Rule 63(1)

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 0953

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: CHRISTOPHER TRAILL

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	15 December 2022
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street Southbank 3006
Hearing Dates:	17 – 19 November 2020, 8 June 2021.
Appearances:	Mr Gary Taylor of Counsel on behalf of the family (instructed by Bowen & Knox Lawyers). Ms Debra Foy of Counsel on behalf of Bendigo Health (instructed by Minter Ellison Lawyers).

Counsel Assisting the Coroner: Leading Senior Constable Jeff Dart, Police Coronial Support Unit

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I, AUDREY JAMIESON, Coroner having investigated the death of CHRISTOPHER TRAILL

AND having held an Inquest in relation to this death on 17, 18 & 19 November 2020 and 8 June 2021

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006

find that the identity of the deceased was CHRISTOPHER TRAILL

born on 26 September 1961

died on 25 February 2017

at Bendigo Base Hospital, Bendigo Health Care Group, 100 Barnard Street Bendigo, Victoria 3550

from:

1 (a) HANGING

In the following summary of circumstances:

On 24 February 2017 CHRISTOPHER TRAILL was admitted to Bendigo Base Hospital Psychiatric Unit as a compulsory patient on an Assessment Order. On 25 February 2017, CHRISTOPHER TRAILL was located by staff suspended by a ligature around his neck. He was unable to be resuscitated. An Inquest into his death is mandated by section 52(2)(b) *Coroners Act 2008*.

BACKGROUND CIRCUMSTANCES

1. CHRISTOPHER TRAILL (**Chris**)[1] was 55 years of age at the time of his death. He had four biological children and one stepchild and was living in Romsey with his long-term domestic partner.[2]

2. Chris was a self-employed lawyer specialising in the area of criminal defence. In the 12 months leading up to his death it was reported that he had stopped enjoying his work and consequentially, failed to complete regular business activity statements resulting in a taxation debt of approximately $150,000.00. He faced bankruptcy – a position he had been in approximately 15 years previously.

3. Chris had a history of alcohol dependence dating back to his twenties. After his drinking had become problematic, he ceased drinking alcohol at the age of 32 years with the help of Alcoholics Anonymous. In the 12 months leading up to his death Chris recommenced his alcohol consumption again to problematic levels.

4. Chris also had a history of mental ill health. At the age of 27 years, he was admitted to Melbourne Clinic for a period of 2 – 3 weeks in the context of suicidal ideation. He was commenced on antidepressant medication but ceased taking this medication shortly after his discharge due to the side effects he was experiencing.

5. In October 2016 Chris experienced suicidal ideation. He drove to an isolated area and prepared a noose with the intention of taking his life but changed his mind and called Lifeline for support.

6. On 11 February 2017, Chris had been drinking alcohol when he drove to pick up his partner who had been involved in a motor vehicle collision. He was pulled over by Police on a random check and breathalysed. The Police officers conducting the check knew Chris professionally. He recorded a blood alcohol content (**BAC**) of 0.155% resulting in an immediate suspension of his driver's licence. He was aware that he

[1] With the consent of Christopher Traill's family he was referred to as "Chris" during the course of the Inquest. For consistency, save where formality requires, I have also referred to him as Chris throughout the Finding.

[2] On 18 November 2020 I made an Interim Suppression Order on the application of the family's legal representatives with the aim of protecting the identities of the family members. No substantive application to convert the Interim Order to a Proceeding Suppression Order was made. I subsequently revoked the Interim Order after the Inquest had concluded but nevertheless have endeavoured to keep the personal details of the family to a minimum.

would be required to attend the local Magistrates' Court where he also practised and was concerned about the impact this would have on his career and reputation. He continued drinking through the night and early on the following day.

7. On the following morning Chris drove to a secluded location and made an attempt to take his life by fitting a pipe to the exhaust of his car. He however desisted and returned home but continued to drink alcohol and made another attempt to take his life again by fitting a pipe to his exhaust and feeding it into the interior of his car where he sat with the engine running. His partner located him and telephoned the Police.

8. Chris was conveyed to the Royal Melbourne Hospital (**RMH**) by Police utilising powers under the *Mental Health Act 2014* (**Mental Health Act**).[3] He was admitted to the John Cade Mental Health Unit (**John Cade**). He recorded a BAC of 0.225% on admission. On 15 February 2017, Chris was discharged after not meeting the criteria for ongoing compulsory treatment. It was recommended that he remain in hospital as a voluntary patient, but he discharged himself against this medical advice. A discharge summary provided with a referral to Kyneton Community Mental Health Service (**KCMHS**)[4] indicates that Chris did not make significant improvement to his mental health during his admission to John Cade and although his discharge was considered premature, Chris did not meet the criteria under the Mental Health Act for compulsory treatment. The plan for his discharge involved his family agreeing to supervise him full time and Chris agreeing to enact a three-step plan if he again began to experience suicidal ideation. The plan consisted of Chris agreeing to speak to his partner and adult children, contacting Lifeline, and if his ideations continued Chris would telephone the mental health triage service or 000. Chris was agreeable to follow up with his General Practitioner and KCMHS.

SURROUNDING CIRCUMSTANCES

9. On 20 February 2017, Chris had his first contact with KCMHS where he disclosed to his case manager that he experienced suicidal ideation but without a plan or intent on

[3] Section 351 *Mental Health Act 2014.*

[4] Kyneton Community Mental Health Service (**KCMHS**) is a regional area mental health service attached to Bendigo Health.

the day of his discharge from RMH after drinking two beers.[5] He was advised to cease drinking alcohol in order to reduce his suicide risk, to which he agreed.

10. Over the following days Chris' KCMHS case manager facilitated a referral to a financial counselling service outside of the local area, on the grounds that Chris had expressed concern about the possible impact on his career and reputation if he sought advice from a local service whom he had dealings within a professional capacity. Chris' case manager spoke to him and his partner by telephone to keep them apprised of the progress of this referral.

11. On 23 February 2017, Chris had an appointment with KCMHS consultant Psychiatrist, Dr Dianne Kirby (Dr Kirby) and lead clinician, Registered Psychiatric Nurse Jackie Neilson (RPN Neilson). His partner and his mother also attended. It was apparent that Chris had been drinking alcohol prior to the appointment which he admitted to. Chris was assessed as presenting with alcohol dependence and a major depressive episode with a recommendation that he be admitted to hospital. Chris declined admission stating he needed to work but agreed to take part in twice weekly reviews by the community team. Dr Kirby also advised Chris against working as she felt it too would increase his suicide risk. He agreed to refrain from working in the short term but was ambivalent about ceasing alcohol. A follow up with Dr Kirby was arranged for the next week with an interim follow up to occur with RPN Neilson.

