IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 4173

FINDING INTO DEATH WITH INQUEST

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

Findings of:	Caitlin English, Deputy State Coroner
Deceased:	William Thomas Flanagan
Delivered on:	30 July 2020
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank
Hearing date:	30 July 2020
Assistant to the Coroner:	Leading Senior Constable Jeff Dart

INTRODUCTION

1. William Thomas Flanagan was a 57-year-old man at the time of his death.

2. Mr Flanagan had suffered from schizophrenia for approximately 28 years. He required increasing support to live independently and had been living in a supported residential service, Delany Manor in Bright.

3. In the three or four years prior to his death, Mr Flanagan's mental health had deteriorated, and he spent long periods of time in the Kerferd Unit[1] with acute on chronic exacerbations[2] of his illness.

4. Mr Flanagan's medical history also included hypertension, hypothyroidism, large incisional abdominal hernia, elevated lipids, and he underwent coronary artery bypass surgery in 2001. He was a heavy smoker.

5. Mr Flanagan was estranged from his brother and sister.

6. On 15 August 2014, Mr Flanagan took his own life by intentionally stepping in front of a moving train.

THE PURPOSE OF A CORONIAL INVESTIGATION

7. Mr Flanagan's death was reported to the coroner as his death was unnatural and the result of accident or injury and therefore within the definition of a reportable death pursuant to section 4 of the *Coroners Act 2008* (Vic) (the Act).

8. As he was a person 'in care or custody' immediately before his death, his death also fell within the definition of a reportable death in the Act. [3]

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[1] The Kerferd Unit is the Acute Adult Mental Health Inpatient Unit in Wangaratta. It is an open or unlocked unit which has a general Low Dependency (LDU) area and a four bed High Dependency Unit (HDU) which can be locked. The entire unit can be locked but this is not usual practice.

[2] The term "acute on chronic" refers to a patient who experiences ongoing (chronic) psychotic symptoms as baseline and is currently experiencing an exacerbation of symptoms above that of their baseline (acute).

[3] Section 3(1) of the *Coroners Act 2008* (Vic) defines the term *"person placed in custody or care"*. A patient detained in a designated mental health service (DMHS) within the meaning of the *Mental Health Act 2014* (Vic) is deemed to be a person placed in custody or care. (The *Mental Health Act 2014* came into effect on 1 July 2014, which is after Mr Flanagan's initial admission.) In order to be detained in a DMHS, a person must be subject to an Inpatient Assessment Order, an Inpatient Temporary Treatment Order, or an Inpatient Treatment Order. At the time of his initial admission on 6 April 2014, Mr Flanagan was subject to an Involuntary Treatment Order made on 5 August 2013 pursuant to section 12 or 12AA of the *Mental Health Act 1986* (Vic). According to the transitional provisions (section 394), upon the 2014 legislation coming into effect, Mr Flanagan's Involuntary Treatment Order was converted to an Inpatient Treatment Order, which required him to be taken to, and detained and treated in, a DMHS as a compulsory patient.

9. Pursuant to section 52(2) of the Act, it is mandatory for a coroner to hold an inquest if the deceased was, immediately before death, a person placed in custody or care. As Mr Flanagan was a patient detained in a designated mental health service within the meaning of the *Mental Health Act 2014*, he is deemed to be a person placed in care.

10. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[4] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[5]

11. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[6] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[7] or to determine disciplinary matters.

12. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

13. For coronial purposes, the phrase "*circumstances in which death occurred*,"[8] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

14. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of comments and recommendations by coroners.

15. The coronial investigation in this case was undertaken by a member of Victoria Police who was appointed as the coroner's investigator, Leading Senior Constable Jo Miller. A coronial brief was prepared with witness statements taken from the train crew, the medical and nursing staff at Kerferd Acute Psychiatric Unit and included the forensic pathologist's medical examiners report and toxicology report. Additional information was sought from Albury Wodonga Health regarding care for involuntary patients and measures to prevent absconding. Albury Wodonga Health provided a statement by Dr Alan England, Director of Psychiatry,

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[4] Section 89(4) *Coroners Act 2008* (Vic).
[5] Preamble and section 67 *Coroners Act 2008* (Vic).
[6] *Keown v Khan* (1999) 1 VR 69.
[7] Section 69(1) *Coroners Act 2008* (Vic).
[8] Section 67(1)(c) *Coroners Act 2008* (Vic).

the Root Cause Analysis Report and Recommendations, the Risk Reduction Action Plan and a table detailing implemented recommendations. The Coroners Prevention Unit also provided advice regarding Mr Flanagan's mental health care and management.

16. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[9] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[10] The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

17. Coroner Rosemary Carlin had the original carriage of this investigation. Following her appointment to the County Court, I took over the carriage of this investigation in December 2019.

18. At the conclusion of the coronial investigation I was satisfied I was able to find, pursuant to section 67 of the Act, as far as possible, the identity, the cause of death and the circumstances in which death occurred. As a result, this case was listed for a summary inquest for me to deliver my findings.

IDENTITY OF THE DECEASED PURSUANT TO SSECTION 67(1)(a) OF THE ACT

19. On 19 August 2014, William Thomas Flanagan, born 28 November 1956, was identified via his fingerprints.

20. Identity is not in dispute and requires no further investigation.

BACKGROUND

21. In 2013 Mr Flanagan was placed on a Community Treatment Order (CTO) under the *Mental Health Act 1986* and was being case managed by the North Eastern Hume Adult Mental Health Service.

[9] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[10] (1938) 60 CLR 336.

22. On 6 April 2014, Victoria Police members found Mr Flanagan trying to light a fire in the bush near his residence, Delany Manor, in Bright. His CTO was revoked[11] and he was admitted as an involuntary patient to the Kerferd Unit.

23. Mr Flanagan had been receiving a regular zuclopenthixol[12] long-acting injection although he stated he had not been taking his oral psychiatric medications (venlafaxine[13] and olanzapine[14]) for some time. He had been apparently compliant with medications for his various physical conditions.

24. Mr Flanagan had a long standing chronic psychotic illness which had been diagnosed as schizophrenia with a differential diagnosis of schizoaffective disorder. It appears his illness was becoming treatment resistant.

25. According to the admitting doctor's notes, on admission to the Kerferd Unit Mr Flanagan presented with distressing auditory hallucinations, which appeared to be derogatory and sometimes command in nature.[15] On his first review by Dr Jennifer Ellix, his treating psychiatrist, he explained voices had been telling him to do things, including to leave the SRS, but they were no longer telling him to run away nor to hurt himself.

26. According to Dr Ellix, during his lengthy admission to the Kerferd Unit, Mr Flanagan frequently expressed a wish to die, although he only twice expressed a wish to self-harm during the admission. He continued to experience distressing psychotic symptoms. Attempts to treat Mr Flanagan's illness more effectively were made but it proved very difficult due to his comorbid medical conditions as discussed below.

27. Mr Flanagan was initially nursed in the Low Dependency Unit of the Kerferd Unit. He was placed on 15-minute observations.

28. On 10 April 2014, this was reviewed by Dr Ellix and he was placed on standard observations (mealtimes and change of shift) and allowed escorted leave (with staff). According to

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[11] In 2013 Mr Flannigan was made subject to a community treatment order (CTO) under the *Mental Health Act 1986* (Vic). His CTO was revoked (meaning he breached the conditions allowing him to remain a community patient) on 6 April 2014 and he was admitted to hospital. In June 2014 the *Mental Health Act 2014* (Vic) came into effect and the terminology in the new act changed. Under the 2014 Mental Health Act when a person breaches the conditions of their CTO, the CTO is varied to an inpatient treatment order, and when a person is taken off a CTO the CTO is revoked.

[12] Zuclopenthixol decanoate is a long acting (depot) antipsychotic. It can be used for initial treatment of acute psychotic episodes of exacerbation of psychosis associated with schizophrenia.

[13] Venlafaxine is an antidepressant indicated for treatment of depression and anxiety.

[14] Olanzapine is a second-generation antipsychotic medication.

[15] Command auditory hallucinations involve voices telling the person to do things. This can vary from mundane (telling the person to sit down or brush their teeth) to serious (kill self or others).

Dr Ellix, Mr Flanagan had been able to take direction from staff, not attempted to leave the Unit, and had not tried to self-harm or spoken of self-harming.

29. On 22 April 2014, Mr Flanagan was granted unescorted leave for two periods of one hour per day to go to the local café.

30. On 24 April 2014, Mr Flanagan reported voices telling him to go to Yarrawonga. His unescorted leave was cancelled, and he was placed back on 15-minute observations. He was allowed to have escorted leave.

