[30] Ms Tranter told her son-in-law that her son felt he needed to protect her son-in-law from her. Ms Tranter's son-in-law told Mr A that his mother-in-law was the safest person he knew. Mr A handed over the knife and asked his brother-in-law to put the knife in his room. Upon entering the room, his brother-in-law observed a number of the kitchen knives on the bed.[31]

34. OYH was not contacted by Ms Tranter or her son-in-law about these events.

35. Ms Tranter's daughter arrived home at 7pm and was informed of what occurred. The family ate dinner together. Mr A was said to be a bit wary of his mother.[32] The remainder of the evening proceeded without incident. Ms Tranter's daughter stated she was 'very worried and had a sleepless night due to what Mr A had said about his mother during the night'.[33]

36. The next morning, Ms Tranter's daughter and her husband left the house by 8:30am. Ms Tranter told her daughter that she would take Mr A back to OYH at around 10am.

37. A neighbour indicated that at approximately midday he heard what sounded like a yelp, followed by another sound which sounded stressed or panicked.[34]

38. At approximately 5pm Ms Tranter's daughter received a telephone call from her husband. He stated her brother had contacted him. He had attended the hospital and reported that Mr A had not returned and that Ms Tranter had not made any contact. Ms Tranter's daughter contacted OYH by telephone. In her statement she recalled:

> I spoke to a male and tried to find out what had happened…they said they had tried to call Mum but couldn't get hold of her and that they were thinking of calling the police.[35]

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29 Coronial Inquest Brief of Evidence, above n 3, 524.
30 Ibid 97.
31 Coronial Inquest Brief of Evidence, above n 3, 97.
32 Ibid 98.
33 Coronial Inquest Brief of Evidence, above n 3, 98.
34 Ibid 109-110.
35 Coronial Inquest Brief of Evidence, above n 3, 88.

39. Ms Tranter's daughter requested her husband contact his father and ask him to go to Pentland Street. She left work and made her way home. She called her husband's father on the way and asked him to meet her at the house.

40. Ms Tranter's daughter arrived at approximately 6.00pm. She proceeded to the backyard, entered the shed and saw her mother deceased on the ground, covered in blood.[36]

41. Mr A entered the shed and attempted to restrain his sister; he was not physically violent but prevented her from calling an ambulance. He spoke of a government conspiracy and said that she had known these events would occur as it had been 'planned the night before with our minds'.[37]

42. Her father-in-law arrived at the house shortly after. Mr A allowed his sister to talk to her father-in-law. She told him what happened and her father-in-law immediately called the police.

43. Mr A remained at the scene until police arrived and was placed under arrest by Constable Daniel Jacuta and subsequently charged with the murder of his mother.

44. On 6 March 2009 Forensic Pathologist Dr Noel Woodford conducted a post mortem examination on Ms Tranter. Dr Woodford determined her cause of death as: 1 (a) head injuries:

> There was evidence of multiple blunt force injuries to the head and face associated with extensive deep scalp bruising, fractures of the nose and mandible, and acute subdural and subarachnoid haemorrhage. The cutaneous injuries comprised bruising, abrasions and lacerations indicating multiple blows delivered to the head and face...areas of laceration to the face and scalp are more suggestive of contact against a firm surface.[38]

MENTAL HEALTH MANAGEMENT

45. Mr A was detained as an involuntary patient for the duration of his admission at OYH. He was treated with anti-psychotic medication and intermittently reviewed by several consultant psychiatrists and multi-disciplinary nursing staff. His family were actively involved in his care; his mother and siblings attended weekly meetings with hospital staff. In

46. a recent Canadian investigation, the prevalence of schizophrenia and psychosis among parricide[39] offenders was identified. While many of the fatal incidents were found to have

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36 Ibid 89.
37 Coronial Inquest Brief of Evidence, above n 3, 90.
38 Victorian Institute of Forensic Medicine Autopsy Report, 15.
39 The event of a son or daughter killing a biological or step-parent.

taken place without warning, others occurred in a context of risk indictors being clearly present. The researchers involved in this study concluded that clinicians treating individuals with schizophrenia should appropriately advise family members of the inherent risks associated with their family member's condition.[40] Ms Tranter and Mr A's family members could have benefited from a level of engagement and explanation as to the potential risks involved in caring for Mr A overnight, as well as being informed of signs of escalation that could be identified and responded to. This may well have occurred, but is not documented.