12. On 24 February 2017, at a clinical team discussion involving Psychiatric Registrar Dr Katherine McAlpine (**Dr McAlpine**) and Dr Kirby at KCMHS, Chris' risk profile was reviewed and assessed as not being fully managed due to lack of supervision and support available over the upcoming weekend. It was planned to have Chris admitted to the Adult Acute Unit (**AAU**) of Bendigo Health as a compulsory patient in the Low Dependency Unit (**LDU**). RPN Neilson later visited Chris at his home and explained the reassessment and plan for admission. Although dissatisfied, Chris cooperated with his transfer to Bendigo Health by ambulance as a compulsory patient, under an Assessment Order. Dr McAlpine, undertaking her role as Hospital Medical Officer (**HMO**) assessed Chris and admitted him to the LDU. He was commenced on 15-

[5] After Chris left the meeting, his partner who had also attended advised the case manager that she had seen him drink at least three beers that same evening.

minute visual observations during the day. 60-minute visual observations occurred overnight.

13. On Saturday 25 February 2017 at 11.30 am, Chris was reviewed by the on-call[6] Consultant Psychiatrist Dr Mona Hassaballa (**Dr Hassaballa**). Chris' contact nurse, Nurse Jessica Poynton (**Nurse Poynton**) was present during this review. Dr Hassaballa met separately with Chris's partner and his mother to gain their perspective of Chris' problems and then a joint meeting was convened with them all. Chris asked to be discharged. He denied suicidal ideation and blamed alcohol for his previous attempts. Dr Hassaballa placed Chris on an Inpatient Temporary Treatment Order (**ITTO**) and reduced his visual observations from 15-minute to 60-minute visual observations. He was assessed as a low risk of suicidality, high risk of use of alcohol, with moderate risks of non-compliance, liver problems (assumed related to his alcohol intake) and cultural risk associated with dealing with ongoing legal issues. His overall risk was rated as moderate.

14. Chris was granted two hours of accompanied leave on hospital grounds which he took with his family, returning to the Unit without incident at approximately 3.40 pm. Throughout the afternoon and evening Chris continued to voice his dissatisfaction about being in hospital although he was reported to have remained calm and settled.

15. Nurse Kathleen Daw (**Nurse Daw**) was on duty and assigned the care of Chris for the afternoon and evening of 25 February 2017. She had received a handover from Nurse Poynton. As Chris was on 60-minute observations and had returned from accompanied leave, she did not consider it necessary to remove his personal belongings such as his belt. Nurse Daw observed Chris at 6.00 pm, 7.00 pm and 8.00 pm. She completed a handover to the night shift manager, Nurse Rowan Coca **(Nurse Coca)** before completing her shift at 10.00 pm.

16. At approximately 10.00 pm, Nurse Ian Hasler (**Nurse Hasler**) observed Chris in his room and wished him a good night. At 10.10 pm Chris attended at the Nurses Station

[6] Dr Hassaballa explained that the Consultant Psychiatrists would be on-call for a weekend commencing at 8.00 am on the Saturday covering the next 48 hours through to the Monday morning – T at p 23.

requesting medication. Nurse Christine Scott **(Nurse Scott)** notes that Chris was calm, polite and co-operative. They bid each other good night and Chris returned to his room.

17. On 25 February 2017 at approximately 11.00 pm, the night duty nurses commenced their visual observations of the patients in the Unit.

18. At approximately 11.06 pm Chris was located in his room by Nurse Sarah Trevena (**Nurse Trevena**) hanging from the bathroom door frame by his belt. Other articles of clothing had also been used by Chris to facilitate his actions. A Code Blue was called, and cardio-pulmonary resuscitation (**CPR**) initiated however, Chris could not be revived. Christopher Traill was declared deceased at 11.38 pm.

19. A "suicide note" was subsequently located inside the cover of Chris' diary.[7]

JURISDICTION

20. The death of CHRISTOPHER TRAILL was a reportable death under section 4 of the *Coroners Act 2008* (**the Act**), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury. In addition, immediately before death, Chris was a patient within the meaning of the *Mental Health Act 2014* and immediately before his death, a person placed in custody or care as defined by section 3 of the Act.

PURPOSE OF THE CORONIAL INVESTIGATION

21. The Coroners Court of Victoria is an inquisitorial jurisdiction.[8] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[9] The cause of death refers to the medical cause of death, incorporating where 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

[7] CB at p 146.

[8] Section 89(4) *Coroners Act 2008*.

[9] Section 67(1) *Coroners Act 2008*.

proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death. [10]

22. The broader purpose of 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.[11] Coroners are also empowered to report to the Attorney-General on 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.[12] These are effectively the vehicles by which the prevention role may be advanced.[13]

23. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

24. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown. Chris was a person placed in care – he was a patient detained in a designated mental health service and subject to a Temporary Treatment Order. An Inquest was thus mandated.

25. This finding draws on the totality of the material, the product of the Coronial Investigation into the death of Chris. That is, the court records maintained during the Coronial Investigation, the Coronial Brief and further material sought and obtained by

[10] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[11] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

[12] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[13] See also sections 73(1) and 72(5) of the Act 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.

the Court, the evidence adduced during the Inquest as well closing submissions from Counsel Assisting and Counsel representing the Interested Parties.

STANDARD OF PROOF

26. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in *Briginshaw v Briginshaw*. [14] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

27. The effect of the 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.

INVESTIGATIONS PRECEDING THE INQUEST

Identity

28. On 26 February 2016, Christopher Traill was visually identified by his mother, Beth Wallace at Bendigo Hospital and a Statement of Identification was completed.

29. Identity was not in dispute and required no additional investigation.

[14] (1938) 60 CLR 336.

Medical Cause of Death

30. On 27 February 2017, Forensic Pathologist Dr Matthew Lynch at the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination of the body of Christopher Traill and reported that the findings were consistent with the reported history noting that Dr Lynch had identified an ill-defined mark on the neck consistent with some form of ligature.

Toxicology

31. Toxicological analysis of blood identified Diazepam[15] ~0.4 mg/L and its metabolite, Nordiazepam ~0.3 mg/L, Desmethylvenlafaxine[16] ~1.0 mg/L and Paracetamol ~5 mg/L.

Forensic pathology opinion

32. Dr Lynch ascribed the cause of death of CHRISTOPHER TRAILL to hanging.

Coroners Prevention Unit[17]

33. At my request, the Coroners Prevention Unit (**CPU**) completed a review and provided a summary of deaths involving ligatures among Victorian mental health inpatients between 2000 – 2017.[18] In this review, the CPU identified 58 ligature-involved suicides in Victorian inpatient psychiatric units between 2000 - 2017.[19] Of the 58 ligature-involved suicides, 37 of them used personal items, and 11 of those were with belts. Among these suicides, as of 29 January 2018, Victorian Coroners had delivered

[15] Diazepam is a sedative/hypnotic drug of the benzodiazepines class.

[16] Desmethylvenlafaxine is indicated for the treatment of depression.

[17] The Coroners Prevention Unit was established in 2008 to strengthen the prevention role of a coroner, the CPU assists coroners with research in matters related to public health and safety. The Unit also reviews the medical care and treatment administered to patients in matters referred to it by a coroner where concerns have been identified. The CPU is comprised of health professionals with training and skill in a range of areas including medicine, nursing, public health and mental health. Any review undertaken by the CPU on behalf of the Coroner is intended to provide clarity to matters that are in dispute and assist the Coroner to determine whether further investigation is warranted, including by way of expert report, or whether there is sufficient material on which to finalise the investigation.