31. On 5 May 2014, Dr Ellix reviewed Mr Flanagan at which time he reported his voices were telling him he would burn in hell but denied any voices telling him to walk to Melbourne or Yarrawonga or to kill himself. He was again placed on standard observations and granted short periods of unescorted leave to go to the local café. Despite saying he would go to the shop, he went to the local railway station. Station staff noticed him standing on the platform. He returned willingly with Kerferd staff to the Unit. At that time, he told nursing staff he intended to jump in front of the train but changed his mind. Unescorted leave was then cancelled. He continued to be nursed on 15-minute observations.

32. By 19 May 2014, he had not significantly improved despite various trials of medication. He was reviewed for his fitness for electroconvulsive treatment (ECT) by the anaesthetic department. He was deemed fit for an anaesthetic and ECT, but on the day ECT was to commence, 26 May 2014, he became unwell and was later found to have had a type of cardiac infarct (heart attack). This led to him being unfit for ECT. Attempts to manage his cardiac condition in the Coronary Care Unit at Wangaratta Hospital proved difficult as he was uncooperative, and he returned to the Kerferd Unit on 28 May 2014.

33. By June 2014, Mr Flanagan's psychiatric condition had not improved, and he was mute on one occasion apparently due to voices telling him not to speak. He asked to be nursed in the High Dependency Unit (HDU) on 6 June as he *"couldn't breathe"* in his room. Advice was sought from the Neuropsychiatry Unit at Royal Melbourne Hospital (who provide a state-wide expert primary and secondary consultation service). Their advice was that pursuing ECT would carry a high risk of death. The alternative treatment considered was clozapine.[16] However, cardiology specialists advised advised he was not suitable for this medication.

[16] Clozapine is an antipsychotic medication considered to be very effective in treating treatment resistant schizophrenia and psychosis. It carries significant risks and is subject to a strict monitoring protocol. Treatment for treatment resistant schizophrenia could not be considered to be complete without consideration of a trial of clozapine.

34. By mid-July 2014, Mr Flanagan's antidepressant (venlafaxine) was further increased with some positive response noted. He was more talkative and interactive and asking for leave to go to the local shop for cake and coffee. He managed to do this successfully for two days but on the third day he repeatedly left the Kerferd Unit without permission on multiple occasions and he was found smoking in his bedroom causing a small fire. Unescorted leave was again stopped.

35. A referral was made for Mr Flanagan to go to the Psychogeriatric Aged Care Facility,[17] Blackwood Cottage. A joint assessment by Aged Care Assessment Service and the Older Persons Mental Health Service agreed this was an appropriate place for him to live. He was due to be admitted there on 21 August 2014.

36. Several days later, Mr Flanagan began to refuse his medication and wanted to sue Dr Ellix and the Mental Health Tribunal.

37. On 28 July 2014, Mr Flanagan told his psychiatrist he wanted to be dead but denied any plan to kill himself. He later absconded from the unit and was found having lit a small fire up the street. He said he was going to throw himself in the river and kill himself. This was the second occasion that Mr Flanagan expressed a wish to take his own life. He spent the night in the HDU but was moved back to the low dependency unit the next day once he settled. Escorted leave was cancelled.

38. His final psychiatrist review with Dr Ellix was on 12 August 2014. His mental state was described as unchanged. He was experiencing derogatory auditory hallucinations, lowered mood, and said that he felt guilty. He was eating although he needed prompting to eat with others, and his sleep was described as good. He was not found to have suicidal ideation. He was continued on 15-minute observations with escorted leave only.

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(c) OF THE ACT

39. On 15 August 2014, Mr Flanagan ate his breakfast and lunch and was assisted to shower. Medical records reveal that on mental state review he gave monosyllabic responses and *"nil*

[17] Psychogeriatric ACFs are highly specialised facilities run by local area Aged Persons Mental Health Services. They are secure and cater to generally older people with difficult to manage psychiatric and neurological conditions. A person also needs to have certain physical or behavioural care needs to be eligible for the units as they are Aged Care Facilities.

suicidality illicited (sic)". He was noted to be isolating himself in his room. He was given cigarettes on an hourly basis as usual.[18] Mr Flanagan remained on 15-minute observations.