47. In light of the nexus between Mr A's acute episode of mental ill-health and Ms Tranter's death, I requested an expert opinion. Accordingly, Dr Richard Newton, Medical Director of the Mental Health Clinical Service Unit at the Austin Health, provided a report, dated 28 July 2011.

48. This report responded to five questions posed by the Coroners Prevention Unit[41] who reviewed the death at my request. The issues raised by CPU and addressed by Dr Newton were:

1. Mental health diagnosis;
2. Evidence of interpersonal conflict and aggression;
3. Assessment of risk to self and others;
4. Appropriateness of overnight leave;
5. Procedural and policy compliance;
6. Failure to notify of Mr A's absence; and
7. Medication Regime.

49. Dr Newton espoused:

> It seems clear from the notes that Mr A had a significant risk of harm to other people and it does seem that this risk was not fully explored or managed throughout the admission. The formal risk assessments, the documentation of which ceased on 12th February, do not accurately reflect the clinical risk he presented to other people and one gets the impression on reading the file that although the clinicians involved in his care did respond when he was assaulting on the

40 Gagne Bourget, 'Parricide: A comparative study of matricide versus patricide' (2007) 35 *Journal of the American Academy of Psychiatry Law* 306-312.

41 A specialist service for coroners created to strengthen their prevention role and provide them with expert assistance. Hereafter referred to as 'CPU'.

unit by providing increased observations, there seems little exploration of the significance of his assaultive behaviour and the need to incorporate this risk into his management plan. Certainly his history merited regular careful assessment of this risk in association with careful exploration of his mental state as his aggression risk seems to be driven by his psychotic symptoms.[42]

Mental health diagnosis

50. Dr Newton opined that:

> The prescription of Risperidone and Quetiapine, in combination with Diazepam, are in keeping with national and international practice guidelines for the pharmaceutical treatment of first episode psychosis.[43]

Evidence of interpersonal conflict and aggression

51. There was no evidence of Mr A being violent toward family members or strangers prior to the onset of his mental illness. Victoria Police LEAP records contain no prior charges for violence or involvement in family violence incidents.

52. As outlined above, several episodes of assaultive behaviour occurred over the four month period preceding Ms Tranter's death. Accordingly, I find that Mr A's aggressive behaviour was directly linked to his mental illness.

53. Dr Newton made the observation that:

> It seems clear from the notes that Mr A had a significant risk of harm to other people and it does seem that this risk was not fully explored or managed throughout the admission .[44]

54. He stated that there is little documented exploration around the circumstances pertaining to the various assaults and conflict Mr A was involved in and that the trigger events may not have been well understood. This had implications for assessment of risk carried out in relation to Mr A's behaviour.

Assessment of risk to self and others

55. During the three month period that Mr A was an involuntary patient, various assessments regarding his risk of self-harm and harm to others were conducted. These included: entries in progress notes; inpatient unit weekly nursing summary reports; and

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42 Report of Associate Professor Richard Newton, 9.
43 Ibid 6
44 Report of Associate Professor Richard Newton, above n 42, 8.

formal mental health risk assessments. The outcome of these assessments varied over time, resulting in changes to Mr A's management requirements.

56. Throughout Mr A's inpatient admission, he was regularly seen by psychiatric and nursing staff. Frequent meetings and contact with his family also occurred and assessment of his risk to self and others was recorded in his progress notes. Formal mental health risk assessments were completed on 3, 10, 14, 20 and 30 January 2009. Over this period, he was generally regarded as being a low risk to self and others. The last formal mental health risk assessment included in the Inquest Brief is dated 12 February 2009. On this occasion, he was assessed as being a significant risk to himself and low risk to others.[45] Based on the information provided in the Inquest Brief, no formal risk assessment was completed from this point onwards. Accordingly, a formal risk assessment had not been undertaken for 20 days up to the index offence.