[18] Coroners Prevention Unit review of Ligature-involved suicide among the Victorian Mental Health In-Patient Units for the period 1 January 2000 – 31 December 201, dated 29 January 2018.

[19] Which included the death of Christopher Traill.

Findings in 53 deaths; 16 Findings included recommendations[20] regarding ligature points, and nine Findings included recommendations regarding access to ligatures.

Conduct of my Investigation

34. The investigation and the preparation of the Coronial Brief was undertaken by Detective Senior Constable (DSC) Andrew Hazelwood of the Bendigo Crime Investigation Unit (CIU) on my behalf.

INQUEST

35. Due to COVID-19 restrictions, the Inquest was conducted with the assistance of the Cisco WebEx platform.

Direction Hearing/s[21]

36. On 13 February 2020 a Directions Hearing was held. I was assisted by Senior Constable Jeff Dart (**S/C Dart**) from the Police Coronial Support Unit (**PCSU**). Interested parties included:

    - Mr B. James from Bowen & Knox Lawyers appeared on behalf of the family of Chris.
    - Mr Mark O'Sullivan from Minter Ellison Lawyers appeared on behalf of Bendigo Health.

37. The purpose of the Directions Hearing[22] was to discuss the progress of my investigation thus far with the Interested Parties, and what issues required further exploration at Inquest. I indicated to Mr O'Sullivan that there was material in the Coronial Brief that identified that it took eight minutes from the time the Code Blue was called and the Code Blue Team arriving at the Mental Health Unit; that this was perhaps due to the Team having difficulty locating the code location as no one from the Unit had come forward to chaperone the Team to the exact location. In addition, I indicated that the

[20] I have previously made a recommendation regarding the removal of items that can be used for self-harm in the Finding into Death with Inquest of Maria Nigro COR 2009 0829.

[21] See Transcript (**T**) of proceedings for 13 February 2020 – pp 1 – 19.

[22] On 15 January 2020 correspondence was sent to the Interested Parties advising them for the Directions Hearing date and identifying 5 areas for discussion: 1. The immediate circumstances of 25 February 2017; 2. Access and response times by code blue teams to the psychiatric unit; 3. The reasonableness of Dr Mona Hassaballa assessment of Mr Traill; 4. The reasonableness of Nurse Daw's assessment of Mr Traill and the decision to allow Mr Traill to keep his belt; 5. Mr Traill's assessment prior to and return from leave.

enabling of in-patients to retain personal items that can be used for self-harm[23] purposes was of concern to me, and queried whether the risk assessments undertaken by Nurse Daw and Dr Hassaballa enabling Chris to retain personal items were adequate for the circumstances.

38. On 3 April 2020, correspondence was received through the legal representatives for Bendigo Health addressing the matters raised by me at the Directions Hearing on 13 February 2020 which were relevant to the Code Blue response. Associate Professor Phillip Tune (**A/P Tune**), Clinical Director of Mental Health Services at Bendigo Health was the author and advised that Chris' death had occurred within the first 3 weeks of the move to the new hospital campus. The Code Blue Team were still unfamiliar with the layout of the very large and brand-new hospital. Familiarity with the layout of the hospital and the location of all the units was soon achieved and thus ameliorated the risk that such a delay would occur again. A/P Tune also provided assurance that a system had been implemented whereby a staff member from a unit where an emergency code has been activated is required to meet the responding team at the entry to the precinct to guide the responding team to the specific unit.

ISSUES INVESTIGATED AT THE INQUEST

39. I was satisfied that A/P Tune had adequately addressed my concerns regarding the issues surrounding the delay in the Code Blue Team arriving at the scene of Chris' hanging both in relation to the Team locating and accessing the Unit and thus the overall time that it took them. It was therefore not necessary to explore these issues further at the Inquest.

40. The remaining issue to be explored remained the reasonableness or otherwise of allowing patients to retain personal items that could potentially be used for self-harm purposes.

[23] I also referred to the Coroners Prevention Unit review of Ligature-involved suicide among the Victorian Mental Health In-Patient Units for the period 1 January 2000 – 31 December 2017, dated 29 January 2018..

Appearances

41. S/C Dart continued to act as Counsel Assisting the Coroner. Mr Gary Taylor of Counsel appeared on behalf of Chris' family and Ms Debra Foy of Counsel appeared on behalf of Bendigo Health.

***Viva Voce* Evidence at the Inquest**

42. *Viva voce* evidence was obtained from the following witnesses through the Cisco WebEx medium:

- Dr Mona Hassaballa, Consultant Psychiatrist[24]
- Kathleen Daw, Registered Nurse[25]
- Associate Professor (A/P) Peter Doherty, Independent Expert Psychiatrist – on behalf of Bendigo Health.[26]
- A/P Phillip Tune, Consultant Psychiatrist & Clinical Director of Mental Health Services, Bendigo Health.[27]

Dr Mona Hassaballa, Consultant Psychiatrist

43. Dr Hassaballa explained that her responsibilities as the on-call psychiatrist over a weekend are different to those of the treating psychiatrist working Monday to Friday.[28] These responsibilities would include seeing every new admission, reviewing management plans if necessary and liaising with treating teams but the interaction with patients is *less comprehensive*[29] and the Monday to Friday treating psychiatrist *involves a lot more involvement in someone's life and care, and it has an element of continuity, which doesn't happen on a one-off contact over the weekend*.[30]

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[24] Exhibit 1 – Statement of Mona Hassaballa dated 22 May 2017 (with amendment on p 19).

[25] Exhibit 2 – Statement of Kathleen Daw dated 27 July 2017.

[26] Exhibit 3 – Statement of A/P Peter Doherty dated 20 December 2019 & Exhibit 4 – Statement of A/P Peter Doherty dated 3 March 2020 (as amended).

[27] Exhibit 5 – Statement of A/P Phillip Tune dated 4 January 201 (with attachments), Exhibit 6 – Second statement of A/P Phillip Tune dated 9 March 2018 & Exhibit 7 – Third statement of A/P Phillip Tune dated 3 April 2020.

[28] T at p 54.

[29] T at p 54.

[30] T at p 55.

44. As Chris was admitted under an Assessment Order under the Mental Health Act, he was required to be assessed within 24 hours of admission by a Consultant Psychiatrist. For her assessment of Chris, Dr Hassaballa had access to Chris' medical records including the KCHMT records but because it was a weekend, she did not have the opportunity to speak to Dr Kirby or RPN Neilson[31] about their involvement with Chris. Similarly, Dr McAlpine who had assessed Chris on 24 February 2017 for the purposes of his admission, was also not available over the weekend for Dr Hassaballa to speak to. She did however have Dr McAlpine's assessment of Chris.