40. At 2.30pm, Mr Flanagan was sighted by a nurse who gave him a cigarette. The nurse stated that Mr Flanagan did not exhibit any unusual behaviour at the time, *"he was just his normal self"*. Mr Flanagan thereafter went out into the yard, which is a common area at the back of the clinic.

41. His primary nurse sighted Mr Flanagan again at 3.00pm.

42. Mr Flanagan was reportedly last seen at approximately 3.00pm by a staff member who was not working at Kerferd but who recognised him.

43. At 3.15pm, staff were unable to sight Mr Flanagan and began looking around the clinic for him. Staff were searching for him when police notified the unit that an incident had occurred at the train station.

44. Mr Flanagan had walked approximately 300 metres to the Wangaratta Railway Station and stepped in front of a freight train travelling north through Platform 1. He was struck by a train at 3.12pm and died instantly.

45. Police attended the scene at the Wangaratta Railway Station and Detective Sergeant Mick Doolan attended the Kerferd Unit. He searched Mr Flanagan's room and located a note which made mention of death being under State Trustees. [19]

MEDICAL CAUSE OF DEATH PURSUANT TO SECTION 67(1)(b) OF THE ACT

46. On 19 August 2014, Dr Paul Bedford, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection and provided a written report, dated 25 August 2014. In that report, Dr Bedford concluded that a reasonable cause of death was *"Multiple injuries – struck by train"*.

47. Toxicological analysis identified the presence of venlafaxine and its metabolite, zuclopenthixol, the metabolite of risperidone,[20] diazepam[21] and its metabolite, and paracetamol.[22]

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[18] These notes were made retrospectively as they mention the facts that Mr Flanagan went missing and of his death.
[19] This note is located at Appendix 2 of the Coronial Brief. There is no statement on the coronial brief by Detective Sergeant Doolan but the summary prepared by LSC Miller refers to him finding it in Mr Flanagan's room at the Kerferd Unit. Whilst it is undated, non-specific and ambiguous, it could be construed as a suicide note.

48. I accept Dr Bedford's opinion as to cause of death.

49. I am satisfied given the method and previous suicidal actions and statements expressed by Mr Flanagan and detailed in paragraphs 31, 34 and 37, that Mr Flanagan intended to end his own life.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

50. Mr Flanagan's case was referred to the Coroners Prevention Unit (CPU) to review the care he received at the Kerford Unit.

51. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

Mental health care

52. The CPU noted that Mr Flanagan had a longstanding chronic psychotic illness, which had been diagnosed as schizophrenia with a differential diagnosis of schizoaffective disorder. Schizoaffective disorder can be diagnosed when a person experiencing schizophrenia seems to have a mood or affective component to their presentation. This is usually diagnosed in patients who have an elevated mood at times when they are psychotic. Many people with schizophrenia can also have a diagnosis of major depression at times.

53. Medication to treat Mr Flanagan's illness had included mood stabilisers[23] in the past, but in the few years before he died was more limited to antipsychotics and antidepressants. There is nothing in his final admission notes to suggest he had an elevated mood. Mr Flanagan was being treated with antidepressants, which were adjusted during his final admission. He also presented at times to the psychiatrist as low in mood, as feeling guilty and as wanting to die because he was sick of things.

54. Mr Flanagan also experienced a lot of distress secondary to his ongoing positive psychotic symptoms, particularly his auditory hallucinations, which were derogatory and could be

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[20] Risperidone is an atypical antipsychotic prescribed for schizophrenia and some behavioural disorders.
[21] Diazepam is a sedative/hypnotic drug of the benzodiazepines class.
[22] Paracetamol is an analgesic drug.
[23] Mood stabilising medication is used generally for people who experience recurrent elevations or depressions in their mood (for example, bipolar affective disorder, schizoaffective disorder).

command in nature. He had responded to these hallucinations at times by trying to walk to Melbourne, by spending nights outside his home, by not speaking or lying on the ground. The CPU noted that there is always a risk that people experiencing these command hallucinations will act on them and this could lead to suicide or accidental harm. Mr Flanagan was also very distressed by the experience of chronic derogatory auditory hallucinations and this is reflected in the frequent notation of his distress by staff in his medical records.