57. Dr Newton commented that the 'formal documentation of risk to others in the file is somewhat inconsistent'.[46] He referred to the limited exploration of Mr A's assaultive behaviour, including a lack of formal documentation of the associated increased risk to other people after the assault on his brother on 13 February 2009:

> It seems clear from the notes that Mr A had a significant risk of harm to other people and it does seem that this risk was not fully explored or managed throughout the admission. The formal risk assessments, the documentation of which ceased on 12th February, do not accurately reflect the clinical risk he presented to other people and one gets the impression on reading the file that although the clinicians involved in his care did respond when he was assaultive on the unit by providing increased observation, there seems little exploration of the significance of his assaultive behaviour and the need to incorporate the risk into his management plan. Certainly his history merited regular, careful assessment of this risk in association with careful exploration of his mental state as his aggression risk seems to be driven by psychotic symptoms.

Appropriateness of overnight leave

58. Dr Newton was asked to comment on the appropriateness of overnight leave being approved for Mr A into the care of his mother. This decision was made following a review by Dr Phelan. In his statement, Dr Phelan stated:

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45 Coronial Inquest Brief of Evidence, above n 3, 554.
46 Report of Associate Professor Richard Newton, above n 42, 8.
47 Ibid 8-9.

I considered all of the collected information in making the judgement that it was reasonable for Mr A to go on overnight leave to his mother's house. The specific factors in this judgement were the positive trajectory of his illness described in his medical notes, the corroboration of this by the nursing staff, the report of multiple successful episodes of prior leave and the apparent absence of ongoing delusional or perceptual abnormalities, and the presence of insight elicited from my interview with him.[48]

59. Dr Newton describes a number of factors that might have also been considered in relation to the decision made. In brief, these include: greater exploration of the circumstances in which Mr A had previously assaulted people; a plan to manage the risk of possible assaults occurring against family members, after it was identified by a nurse in mid-February that assaultive behaviour by Mr A was most likely to be directed at family; and consultation with Ms Tranter after she had previously taken Mr A on escorted leave, in light of his apparent preoccupation and staring behaviour upon his return. Notably, Dr Newton opined, 'I think it was appropriate for overnight leave to be considered provided thorough risk assessment had been conducted.'[49] The Inquest Brief does not contain evidence that this occurred.

60. Dr Newton further opined:

> Through the notes there is no clear documented orientation of his family to possible risk issues, nor any documented feedback from them regarding any information they could provide to the treatment staff regarding their observations of Mr A when he was on leave, including collecting any information about difficulties on leave from the people he was on leave with.
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> For brief overnight leave that has been well planned with the carers, community mental health support in the form of a visit may not be necessary, but certainly proper orientation of the family to recognition of warning signs, recognition of risk and how to access appropriate support would now be considered good practice. A visit or a phone call could be discussed as part of this...
>
> The leave was granted without clear consideration of the need for the mother to orientate her to warning signs, risk issues or emergency management plans if needed. The mother was informed to contact the ward if there were any risks and it may be that this brief entry refers to a much broader in depth discussion. Because of an absence of regular structured risk assessments that took into account the manifest risks that Mr A was presenting with, including repeated assaults on

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48 Coronial Inquest Brief of Evidence, above n 3, 81.

49 Report of Associate Professor Richard Newton, above n 42, 9.

other people, may have meant that the consultant psychiatrist who did the review for leave, did not have all the available information to make his decision.[50]

61. Notably, Dr Newton espoused that leave would have been reasonable provided it was associated with 'a clear cut assessment of his risks, his mental state, a discussion of those risks and how they might be managed with the family'. He noted that this may have in fact occurred, but little of which was documented.[51]