45. Dr Hassaballa placed Chris on an ITTO because there was concern regarding his ability to follow through on the agreed plan that he would abstain from alcohol. He appeared to have been minimising the risks associated with his drinking *and the impact it has on his mental health and the potential element of impulsivity that can be associated with that.*[32] He was articulating that he felt betrayed by the Community Team and was refusing to remain in hospital as a voluntary patient – Dr Hassaballa *didn't feel that it was safe for him to leave the hospital*.[33] Chris was denying any active plans or suicidal ideation but Dr Hassaballa said that it was clear from his history that whenever he started drinking alcohol *his depressive symptoms became too intense for him to handle and there was a risk of him acting impulsively*.[34] At the time of her assessment Chris was however sober having been free of alcohol for at least 24 hours and he was engaging, *recounting events that were very difficult for him to remember*.[35]

46. As Dr Hassaballa was finishing her review of Chris, his family arrived at the hospital. She met with Chris' partner and his mother in a separate room while Chris interacted with his two younger children in another. Dr Hassaballa then met with Chris, his partner and mother without the children before granting Chris two hours of leave within the confines of the hospital grounds to share with his family with the intention to:

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[31] T at pp 23 - 24.

[32] T at p 26.

[33] T at p 26.

[34] T at pp 26 – 27.

[35] T at p 59.

..normalise the experience for the family and at the same time provide Chris an opportunity to demonstrate to everyone that he can act responsibly and he is working towards what's in his best interest and working with the team.[36]

47. Dr Hassaballa stated that she was not personally involved in any decision about Chris' personal items – whether he could retain them or whether some should be removed from him. She said that issue was addressed the night before – by the admitting Registrar[37]– this was part of the management at the first point of contact. She said that the mere fact that that Chris had been placed on 15-minute observations, *I can only speculate that I would have made a mental assumption that those items were already removed and he didn't have access to anything that can be potentially dangerous ...*[38] She said that unless there was a reason for her to be personally involved in that type of decision about the removal of personal items from a patient, most of the time the responsibility would fall to a more junior doctor or the nursing staff.[39] She said that it would be impractical for the Consultant Psychiatrist to be involved in a process checking for personal items – she said the process was in place and *we have to allow other professionals within different disciplines to just use their own skills and cover us in areas without us having to oversee each other every decision we make*.[40]

48. Dr Hassaballa was reluctant to take a position on mandating the removal of all personal items that could be used for self-harm from all patients being admitted to an in-patient psychiatric unit. She preferred that this be done on an individual basis, as it currently is, for fear of removing the patient's sense of individuality. She did however concede somewhat that a "blanket rule" for all patients entering the Unit may be easier to manage. Overall, she remained that individual assessment of risk and the current mandate for removal of plastic bags and all cords was sufficient. Taking all patient's personal items such as belts may mean that their trousers could lose their functionality

[36] T at p 29.

[37] T at p 35.

[38] T at p 36.

[39] T at p 37.

[40] T at pp 81 – 82.

and may therefore not be able to be worn.[41] Dr Hassaballa was also sceptical about the effectiveness of making available alternative clothing, such as tracksuit pants, because even if the advantage was of it being *safer for the unit* the risk *was it takes away their sense of individuality and it makes them feel like they are being imprisoned rather than being treated as individuals.*[42]

Kathleen Daw, Registered Nurse

49. Nurse Daw[43] stated that when a patient is admitted to the psychiatric unit the admitting nurse will see what the patient has on them and what possessions they have. Her practice was to go through the possessions on her own in the first instance and then to go through them with the patient. She would remove any item that was potentially dangerous for that person.[44] If a doctor had already reviewed the patient any items to be removed from the patient would be based on the doctor's risk assessment.

50. Nurse Daw said that there was no specific checklist for use for recording the removal of the patient's items, but her practice was to record the removal of an item in her own notes. When taken to the relevant policy/protocol[45] in place at the time of Chris' death, Nurse Daw said she would have been shown the policy as part of her nursing training and that it would have been the subject of an in-service educational session, or more than one, that she would have attended over the years[46] although she could not be any more specific.

51. Nurse Daw said that she was aware that Chris had a belt – she had been observing him on the hour and he was for the most part lying on his bed. She said that it went into her mind that he had a belt but at the same time she thought, *well, he's in the LDU. He's on 60 minute obs and as I talking with him now, I felt it wasn't a risk and I didn't think*

[41] T at pp 41 – 42.

[42] T at p 42.

[43] Nurse Daw had worked as a registered psychiatric nurse for approximately 37 years and had predominately worked at Bendigo Hospital.

[44] T at p 92.

[45] *Criteria for Searches to Maintain Safety on an Inpatient Unit – For Patients, Visitors and Staff. Protocol*, CB at pp 127 – 145.

[46] T at pp 97 – 98.

anything more about it at that time.[47] Nurse Daw was also aware that Chris had also just returned from leave and that he had said that the leave had gone well.[48]

52. The relevance of 60-minute visual observations to Nurse Daw was that she *would see that as a person being safe to be by themselves*[49]*, because a lot of things can happen in 60 minutes, whereas 15 minutes is a lot more intense.*[50] In relation to her interactions with Chris specifically, Nurse Daw said that he appeared calm, did not appear anxious or agitated and was happy enough to answer her questions to him. He seemed stable in his mental state and responded in the negative when she asked him if he had any plans to self-harm. Nurse Daw stated that Chris gave her no indication that he was at risk of anything.[51] In all of those circumstances, it was routine to allow patients to retain personal items such as a belt.

53. Later in her evidence Nurse Daw agreed with Mr Taylor that she had also recorded that Chris was not happy being on the ward, that he was anxious on the ward, that she had provided Chris with Diazepam because he was agitated and that he had retreated to his bedroom because he had had a long day because of the consultation with Dr Hassaballa.[52]

54. Nurse Daw agreed with the proposition put to her by Counsel Assisting that it would be beneficial to her if the psychiatrist completing an assessment of the patient actually made a note about the patient's access to personal items. She said that it would then make the process very clear particularly if there was also an indication/notation at what risk level the personal items could be returned to the patient. When asked how the process could be improved on, Nurse Daw said that with the benefit of hindsight she

[47] T at p 99.

[48] T at p 102.

[49] Chris had been on leave with family members.

[50] T at p 100.

[51] T at p 101.

[52] T at p 130. See also Exhibit 2 – Statement of Kathleen Daw dated 29 July 2017.

thought all items, including belts, that could be used for self-harm should be removed from the patient[53] On further reflection, she said:

I would like to see all belts removed from everybody, because clearly in my experience of this, Chris presented in such a calm mental state. I couldn't fault in him in his presentation, and I think I would have rather have seen that belt not on him, just to be sure, from now on yes, definitely…because I can't predict what somebody is thinking inside their head and planning inside their head.[54]

A/P Peter Doherty

55. Initially critical of Dr Hassaballa for granting Chris two hours leave with his family when he was on hourly observations[55], A/P Doherty conceded the leave had the potential for an improved therapeutic relationship with Chris and Bendigo Health clinical staff and said that it was not just a decision made by Dr Hassaballa, it was a decision made in the context of a family meeting that morning and it should be seen as part of the treatment plan, and a strategy to remove the stigma or reduce Chris' disgruntlement about being in hospital.[56] He said *it was an appropriate clinical decision*[57] although he was somewhat surprised, later in his *viva voce* evidence when Counsel Assisting informed him that Chris had been on 15-minute visual observations at the time he went on leave and was only formally placed on 60-minute visual observations by Dr Hassaballa when he returned from leave. A/P Doherty responded that it was most unusual to go from 15-minute observations to two hours leave.[58]

56. Similarly, A/P Doherty said he agreed with the recommendation of Dr Kirby that Chris should be admitted rather than remaining in the community as had been originally decided. Dr Kirby was faced with the dilemma of weighing up the benefits of remaining in the community versus the risk that his drinking of alcohol increased his

[53] T at p 105.