55. The CPU observed that Mr Flanagan also experienced the general decline in functioning often seen in chronic long-term schizophrenia. This can be due to a combination of factors. In Mr Flanagan's case, he had to deal with ongoing unpleasant internal experiences, which can be distracting and interfere with someone's ability to do things for themselves and to socialise with others. It is also highly likely he had some brain injury from the illness, which is often seen in chronic schizophrenia. This often leads to people being less able to make good decisions, be apathetic about things that may have mattered to them, be unable to deal with finances or other complex daily matters and be unable to care adequately for themselves. Mr Flanagan had needed supported accommodation for some time and his ability to manage independently had been doubted for several years as evidenced by the many attempts by mental health services to get Mr Flanagan to agree to join the community care unit [24] program and by the need for Mr Flanagan to have intensive home support via the Psychiatric Disability Rehabilitation and Support Services.[25] Mr Flanagan was accepted by the Aged Care Assessment Service and by Aged Mental Health as being appropriate to live in a psychogeriatric nursing home. This would not be offered to someone on the basis of ongoing mental illness or risk of suicide but rather because the person needs assistance in daily care and a supportive environment due to a decrease in ability to function independently.

56. The CPU commented that the other major factor in Mr Flanagan's presentation at the time of his death was his increasing anger and frustration at being detained. Acute Mental Health Units are not generally appropriate for someone to live in for months. His suicide risk and risk of walking off somewhere meant he was restricted in his ability to go out of the Unit most of the time he was an inpatient there. Although staff members could escort him for leave, this is

[24] Community care units provide medium to long-term accommodation, clinical care and rehabilitation services for people with a serious mental illness and psychosocial disability. Located in residential areas, they provide a "home like" environment where people can learn or re-learn everyday skills necessary for successful community living. While it is envisaged that people will move through these units to other community residential options, some consumers require this level of support and supervision for several years.

[25] The non-government psychiatric disability rehabilitation and support services sector is a core component of specialist mental health services complementing clinical mental health services. PDRSS are managed by non-government organisations and focus on addressing the impact of mental illness on a person's daily activities and the social disadvantage resulting from illness. They work within a recovery and empowerment model to maximise people's opportunities to live successfully in the community.

far more restrictive than him being able to move freely. He was also looking at moving to another restrictive environment (Blackwood Cottages).

57. The CPU advised that it appeared that Mr Flanagan was generally deteriorating in his illness and ability to live independently. During his final admission, it also appeared that the treating psychiatrist recognised the severity of his illness and the distress it caused him. The possibility of him harming or killing himself was also clearly recognised and documented. The response of the treating team to his condition included frequent, regular reviews by his treating psychiatrist with attempts to alter his treatment as described previously. Multiple changes to medication were tried and the two major treatments available that may have been effective (ECT and clozapine) were not able to be given due to medical issues. His psychiatrist sought advice through her Peer Review Group and attempted to use their advice. She also sought input from the Neuropsychiatry Service at Royal Melbourne Hospital and from medical colleagues from anaesthesia and cardiology. The decision to refer Mr Flanagan for a place at the psychogeriatric ACF Blackwood Cottage appeared to have been made because not only did he need more care and prompting to manage his activities of daily living, such as dressing, showering etc, he also needed a moderately secure environment.

Environmental factors

58. In terms of providing a safe environment for Mr Flanagan, the CPU observed that the acute unit at Kerferd struggled with the difficulties facing all acute mental health units, which is how to provide a less restrictive environment whilst still keeping someone safe. Being confined within a hospital is difficult for patients and Kerferd is not a locked ward. This means any decision to lock the ward to prevent a patient absconding needs to be balanced against the needs of the patient at risk and the impact on all the other patients. It is also not generally reasonable to use other more restrictive practices unless it is a short-term intervention whilst someone is recovering from an acute episode. For example, the Kerferd Unit has a high dependency unit (HDU), which is locked. This is for more acutely unwell patients who may be behaviourally disturbed or at high risk of self-harm. It would not be reasonable to keep a patient in this area when they were more settled and not at immediate risk of harm just to prevent them absconding, as this would be highly restrictive and distressing and could lead to a deterioration in the person's mental state.

59. The approach of the Kerferd Unit therefore is not unusual in that they used a system of observations to monitor patients' whereabouts. Mr Flanagan was on 15-minute observations when he left the Kerferd Unit. Fifteen-minute observations mean that a staff member should

sight the patient every 15 minutes throughout the day and overnight. This is the highest level of observation used below a patient being placed in the HDU or having one to one nursing care, when a staff member is assigned to be close to one patient. This one to one care is not often used as it is resource intensive and can be intrusive for the patient. It can be used in extremely high-risk situations.