62. In September 2009, the Chief Psychiatrist issued guidelines regarding inpatient leave of absence.[52] The guidelines note that under s.40 of the *Mental Health Act 1986* (Vic), a psychiatrist may permit an involuntary patient to be absent from the approved mental health service in which he or she is detained. It is noted that this should be done within the context of treatment objectives and strategies of the patient's treatment plans. Furthermore, the risks and benefits of the proposed leave need to be adequately considered. Inherent risks include: risk of harm to self or others; the likelihood and consequences of substance use; absconding from care; and patient vulnerability. These risk need to be balanced against the benefits of leave such as maintenance of social contacts and attending to family responsibilities. It is noted that where possible, leave should be planned in advance and occur as a result of a patient's routine treatment planning with the treating clinical team. In situations where leave is requested on short notice, the person making the decision must ensure they are familiar with all aspects of the treatment and care provided, so they can appropriately determine the risks and benefits of the requested leave. Furthermore, it is stated that a patient's mental state and risk assessment should be reviewed immediately prior to commencing leave.

63. A copy of these guidelines were forwarded to the CPU by Donald Trumble Lawyers, who act on behalf of OYH. While this cannot be interpreted as compliance on behalf of OYH, it indicates a level of awareness as to their existence and best practice requirements as they currently stand.

Procedural and policy compliance

64. The CPU obtained the following documents via Donaldson Trumble Layers on behalf of OYH:

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50 Ibid 13-14.

51 Report of Associate Professor Richard Newton, above n 42, 9.

52 Victorian Government Department of Health, *Mental Health and Drugs Division, Inpatient leave of absence: Chief Psychiatrist's Guideline* (2009).

- Clinical Risk Assessment and Management Guidelines (CRAAM) implemented at Orygen Youth Health Inpatient Unit in June 2010;
- Orygen Youth Health CC3.4 – Impatient Observation Levels policy developed in 2006 and current at the time of Kathy Tranter's death;
- North Western Mental Health Service CC3.18 – Absence in Inpatient Policy developed in June 1999; and
- Orygen Youth Health Inpatient Unit Orientation Information Sheet – MHA86 and Amendment and Procedure Sheet for those staff new to Victorian Mental Health Act: This involves guidelines provided to staff regarding leave and other inpatient unit processes as a component of orientation and training.

65. Dr Newton made several observations in relation to these documents, both in general and as they applied to Mr A during his admission. The Inpatient Observation Levels Policy is connected to the Mental Health Risk Assessment form contained in his medical records. This policy requires that patient sightings are to be recorded on an observation sheet. Mr A's medical records provided by OYH do not contain any such records. It is possible that this did occur, but no record of this has been provided in the Inquest Brief.

66. Dr Newton provided comment on the Mental Health Risk Assessment form utilised while Mr A was an inpatient. He espoused that while there is an expectation that any actions used to manage risk are documented on the Clinical Management Plan, no such plan appears to be have produced for Mr A. Here, Dr Newton observed there appears to be a 'disconnect between the risk assessment and risk management and the importance of considering the history of risk'.[53] Furthermore, at the time of his admission, there did not appear to have been a requirement to document risk before or after leave, or regularly throughout the admission.[54]

67. The Clinical Risk Assessment and Management Guidelines (CRAAM) were implemented at the OYH Inpatient Unit in June 2010. According to Dr Newton, these guidelines address some of the deficits he identified in the previous policies. The new guidelines clearly articulate that risk assessment should be performed not only to establish risk but also to manage it. Importantly, it is noted that risk assessment is required to be completed daily in high dependency areas; whenever an absconded patient returns to the unit; whenever there is

53 Report of Associate Professor Richard Newton, above n 42, 12.
54 Ibid.

a change in leave conditions; and on transfer between different parts of the unit and prior to discharge.[55] Further, the new risk assessment form includes space for a management plan and links risk assessment with leave arrangements.

68. In summary, Dr Newton notes that while it might be stated that an implicit risk assessment occurred when Mr A was seen by Dr Phelan prior to overnight leave being granted, 'the lack of a structured approach may have led the consultant doing the review, who was not the regular treating consultant, to not be fully aware of the range of risk issues to other people that this patient presented with. A structured, well documented approach risk assessment is required'.[56] It appears that various deficits in the policy documentation at the time may have contributed to this not having occurred.