[54] T at p 127.

[55] T at p 161 – 162.

[56] T at p 152.

[57] T at p 153.

[58] T at p 205.

suicidality, his partner's concern that she could not stop him drinking and that the available community support over a weekend would not be enough to keep Chris safe – *the CATT team visiting won't stop him drinking.*[59] The relationship between alcohol and increased suicidality is due to the depressive effects of alcohol combined with its effect of lessening inhibitions.[60] He agreed that Chris' risk of suicide was higher when he was drinking.[61]

57. And specifically in relation to the issue about whether in-patients, and in particular, compulsory patients, should or should not be allowed to retain personal items that may be used for self-harm, A/P Doherty said that the issue is one of *judgement with regard to the level of risk that is present and what the assessment of the potential risk is*.[62] He said the level of observations is determined by the assessment of risk and that 60-minute observations mean the patient's risk has changed – 60-minute observations *is a determination made with regard to the risk strategy in terms of management of the person.* And the fact that a patient *is on 60-minute observations does not lower the risk, it just means that is part of the strategy with regard to management of the risk.* Additionally, A/P Doherty explained that *the risk strategy for each patient has to be proportionate and appropriate in line with what the assessment of risk is* and that it was dynamic/changing all the time.[63] He said it was the *wrong way around* for Nurse Daw's reasoning not to take personal belongings/Chris' belt from him, to be based on the fact that Chris was on 60-minute observations.[64]

58. A/P Doherty said he would not countenance a blanket rule to remove all personal items that could be used for harm. He said that a decision to remove personal items had to be judged on its merits by asking *what is the potential risk and is the decision by staff proportionate to the loss of the item by the person, or the potential harm that could be*

[59] T at p 154.

[60] T at p 155.

[61] T at p 193.

[62] T at pp 163 – 164.

[63] T at p 210.

[64] T at pp 164 – 165.

caused if they retained the item.[65] He said that the law does not allow you to take things away except in cases where there is a significant risk to the patient. The advantage of allowing a patient to retain personal items even if they could be used for self-harm, is the normalisation of the person – how they normally dress and how they look is a positive thing for that person when they are an in-patient in a psychiatric facility. The disadvantage is that the item can be used for self-harm.

59. When asked by Mr Taylor at what point should a treating psychiatrist or nurse turn their mind to items in the possession of the patient that may pose a risk to their safety, A/P Doherty set out the mental process. He said:

They should turn their mind to that after they've assessed the person, after they have taken a comprehensive history, after they have examined the mental state of the person, after they have talked to the family, after they have talked to any other person, and then and only then should they turn their mind to what is the strategy we should put in place to minimise risk in this case.[66]

60. A/P Doherty also maintained his opinion that Nurse Daw was justified in leaving Chris with his belt despite having his attention drawn to the hospital's policy/protocol[67] regarding searches stating that these should only be considered if clinical staff have seen a tangible risk – tangible risk to any person being defined as "stemming from a reasonable suspicion that a search of a patient, their room or belongings, may yield objects or substances which may cause them any harm." A/P Doherty responded that the policy has got qualifying points – it has to be tangible.[68] A search was not required to ascertain that Chris had a belt and regardless, staff have a discretion on whether to remove personal items. In exercising that discretion A/P Doherty agreed with Ms Foy that the dignity of the patient has to be considered and removing a man's belt, particularly if it is holding up his trousers is *very likely to be construed by a man as a*

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[65] T at p 168.

[66] T at p 180.

[67] *Criteria for searches to maintain safety on an inpatient unit – For patients, visitors and staff. Protocol.* - see p 127 CB.

[68] T at p 188.

loss of dignity.[69] Ms Foy and A/P Doherty sought to further speculate that Chris would have felt a greater loss to his autonomy if his belt had indeed been removed from him [70]

A/P Phillip Tune, Consultant Psychiatrist & Clinical Director of Mental Health Services, Bendigo Health

61. As a part of his role as Clinical Director of Mental Health Services at Bendigo Health, A/P Tune chairs the Quality and Risk Committee and the Operational Management Group or Senior management Committees and as such has oversight of policy protocol and procedure as they apply to mental health services.[71] A/P Tune also has the responsibility to ensure that any recommendations from the Chief Psychiatrist for changes to policy or processes are reflected in Bendigo Health's policies and practices.[72]

62. In relation to the specific protocol,[73] A/P Tune described the process leading up to the removal of personal items from a patient, explaining that when a patient is being admitted into the Unit the admitting nurse has a number of responsibilities towards that patient including making the patient feel welcome and orientating them to the Unit. He said that as a routine part of the admission process certain items may be removed from them.

    One of those responsibilities is to go through the person's belongings with them preferably to ascertain that there is nothing illegal, inappropriate, or dangerous in their possession which may need to be removed, or something that is quite valuable.[74]

63. If the admitting nurse identifies that an item needs to be removed from the patient's person, where the item is stored will depend on how it is classified. For example, a valuable item will be stored securely on the hospital premises and a receipt is provided

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[69] T at p 199.

[70] T at p 200.

[71] T at p 221.

[72] T at p 222.

[73] *Criteria for Searches to Maintain Safety on an Inpatient Unit – For Patients, Visitors and Staff. Protocol.* - see p 127 CB.

[74] T at p 223.

to the patient and the staff. A dangerous or illicit item/substance may be surrendered to the police. An otherwise innocuous item or item of clothing deemed necessary to remove would be placed in a basket with the patient's room number on it and then placed in a locked room, but these items are not individually itemised or receipted. The removal from the patient of a specific possession or item of clothing, should be recorded in the admission notes or nursing progress notes. A/P Tune said:

..if it was considered that a personal item could be used for harm, that would be removed from the patient if the risk assessment indicated that that was warranted, in which case it would be documented. [75]

64. But items left with the patient, even those that have a potential to be used for harm are not recorded according to A/P Tune. It is the exceptions or changes that are recorded, for example, *the change would be they are going to have the item of clothing removed*.[76]

65. A document called *Generic Adult Patient Admission and Discharge Pathway* (**GAPAD**) replaced a document in the mental health Unit called *Psychiatric Services Inpatient Admission Pathway* although A/P Tune could not recall when this occurred in relation to Chris' death. The GAPAD has a 'tick box' specific to recording 'Property search completed' with additional space to itemise/describe items that have been removed from the patient. However, A/P Tune confirmed that no such document was in Chris' file.[77]

66. When items that were previously removed from a patient are returned to them, they will not, as a matter of course, be documented but if they are returned to a patient in the context of an ongoing risk, A/P Tune said that *the expectation would be that they are carefully documented and the reasons for doing it.*[78]

[75] T at p 227, 232, 236.