60. The proximity of the Kerferd Unit to the Wangaratta train station and its ready accessibility was unfortunate in this situation. It is not unusual for train lines or stations to be close to hospitals to allow ready public access. According to data extracted from the Victorian Suicide Register, between January 2013 and December 2015, four people (including Mr Flanagan) absconded from mental health inpatient units and suicided by train the same day, though one of these was over 15km from the hospital from which they absconded. Given the low frequency of this type of suicide and practicalities, the CPU did not identify any opportunities for prevention in this area.

Service response to Mr Flanagan's death

61. North East Mental Health Service conducted a root cause analysis (RCA) after Mr Flanagan's death, which was provided to the Court. The report provided a comprehensive timeline and assessment of the clinical situation which appeared to be very thorough and reflected accurately the complexity of Mr Flanagan's psychiatric presentation. The report is not critical of the care given by Dr Ellix and comments that the documentation she made was comprehensive.

62. Upon review of Dr Ellix's regular reviews of Mr Flanagan, the changing clinical response to fluctuations in his risk, Dr Ellix's clear documentation and her attempts to improve his treatment, the CPU advised that it is reasonable that the RCA made this finding.

63. The use of the patient observation system is criticised by the RCA report. The observation system is described as a component of risk management that is not clearly linked to a clinical rationale focused on the purpose of the observation level.

64. The use of patient observations is standard throughout Victorian acute psychiatric facilities to assist staff in managing patient risk by a structured means of regularly seeing where patients are. The RCA report quite rightly identifies deficiencies in the patient observation system in use at Kerferd at the time of Mr Flanagan's death. In particular, there was a general time when all the patients were recorded as being seen rather than individually documenting the exact time a patient was seen. This means all the patients were marked as having been seen at the

same time, which is not possible. In Mr Flanagan's case this could have been critical as being seen at 3.00pm might have meant anytime around 3.00pm. His death occurred at 3.12pm. The other criticism was that there was no procedure to engage with the patient or document their condition on these patient observation forms. Although it might be hoped that anyone seen behaving strangely or being distressed would be approached or reported to other staff, this was not part of the requirements of the form.

65. The Risk Assessment Chart (RAC) is also described as not connecting the daily observation levels to a daily management strategy. The comment was made that it is difficult to discern daily management strategies from the clinical documentation. It was commented that it is not evident how patient management and risk is communicated from shift to shift. Daily progress notes are described as often descriptive without imparting a good sense of how the patient was assessed or what interventions may have been made.

66. The use of 'perimeter restraint', whereby the locking of the Kerferd Unit doors could have been used to reduce the risk of absconding, is discussed. The report concludes there is no specific guidelines on the use of perimeter restraint. It does comment that this had been used on at least one occasion in response to Mr Flanagan's risk of absconding.

67. Other issues identified include poor clinical documentation, including failure to document the time of entries, failure to print the name of the person making entries, and failure to document who was present at reviews. The report addressed the need to improve the standard using an accepted tool and to ensure staff can describe the standard. The CPU advised that this appeared to be a reasonable response to the identified deficiencies.

68. The report detailed an action plan to implement these risk reduction strategies. The CPU advised that the recommendations made by the RCA report appeared to adequately address these deficiencies. The sight observation system is recommended to be revised so *it "becomes patient centred, linked to a clinical rationale"*, and an *"adjunct in the detection of patient deterioration and assessment of dynamic patient factors"*. This could have provided better documentation of Mr Flanagan's condition on the day of his death as it may have offered more information about how he was presenting rather than simply approximately when he was last seen. The CPU opined that these improvements could have a beneficial effect on the management of all the patients under sight observations in the Kerferd Unit and potentially reduce the risk of further deaths.

69. Although the Kerferd Unit could have locked the doors of its low dependency unit and did this on at least one occasion to reduce the risk to Mr Flanagan, it is not clear from the notes whether this was considered on other occasions. The RCA report commented that there was no guideline in place which may have helped the staff decide whether this was a reasonable step to take. In general, the decision to lock an open unit is not taken lightly as it is a considerable restriction to other patients and changes the environment considerably. Although having a locked facility would reduce the risk of anyone absconding, it does not always prevent it and there are other considerations such as the impact of this restriction on the person's mental state which must be considered.