Failure to notify of Mr A's absence

69. Mr A's medical records note that he was expected to return from leave at 10am on 4 March 2009. The Inquest Brief contains a copy of the 'Report of a Patient Absent Without Leave' form, completed by a nurse at OYH at 4pm.[57] In the statement of Ms Tranter's son–in–law, he notes he received a telephone call from his brother–in–law at approximately 4.30pm on 4 March 2009. At this time, his brother–in–law was at OYH for the purpose of a family meeting, however neither Mr A, nor his mother, were present.

70. An entry in Mr A's medical records by Dr Newman indicates he was informed of Mr A's absence at 4:10pm, and that it was Ms Tranter's son's attendance at OYH that alerted staff to his failure to return.[58] Dr Newman advised the nurse to continue to try and make contact with the family, given Mr A's 'history of paranoia'.[59] A further entry by Dr Newman indicates that he was contacted by a nurse at 8:30pm to advise that Mr A had fatally attacked his mother.

71. The North Western Mental Health Service CC3.18 – Absence in Inpatient Policy, developed in June 1999 and utilised by OYH at the time of the incident, specifies that involuntary patients with approved leave who have not returned by an appointed time are to be considered missing. Under these circumstances it is a requirement that an immediate review by the consultant psychiatrist occur, in order to identify significant risks to the persons

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55 Report of Associate Professor Richard Newton, above n 42, 12.
56 Ibid 13.
57 Coronial Inquest Brief of Evidence, above n 3, 309.
58 Ibid 525.
59 Coronial Inquest Brief of Evidence, above n 3, 525.

wellbeing and the wellbeing of others. For involuntary patients, the consultant can then decide to discharge the patient, place the patient on leave, or report their absence to police for apprehension.

72. The associated procedural documents regarding a patient's absence outlines a series of steps to be followed. These include a requirement to: notify the next of kin; make attempts to locate the patient by contacting family members; inform the relevant CATT team; and forward the 'Report of a Patient Absent Without Leave' to Victoria Police. Clearly, these steps did not occur when Mr A failed to return from leave at 10am. It appears that it was not until the arrival of Mr A's brother at approximately 4pm that it was noticed that Mr A had been absent for the duration of the day and efforts were made to locate him.

Medication Regime

73. Dr Newton reported that Mr A appears to have commenced Risperidone[60] at a dose of 1mg per day following initial contact with Bendigo Health in November 2008. On admission to Bendigo Hospital on 31 December 2008, Risperidone was increased to 3mg per day. This remained his dose on transfer to OYH in early January 2009, and was increased to 4mg per day on 12 January 2009. In addition, he was prescribed Diazepam[61] for sedation, PRN Temazepam[62] for sedation, and Olanzapine[63] for agitation.

74. From early February, a decision was made for Quetiapine XR64 to be introduced. This reportedly occurred due to a plateau in Mr A's treatment response. On 12 February 2009 he received 3mg of Risperidone and 600mg of Quetiapine XR. From 13 February 2009 his Quetiapine was increased to 800mg, and Risperidone reduced to 2mg. As of 16 February 2009, Risperidone was ceased entirely.

75. Dr Newton states that the prescription of Risperidone, Quetiapine and Diazepam for were within national and international practice guidelines for pharmaceutical treatment of first episode psychosis. An important observation made by Dr Newton is the possible improvement in Mr A's mental state in early February while taking Risperidone 4mg, with minimal side-effects reported. He notes that both Royal Australian and New

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60 Risperidone is an atypical anti-psychotic used to treat schizophrenia and schizoaffective disorder.
61 Diazepam is a benzodiazepine used for treating anxiety, insomnia and seizures.
62 Temazepam is benzodiazepine used for treating sleeplessness.
63 Olanzapine is an atypical anti-psychotic used to treat schizophrenia and bipolar disorder.
64 Quetiapine is an atypical anti-psychotic used to treat schizophrenia and bipolar disorder.