[76] T at p 233.

[77] T at p 237, 238.

[78] T at p 241.

67. The policy in relation to the removal of items from a patient that has been in place since Chris' death[79] includes a list of potentially dangerous items in Appendix 1 of the document.[80] Belts are specifically listed in Appendix 1 and as A/P Tune stated, *is in line with the Chief Psychiatrist's Guideline on this matter* and from which Bendigo Health's policy heavily borrows.[81] Clinical judgement is exercised in making a decision to remove an item that is "inherently innocuous but potentially dangerous" and again A/P Tune stated that their policy is consistent with the Chief Psychiatrist's Guideline. Belts are treated differently from plastic bags because plastic bags pose a risk and are readily replaced with an appropriate alternative such as a paper bag and are not needed in an in-patient Unit – plastic bags are not allowed in the Unit. On the other hand, although conceding that there were also alternatives available for belts, whether they were appropriate, A/P Tune said, was a matter for judgement.[82] He said that in some cases for example in the "old person's unit" many of the gentlemen wear quite baggy pants which would *absolutely fall down* if they did not have a belt which in turn would *create a falls risk*.

68. An alternative proposition to wearing trousers/pants that required a belt to stay up was put to A/P Tune by Counsel Assisting – advising a patient such as Chris who was being admitted from his home, to bring in tracksuit pants (because belts are prohibited in the Unit) or for the Unit to provide tracksuit pants. His response was quite emotive. He said:

Now, you know, my personal view is I won't be seen outside my house in tracksuit pants. I don't think anyone should wear tracksuit pants in public personally, I think they are appalling. And I would feel personally very demeaned and humiliated if I was required to wear tracksuit pants as well as being admitted compulsorily to a psychiatric inpatient unit. And I can imagine that Chris was exactly that sort of person

[79] A/P Tune advised that the protocol contained in the CB at p 56 – called *Searches of Patient's and Visitor's in Psychiatry Inpatient and Residential Units Protocol* (noted to have been approved by the governing committee on 28/07/17) has been replaced with a further version dated 28 June 2018 although he said that *the differences are not substantial*. – T at p 241.

[80] See p 71 CB.

[81] T at p 242.

[82] T at pp 245 – 246.

as well, being a professional man, being a proud man. I think that would have quite possibly added to his distress.[83]

69. A/P Tune continued to express his disdain of tracksuit pants and the risk they posed of increasing the stigma of psychiatric patients around the hospital, including but not limited to the unintended risk of a psychiatric patient attending the hospital coffee shop in tracksuit pants which could result in colleagues of A/P Tune pointing them out with a *nudge nudge, wink ,wink – look they're a psych patient.*[84] A/P Tune said that attempts had been made to minimise the stigma attached to psychiatric patients including from a geographical perspective by ensuring the new hospital had all the units located inside the hospital and co-located with part of the physical infrastructure. He said they wanted psychiatry to be seen as a part of medicine, as a part of health and not stigmatised by being seen as in an asylum and *dressed like One Flew Over the Cuckoo's Nest*.[85] He said that Chris was *the quintessential person who looks nothing like the stereotype of the psych patient….he was an articulate, well groomed, neatly dressed, calm, cooperative, pleasant, nice man. So you don't want to stigmatise….you don't want to have people thinking he's a psych patient.* A/P Tune further reflected that Chris felt a sense of shame about the notion of having to go before a magistrate on the drink driving charge and that he felt shame about his admission to hospital and opined:

I think he would have multiplied that shame by saying ….you've also got to dag around in trackie daks.[86]

70. A/P Tune did acknowledge that the in-patient Unit had a stock of second-hand clothes and spare toiletries that could be used to provide "something appropriate"[87] for new patients to wear in circumstances where no pre-planning for admission had been possible.[88] In providing this information he made no reference to the potential shame or

[83] T at pp 246 – 247.

[84] T at p 247.

[85] T at p 247.

[86] T at p 248.

[87] T at p 315.

[88] A/P Tune had previously said "about 50 per cent of our patients are compulsorily admitted …done in a fairly quick manner … so they actually don't have the opportunity to go back home" - T at p 295.

stigma these patients might experience by being provided with appropriate clothing and other personal items from a psychiatric unit.

71. In relation to Chris' risk, A/P Tune did agree with Mr Taylor of Counsel that risk was a dynamic concept and that although Dr Kirby had advised Dr McAlpine that "Chris minimises his drinking and suicidal intention" and that she was of the view that Chris was "extremely high risk", he said that it was a very reasonable conclusion for staff to reach that his risk was significantly reduced by admission.[89] The immediate cause for his admission being *the concern in relation to being able to support him sufficiently over the weekend, particularly in the context of his ongoing access to alcohol and his difficulty containing himself in using alcohol, which is an important dynamic risk factor.* Chris' suicide attempts had formed the basis of the admission to the Royal Melbourne Hospital and although this was important information to be known, these suicide attempts were not the immediate cause for this admission.[90] On admission the observations of Chris were that his risk had been appropriately estimated according to A/P Tune and the plan in place was suitable – he was calm, able to concentrate, sitting reading, eating, sleeping and engaging with staff and not demonstrating behaviours that would make staff raise the risk awareness and be more concerned.[91]

72. A/P Tune did acknowledge that there was also evidence that Chris was "agitated" and "anxious on the ward".

73. A/P Tune was also taken to the internal review undertaken by the Health Service after Chris' death. He said that the outcome was aimed at strengthening the clinical context within which a search of a patient is to be undertaken. A/P Tune read from his statement:

    To summarise the findings of the root cause analysis undertaken by the service it was concluded that the policy for searching patients could be strengthened by giving clearer direction and examples regarding circumstances that would make a search and

[89] T at p 265.

[90] T at pp 266 – 267.

[91] T at p 272.

removal of certain personal belongings necessary, reasonable and proportionate to the risk of harm.[92]

74. Any search should only be considered if a clinical assessment identifies a serious risk[93] to patient, staff or others if a search of the patient, their room or belongings may yield objects/substances which may cause significant harm.

75. Overall, A/P Tune emphasised that they tried to manage their patients in the least restrictive environment as prescribed by the Mental Health Act and that required giving the person autonomy and dignity and self determination which, as I understood A/P Tune's evidence did not sit well with a process of removing personal items from them.