70. Although Mr Flanagan could also have been kept in the high dependency unit to reduce his risk of absconding, this would generally not be a reasonable response to manage a risk of absconding in absence of other risks and again would have a significant impact on the person's mental health. The CPU noted that it was reasonable that the RCA did not identify this as a potential risk management tool in this situation.

71. I accept the CPU's conclusions and that no prevention opportunities were identified.

Update regarding the implementation of the RCA recommendations

72. In February 2020, I requested information from Albury Wodonga Health regarding the implementation of the recommendations made in the RCA.

73. In May 2020, Dr Elizabeth McArdle, Clinical Director at Albury Wodonga Mental Health Service provided me copies of:

(a) the Clinical Handover Procedure, which sets out a standardised and structured process when conducting clinical handovers and outlines when handovers should be completed;

(b) the Risk Management Inpatient Care Procedure, which sets out the process to assess, document, and manage patients' risks to themselves and others;

(c) the Kerferd Unit – Risk Monitoring, Nurse Observation & Engagement Tool – Part A, which is a form to capture a patient's individual risk and the level of observation that they require;

(d) the Kerferd Unit – Risk Monitoring, Nurse Observation & Engagement Tool – Part B, which is a form to record observations of a patient, prompting staff to record time, location, and presentation;

(e) the Mental Health Risk Assessment for, which captures a patient's risk factors and their general level of risk; and

(f) a timetable for staff education regarding the nursing capability framework for August 2019.

74. I am satisfied these documents address the deficiencies identified by the RCA.

Conclusion

75. Mr Flanagan died on 15 August 2014 as a result of being struck by a train whilst absent without leave from the Kerferd Unit acute psychiatric unit. His death occurred whilst he was a compulsory psychiatric patient during a prolonged admission for an acute on chronic deterioration in his longstanding schizophrenic illness.

76. He was in the low dependency unit on 15-minute observations due to the recognised risk of him absconding and self-harming or coming to harm by misadventure. Mr Flanagan's ability to care for himself was steadily declining and he was assessed as suitable for aged care accommodation. He had been accepted at Blackwood Cottage, psychogeriatric ACF, but was waiting for a place there. Although the ACF would be locked, it is still possible for residents to abscond from these facilities. This is a less secure environment than an acute psychiatric unit. While there is no trainline in Beechworth (where Blackwood Cottage is located), this in itself could not have provided a guarantee of Mr Flanagan's safety as he may have come to accidental or deliberate harm from other means. Mr Flanagan had previously spent nights outside in the cold, wandered long distances, and talked of jumping in a river in response to his symptoms.

77. Mr Flanagan's condition was deteriorating: he had spent long periods of admission in the acute psychiatric unit over the previous three years, as well as the five months prior to his death. His distress at his chronic derogatory and command auditory hallucinations was well recognised and documented by his psychiatrist and the treating staff. Treatment options were limited by his medical comorbidities so that neither ECT nor clozapine antipsychotic treatment were available to him.

78. I am satisfied on the evidence that Mr Flanagan intended to end his own life.

79. No deficiencies in the psychiatric care provided to Mr Flanagan appear to have contributed to his death.

80. Overall, the service's identification of issues in documentation and in the procedure for sight observations appears to have been thorough and the recommendations made to address these issues reasonable.

81. I am therefore satisfied that the care Mr Flanagan received at the Kerferd Unit was reasonable and I have not identified any prevention opportunities.

FINDINGS AND CONCLUSION

82. Having investigated the death, and held an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that William Thomas Flanagan, born 28 November 1956, died on 15 August 2014 at Wangaratta Railway Station, Wangaratta, Victoria, from multiple injuries in the circumstances described above.

83. Pursuant to section 73(1) of the *Coroners Act 2008* I direct this finding be published on the Internet.

I convey my sincere condolences to Mr Flanagan's family for their loss.

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

Ray Flanagan, Senior Next of Kin
Albury Wodonga Health
Office of the Chief Psychiatrist
Department of Transport
Leading Senior Constable Jo Miller, Victoria Police, Coroner's Investigator.

Signature:

CAITLIN ENGLISH
DEPUTY STATE CORONER
Date: 30 July 2020