Zealand College of Psychiatrists (RANZCP) Guidelines and International Clinical Guidelines for Early Psychosis allow for increasing Risperidone and Quetiapine in the absence of side-effects. Dr Newton observed that while it might be speculated that continuing with Risperidone was a preferred treatment option for Mr A, in light of the events that occurred, both the dose change and medication change were within clinical practice guidelines and it appears Mr A was showing a partial response.[65]

REPORT OF DR NIGEL STRAUSS

76. Maurice Blackburn Lawyers, acting on behalf of Ms Tranter's daughter, requested a report from psychiatrist, Dr Nigel Strauss, on the standard of psychiatric care provided to Mr A while he was an inpatient at OYH in 2009. This report was provided to the Court on 27 August 2013.

77. After examining Mr A's medical file, Dr Strauss concluded that there were inadequate risk assessments carried out, particularly in the days and weeks before Mr A went on overnight leave on 3 March 2009. [66]

78. Dr Strauss opined that risk assessments should have been carried out after 12 February 2009, particularly because Mr A continued to manifest agitated problematic behaviour, and that if they were so done, it would have been inappropriate to grant Mr A overnight leave and more appropriate to allow him several opportunities at day leave, before overnight leave was granted.[67]

79. He further stated that there was no appropriate longitudinal medical assessment process which would have given a better indication of Mr A's mental state and potential risk behaviour and that because he was not appropriately assessed he was granted overnight leave at a time when he posed a significant risk. [68]

80. Dr Strauss was informed by Ms Tranter's daughter that multiple family members raised concerns about Mr A's erratic and aggressive behaviour during leave and family visits to OYH, and Dr Strauss concluded that this tends to suggest that inadequate care and attention in relation to Mr A's risk assessments, as family feedback 'appears not to have been noted and... ignored in relation to the potential risks posed by [Mr A's] behaviour.[69]

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65 Report of Associate Professor Richard Newton, above n 42, 7.
66 Report of Dr Nigel Strauss, 9.
67 Ibid 9-10.
68 Report of Dr Nigel Strauss, above n 66, 9.
69 Ibid 9.

81. Dr Strauss concedes that although he is not sure what information was provided to the family when Mr A was released into the care of his mother on 3 March 2009, the family should have been warned about the dangers involved in allowing him to spend time [70] with the family overnight and behaviour to look for which would ring alarm bells.

82. In relation to Mr A's failure to return to OYH at 10.00am, Dr Strauss formed the belief that contact with the family was not pursued intensively and that due to a lack of risk management material and being assessed as low risk regarding Mr A's behaviour, there was an inadequate response and delay in informing the consultant and particularly the police.[71]

REPORT OF PROFESSOR NICHOLAS KEKS

83. K & L Gates, acting on behalf of Melbourne Health, requested a report from psychiatrist, Professor Nicholas Keks, in relation to the management of Mr A while he was an inpatient at OYH in 2009. This report was provided to the Court on 4 December 2013.

84. After reviewing the clinical records and a chronology of treatment of Mr A, Prof Keks concluded that clinical and safety considerations were carefully considered by a number of clinicians, and lead to entirely appropriate management and inpatient care by OYH, and that 'the decisions of the clinical staff reflected standard clinical practice by psychiatrists of good reputation and standing, and were entirely appropriate.'[72] He commented that completion of a risk assessment form does not constitute clinical assessment of patient safety and that clinical notes are more valuable in conveying priorities and context of a case. He stated that in this case, Mr A received careful physical [73] evaluation and appropriate investigations were carried out. He said, 'assiduous efforts were made to establish a therapeutic alliance with the patient, and continuing communication was undertaken with members of the patients family by various disciplines of clinical staff'.[74]

85. Professor Keks espoused that management of Mr A was entirely consistent with accepted clinical guidelines for the management of schizophrenia, such as those of the Royal

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70 Report of Dr Nigel Strauss, above n 66, 10.
71 Ibid 11.
72 Report of Professor Nicholas Keks, 16.
73 Ibid 14.
74 Report of Professor Nicholas Keks, above n 72, 14

Australian and New Zealand College of Psychiatry and the National Institute of Clinical Excellence.