76. Towards the conclusion of A/P Tune's *viva voce* evidence I asked him to clarify his oft reference that the intention of Chris' admission was to have him stop drinking. He agreed with me that a person would not be admitted to a mental health Unit solely on grounds that they needed to stop drinking – that it was indeed more complex – that there needed to be other signs of mental ill health for an admission to occur. He clarified by saying:

We certainly would not admit him [Chris] just to stop him drinking but in the context of having a moderately severe depressive illness which we know is exacerbated by alcohol both in terms of the – well, alcohol stops you recovering. It effectively opposes the action of anti-depressants so it makes it much harder to recover but it also acutely exacerbates the depressed mood and impresses the risk of suicide through disinhibition. So it is a very significant dynamic risk factor and to be able to remove that dynamic risk factor from the equation was the reason for admission.[94]

Subsequent enquiries

77. At the conclusion of the *viva voce* evidence from the scheduled witnesses I agreed with a submission from Mr Taylor that clarification should be sought from Dr McAlpine about her comments in her Discharge Summary dated 30 March 2017 that Chris' belt

[92] CB at p 53 (Exhibit 5 – Statement of A/P Phillip Tune), T at p 279.

[93] The use of "serious risk" had changed from the previous policy which used the words "tangible risk".

[94] T at pp 319 – 320.

and shoelaces should be removed from him. A statement dated 11 December 2020 was subsequently received from Dr McAlpine stating that she had a clear recollection that she did form that opinion after her review of Chris in the presence of RN K S Donnan (**Nurse Donnan**) however, Nurse Donnan did not agree. Dr McAlpine further conceded that she did not make a contemporaneous note of her opinion/assessment or of her discussion with Nurse Donnan.[95] I accept that Dr McAlpine never gave a specific instruction to remove Chris' belt and/or shoelaces and in the absence of a contemporaneous recording of her opinion I accept that there was no documentary opinion/instruction or plan for other clinicians (which includes nurses) to follow arising from the admission review of Chris.

COMMENTS

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

1. In a custodial or institutional type setting such as a LDU in a mental health facility, eliminating access to means of self-harm is recognised as a significant suicide prevention method. The Chief Psychiatrist has developed Guidelines titled *Criteria for searches to maintain safety in an inpatient unit – for patients, visitors and staff*[96] with the first "Key message" of the Guidelines stating:

   As the safety of patients, visitors and staff of mental health services is paramount, patients should not have access to items that are dangerous or may lead to harm to self or others or assist in absconding during their inpatient stay.

2. Despite the Chief Psychiatrist's Guideline and attempts by individual facilities to base their own policies/protocols around the Guideline, it remains a vexed task for the clinicians in an in-patient Unit and requires vigilance on their behalf as risk is not inanimate but fluid and often labile. Some items brought into the Unit by patients are "obvious" high risk items and are removed without hesitation – plastic bags, lighters, for example. But other items, albeit that they are recognised for their potential to be used for self-harm, are allowed to be retained by the patient in the Unit if their risk is

[95] It had already been established that Nurse Donnan similarly made no note of that discussion with Dr McAlpine.

[96] CB at p 172.

assessed at any level other than high. It is not consistent, it is not an equitable approach, and it is clearly fraught. I fear that an over emphasis on "managing people in the least restrictive means possible" has confabulated how that should be achieved in an in-patient Unit in general, and also specifically, as it did with regard to Chris.

3. From the information provided[97] to me from A/P Tune, the admission process appears robust. The initial interview undertaken on admission is performed by a "doctor in training" – a registrar or hospital medical officer accompanied by a nurse, and a psychiatric review is undertaken within 24 hours of the admission. This all occurred but there is not one document or entry in any notes, other than Dr McAlpine's retrospective 'Discharge Summary', that anyone turned their mind to the removal of Chris' personal items that could be and were indeed used for, self-harm. I am therefore left to contemplate whether this lack of documentary evidence reflects some conscious decision to care for Chris in the least restrictive manner, or that it just happened without any conscious reflection about his personal items and/or what caring for him in the least restrictive manner might constitute, given his actual level of risk. At best, the process for removing personal items "lacks clarity" as stated by Nurse Daw but as I am left to construct what might have been factored into the making of the decision to allow Chris to retain his personal items, his belt, I can only conclude that the process is unsatisfactory and falls below best practice, regardless of the evidence of A/P Tune and the submissions of Ms Foy that *the process is clear and that is the task of the admitting nurse in consultation with the admitting doctor to determine whether items should or should not be removed.* [98] The contrary evidence of an employee responsible for the implementation of this "clear process" reflects a systemic problem.

4. It is noteworthy that both Dr Hassaballa and Nurse Daw supported a 'blanket rule' that all personal items be removed from patients on the grounds that such a process would be easier to manage.

5. The evidence of A/P Tune, reiterated by Ms Foy in her closing submission that clinicians should not have to record what items are left with a patient, only what is removed – recording by exception; as this would be over burdensome, is somewhat

[97] T at p 260.

[98] T at p 347.

misguided. Clinicians are apparently *already drowning in a considerable amount of administrative paperwork* [99] but this comment *prima facie* misses the point that clinical records of a patient's care are intended to act as a means of communication, as an *aide memoir* and are also a legal document. The absence of any documentation that reflects that any one clinician turned their mind to Chris' personal items reflects a complete lack of communication in this regard, provides no reference that acts as the *aide memoir* to clinicians and reflects a gap in the clinical record that is the legal document. A stand-alone document that reflects that the clinician – likely nursing staff – have turned their mind to the patient's personal items is unlikely to lead to them drowning in paperwork particularly if such a document remains simple but fit for purpose. For example, *Have you checked or spoken to the patient about personal items in their possession* – yes/no; *if no why not? – provide reasons*; *have you removed any personal items from the patient* – yes – *please list*; *have you identified any personal items with the patient that may be used for self-harm but have been left in the patient's possession?* – if yes, *list the items and state why they have been left with the patient* – for example: belt and shoe laces – patient has been assessed as low risk / patient has not yet had psychiatric assessment for example.[100]

6. I acknowledge that the objectives and the principles as set out in the *Mental Health Act 2014* state that a person receiving mental health services should be provided with assessment and treatment in the least restrictive way possible and should have their rights, dignity and autonomy respected <u>but</u> these objectives and principles should not be 'wheeled out' and regurgitated for an excuse as to why something was not done, why all care and responsibility towards the patient in a facility's care was not discharged or indeed, cannot be proven to be discharged. There must be a balance between the duty to provide reasonable care, keeping the patient safe and endeavouring to do it in the least restrictive way according to the circumstances. It cannot be ignored that Chris was admitted as a compulsory patient and remained a compulsory patient after a psychiatrist

[99] T at p 348.