86. Prof Keks further espoused that graduated leave was a key part of Mr A's therapeutic program, as prolonged hospitalisation can have serious negative consequences on the patient. He commented that 'discharge management focused on rehabilitation and recovery must consider graduated leave, which will include overnight leave, if at all clinically feasible'.[75]

87. In relation to risk assessment of Mr A, Prof Keks commented upon the necessity to distinguish between static and dynamic risks, and between acute and chronic risks. He opined that risk in psychiatry is an extremely complex concept, and that when carrying out a clinical assessment of patient safety, a complex balanced judgment is undertaken concerning static and dynamic risk factors. He stated that while Mr A's presentation was associated with increased static risk,[76] other critical characteristics are entirely absent, including no history of suicide attempts, threats to kill and multiple episodes of violent behaviour occasioning actual injury, and that such a history is 'no doubt the most important static risk factor for future risky behaviour'.[77] At no stage were command hallucinations elicited (which can be problematic in causing violent behaviour) and he was noted as being shy, not antisocial (the latter of which is a major risk factor). Consequently, the patient had low dynamic/acute/short term risk at the time of his assessment by Dr Phelan.[78] Prof Keks said that, in his opinion, there were no acute indicators of risk to others which should have led Dr Phelan to deny overnight leave.[79]

88. Prof Keks concluded that Mr A was clinically assessed at an appropriate frequency and to more than adequate depth and extent, and that while precise times are not recorded, the notes on March 3 2009 infer that Dr Phelan assessed Mr A only a short time before he went on leave.[80] He concluded that there is no indication from his assessment of the clinical notes that there was 'inconsistency' between various clinicians.[81]

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75 Ibid 15.

76 Risks include: young age, male, presence of psychosis, illicit substance abuse, paranoid thinking, minor assaults.

77 Report of Professor Nicholas Keks, above n 72, 15.

78 Ibid 18.

79 Report of Professor Nicholas Keks, above n 72, 16.

80 Ibid 18.

81 Report of Professor Nicholas Keks, above n 72, 19.

89. Professor Keks opined that Dr Phelan carefully assessed the benefits and risks of Mr A going on overnight leave and that 'most psychiatrists of good reputation and standing would have made the identical decision'.[82] He also concluded that management of OYH was consistent with the principles enunciated in the Chief Psychiatrist's guideline, including the communication with family and agreement with them concerning the appropriate timing of notification of police on 4 March 2009.[83]

FINDING

Accordingly, I find that Ms Kathy Tranter died on 4 March 2009 and that the cause of her death was head injuries, inflicted by her son, Mr A.

COMMENTS

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

1. OYH should monitor internal processes to ensure that mental health risk assessment and risk management is undertaken at regular intervals throughout an inpatient hospital admission and specifically prior to patients taking leave.

2. In accordance with the Victorian Chief Psychiatrist's Guideline titled, *Inpatient Leave of Absence (2009)*, OYH should pay particular attention to the need to communicate with a patient's family as to any special conditions that should be brought to their attention prior to the patient taking leave. In addition, consideration should be given to this discussion being guided by a senior clinician of the treating team, ideally the treating psychiatrist, and include the provision of a crisis plan in the event that difficulties are encountered by the patient or their carer during the leave period.

RECOMMENDATIONS

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

1. That OYH review its current policy and procedures regarding a patient's failure to return from leave. The purpose of this review is to ensure that staff are immediately made aware of a patient's failure to return, and that the necessary actions described in the North Western Mental Health Service CC3.18 – Absence in Inpatient policy, can be actioned in a timely manner.

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82 Ibid 20.

83 Report of Professor Nicholas Keks, above n 72, 20.

2. That OYH give consideration to introducing a process of initiating contact with patients and their family members who have been granted a leave of absence (both escorted and overnight leave). This contact should comprise a telephone call or planned visit, to elicit information on the progress of that leave, the emergence of any risk factors and the associated management of any risks identified.

I direct that a copy of this finding be provided to:
The family of Kathy Tranter
Sergeant Mark Ribbink, Investigating Member, Victoria Police
Interested parties

Signature:

JOHN OLLE
CORONER
Date: 15/7/2020