[100] This example of content for a document to specifically address decision making over either removing or allowing retention of personal items is not intended to be prescriptive or to reflect the extent of the information that may need to be collected by clinicians in regard to the patient's personal items – it merely reflects my thoughts at the time of writing this Finding.

reviewed him. He was a risk to himself. It is thus understandable that Mr Taylor, on behalf of Chris' family would submit *if the admission for a compulsory treatment order is to provide treatment, then to allow him to have an item that has the potential to be used for suicidality defeats the very purpose of the admission*.[101]

7. The suggestion that tracksuit pants could be routinely supplied to patients, prompted outrage from A/P Tune. This suggestion for the supply of tracksuit pants arose in part, from A/P Tune stating with some authority that a good many male patients' pants would fall down if belts were removed from them routinely rather than being determined on an individual basis. His demonstrated outrage was curious, bordered on theatrical and was generally unhelpful. A/P Tune did not support his strident views with any empirical evidence but instead sought to emphasise his outrage by using antiquated references to asylums and classical movies, but even more worrying was A/P Tune's reference to a culture within his own hospital that mimicked a classical Monty Python scene rather than the tolerant and inclusive environment he would have me believe he has been involved in creating. His personal views that no one should be allowed to wear tracksuit pants outside their own home was somewhat autocratic and supercilious[102] and clearly made by someone who has not kept up with current acceptable dress codes. Furthermore, A/P Tune's gratuitous comment that Chris' personal shame about his actions whilst intoxicated would be multiplied if he had to wear "trackie daks" in the Unit appears to have erupted from his own festering prejudice and was unbefitting of a person in an esteemed professional position. Consequently, I have attached little weight to his evidence in this regard.

8. I was also somewhat perplexed at the over simplified explanation given for Chris' admission from both A/P Tune and A/P Doherty. Both Associate Professors referenced that the intention of admission was to have Chris stop drinking. In an inquisitorial process I expect that two prominent psychiatrists would be forthcoming in their evidence to provide me with a clarification on the reasons for or intention of admission in a matter I am investigating, without the need for me to specifically seek it.

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[101] T at p 367.

[102] I informed A/P Tune that I felt his views on tracksuit pants were somewhat "middle class" – to which he agreed. – T at p 320.

9. I agree with Ms Foy that the circumstances specific to Chris' death do not relate to the Search Policy *per se* as it was never necessary to undertake a search of his belongings or about his person. The item that he had in his possession and was known to be an item that could be used for self-harm and was not just suspected to be in his possession but was also seen to be in his possession. And for that very reason it is not helpful to then speculate that Chris would have used some other means to facilitate his intentions even if his belt had been removed from him on the basis that *he was clearly an intelligent and resourceful person, that had he formed an intention to commit suicide that night, there would have been other means available to him besides his belt*.[103] But removing his belt would have minimised the risk by reducing the means available to him. Reducing the means equates to minimising risk and that should be a priority for an in-patient Unit.

10. Similarly, it is unhelpful to speculate that Chris' *suicide later on Friday 25 February was entirely impulsive*[104] based on his perceived openness about his previous suicide attempts, his shame and his previous history of alcoholism and that he advised Nurse Daw that night that he had no intention to take his own life.[105] Equally relevant but forgotten from this analysis is the reporting by Nurse Daw that Chris was "anxious" and requested Diazepam. It was also known that he was not happy about being in the Unit. Also missing from this analysis is the equally but contrary possibility that this same *intelligent and resourceful person* had a plan.

11. Also missing from the analysis about the use of a personal item as a means to harm self is any evidence that supports these oft repeated principles that anyone turned their mind to the dignity, inclusiveness, managing in the least restrictive manner or indeed possible shame that might be caused by removing Chris' belt. Nor is there any evidence that a conscious decision was made to allow him to keep his belt because his pants would fall down. And if it was never determined that his belt had a functional facility rather than a mere accessory, Ms Foy's statement that it would have been returned to him, assuming

[103] T at p 357.

[104] T at p 358.

[105] T at pp 358 – 359.

it may have been removed on admission, when Chris went on his leave, is of itself *impermissible hindsight reasoning.*

12. In 2015 I completed a *Finding into Death with Inquest* in the matter of Maria Teresa Nigro[106] who died at Werribee Mercy Hospital. Ms Nigro was an involuntary patient and used her dressing gown cord for the purposes of self-harm. At that time I made the following Recommendation:

    With the aim of minimising risk and preventing like deaths, I recommend Mercy health develop and implement policies and procedures for the LDU whereby access to items that may be used to self harm are removed or reduced. Such policies and procedures should include checking patients and the unit for potentially harmful belongings and belongings that could be used for self harming purposes, monitoring items brought into the unit by visitors and educating visitors on the potential risks associated with such items.

13. In 2018 Coroner Rosemary Carlin (as she then was) completed a *Finding into Death without Inquest*[107] in the matter of Joy Maree Guppy who while a voluntary patient at the Alfred Road Clinic, a private psychiatric clinic, used her dressing gown tie as a means of self-harm and later died at the Alfred Hospital. Coroner Carlin's Recommendation related to the removal of potential ligatures within the facility but in her Conclusions, she poignantly said:

    Patient safety should be the paramount consideration. It is a tragedy that mentally unwell patients are killing themselves in potentially preventable situations. I do not consider it unreasonable to make a condition of entry to inpatient psychiatric facilities that patients surrender any obvious potential ligatures and agree to lawful searches on clinical grounds, throughout their stay.

14. I concur with my colleague and reiterate the use of the word "tragedy" to describe the loss of life within our mental health facilities in potentially preventable circumstances.

[106] COR 2009 0829

[107] COR 2015 0531

RECOMMENDATIONS

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

1. With the aim of preventing like deaths and promoting public health and safety within a mental health in-patient unit, I recommend that on admission to the in-patient Unit, Bendigo Health mandate the removal of all personal items that could be used for self-harm as described as "Dangerous Items" in the Chief Psychiatrist's Guideline.

2. With the aim of preventing like deaths and promoting public health and safety within a mental health in-patient unit, I recommend that Bendigo Health review their processes related to identifying personal items that have the potential to be used for harm and without identifying all the specifics that should be considered within that review, I recommend it should include reference to whose responsibility it is to make the assessment, to document the assessment and whose responsibility it is to implement the removal of said identified items.

3. With the aim of preventing like deaths and promoting public health and safety within a mental health in-patient unit, I recommend that Bendigo Health implement a practice of providing patients alternative items to replace any personal items removed for risk minimising purposes.

FINDINGS

Pursuant to 67(1) of the *Coroners Act 2008* I make the following Findings:

1. I find the identity of the deceased was CHRISTOPHER TRAILL born 26 September 1961, died on 25 February 2017 at Bendigo Base Hospital, Bendigo Health Care Group, 100 Barnard Street Bendigo, Victoria 3550

2. I find that at the time of his death, Christopher Traill was a compulsory or involuntary patient at Bendigo Base Hospital, subject to a Temporary Treatment Order under the *Mental Health Act 2014.*

3. I accept and adopt the cause of death as ascribed by Dr Lynch and I find that Christopher Traill died from hanging in circumstances where I find that he intended to take his own life.

4. AND I further find that the lack of clarity surrounding the process for removing personal items that have the potential to be used for harm contributed to the circumstances that facilitated the intentions of Christopher Traill to harm himself and as such, I find that the death of CHRISTOPHER TRAILL was preventable while he was a patient at Bendigo Health.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Findings will be published on the internet.

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

Bowen & Knox Lawyers on behalf of the family.

Minter Ellison Lawyers on behalf of Bendigo Health

Office of the Chief Psychiatrist

Signature:

AUDREY JAMIESON

CORONER

Date: 15 December 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.