Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 28/15

I, Sarah Helen Linton, Coroner, having investigated the death of ***Yvonne HENDERSON*** *with an inquest held at the* ***Albany Courthouse*** *on* ***24 – 25 and 28 August 2015*** *find that the identity of the deceased person was* ***Yvonne HENDERSON*** *and that death occurred on* ***6 December 2010*** *at* ***Princess Royal Drive, Albany*** *as a result of* ***multiple injuries*** *in the following circumstances:*

Counsel Appearing:

Sgt L Housiaux assisting the Coroner.
Ms R Hartley (State Solicitor's Office) appearing on behalf of the WA Country Health Service.

TABLE OF CONTENTS

INTRODUCTION

1. On 6 December 2010, Yvonne Henderson (the deceased) was involved in a 'head-on' traffic collision on Princess Royal Drive in Albany, Western Australia. She sustained serious injuries in the collision and died at the scene.

2. At the time of her death, the deceased was an involuntary patient within the meaning of the *Mental Health Act 1996* (WA) (the Act). By virtue of her involuntary patient status, the deceased came within the definition of a 'person held in care' under section 3 of the *Coroners Act 1996* (WA). In such circumstances, an inquest is mandatory.[1]

3. I held an inquest at the Albany Courthouse on 24, 25 and 28 August 2015.

4. The documentary evidence included three volumes of materials obtained as part of the coronial investigation,[2] as well as some additional documentation tendered during the inquest.[3]

5. The inquest focused primarily on the events of 6 December 2010 and the circumstances that led to the deceased being outside the hospital and driving a car at the time she was involved in the collision, despite her involuntary patient status.

6. A number of witnesses gave oral evidence about their interactions with the deceased leading up to her death. Expert evidence was also heard in relation to the deceased's supervision, treatment and care.

THE DECEASED

7. The deceased was one of four children and described her childhood as "ordinary, not happy nor unhappy,"[4] although there was other evidence to suggest she experienced some trauma as a child, including difficulties at school and the

[1] Section 22(1) (a) *Coroners Act*.
[2] Exhibits 1 – 3.
[3] Exhibits 4 – 6.
[4] Exhibit 2, Tab 36, 2.

death of her father at 13 years of age. She left school early and began working not long after.[5]

8. As an adult, the deceased had two sons from two different relationships, although she never married.[6] In 1985, one of her sons died from an accidental drug overdose.[7] The deceased was deeply affected by grief following his death and she began to live an itinerant lifestyle. It was around this time that she began to exhibit signs of a mental illness and made two impulsive suicide attempts.[8]

9. The deceased was not formally diagnosed with a mental illness until 2003, when she was admitted to Graylands Hospital under the Act.[9] The deceased was diagnosed as having a chronic psychotic illness, which her psychiatrists identified as a chronic delusional disorder[10] or possibly chronic paranoid schizophrenia.[11] There is apparently not a great difference between the two diagnoses, although a paranoid schizophrenic is generally more deteriorated and has more symptoms, making it more difficult for them to manage in the community.[12] The deceased experienced paranoid persecutory delusions, including beliefs that a person by the name of "Richard" was injecting her, watching her when she slept, poisoning her and generally tormenting her. These delusions continued throughout the years.

10. The primary aim of the deceased's medical treatment was to assist the deceased to have some partial insight into her illness, so that she could function within society. Until the deceased was stabilised on her medication, psychotherapy and other modes of supportive treatment were unlikely to be effective. Therefore, the deceased was prescribed antipsychotic medications. However, her delusions did not respond well to treatment and she was often non-compliant with her medication regime.[13]

11. To assist in her compliance, the deceased was often discharged from hospital on a Community Treatment Order

[5] Exhibit 2, Tab 36, 2 – 3.
[6] Exhibit 2, Tab 36, 2.
[7] Exhibit 2, Tab 36, 2.
[8] T 50.
[9] Exhibit 1, Tab 32 [20]; Exhibit 2, Tab 36, 2.
[10] Exhibit 2, Tab 32 [18].
[11] Exhibit 2, Tab 36, 7.
[12] T 50, 115.
[13] T 48 – 50; Exhibit 2, Tab 36 3 – 4.

(CTO) under the Act. This allowed the administration of depot injectable antipsychotics, which remain in the system for a long time and are more effective at treating a patient who does not accept they are ill and does not want to get treated or take regular medication.[14] However, there is a limit to the length of a CTO under the Act.[15]

FIRST CONTACT WITH ALBANY HOSPITAL

12. The deceased was admitted to Albany Hospital for the first time on 2 February 2010. She presented to the Emergency Department and it became apparent she was delusional and required psychiatric treatment. It seems she had again stopped taking her medication. She was admitted as an involuntary patient under the Act.

13. During that admission, the deceased presented with a well-systematised delusional system, focussed primarily on the same individual, "Richard," who she believed to be a pilot/police officer/psychologist/psychiatrist who had been tormenting her for many years by threatening to hurt her and poison her.[16] The nature of her delusions made treatment difficult, as the deceased was highly suspicious of the treating medical practitioners and other hospital staff.[17]

14. Following reintroduction of her medications, the deceased's mental state slowly stabilised.[18] Her admission status was changed to voluntary on 25 February 2010 and she was discharged on 3 March 2010 on anti-psychotic medication with follow-up by the local community mental health clinic.[19] The deceased disengaged with her community health service providers in April 2010 and was formally discharged on 24 June 2010, due to her lack of engagement with the service.[20] It appears that, after this time, the deceased stopped taking her medications and her mental health again deteriorated.[21]

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[14] T 49.
[15] T 49; s 69(1) (d) *Mental Health Act 1996* (WA).
[16] Exhibit 2, Tab 36 3 – 4.
[17] T 34.
[18] Exhibit 2, Tab 36, 4.
[19] Exhibit 2, Tab 32 [21]; Tab 36, 4.
[20] Exhibit 1, Tab 30; Exhibit 2, Tab 32 [21].
[21] T 46.

EVENTS ON 8 – 9 NOVEMBER 2010

15. In late October, early November 2010 the deceased developed a delusion that her neighbours were in collusion with "Richard" and were participating in spying on her, raping her in her sleep and poisoning her. In response, she began sleeping in her car and approached Homeswest to advise them she was giving up her accommodation.[22] The deceased's son and his partner became very concerned about the deceased's mental state and the possibility she might put her Homeswest tenancy at risk. They notified Community Mental Health Service of their concerns.[23]

16. A community mental health nurse, Nurse Terri Harwood, spoke to the deceased's son on 8 November 2010. Following their telephone conversation Nurse Harwood visited the deceased at her home in the company of a senior mental health nursing officer, Ms Theresa Sarra. The purpose of the visit was to assess the deceased's mental state and to conduct a welfare check.[24]

17. During the visit, the deceased expressed suspicion as to why the two women were visiting her and informed them of her fixed false belief that the same man was persecuting her, including poisoning her food. She also expressed her belief that he had arranged for the neighbours to spy on her. She stated she was drinking very little water and throwing out all of her food because of a fear of deliberate contamination. The deceased also believed that Albany Hospital staff members were collaborating with this man and that is why she could not go to the hospital for medical care, despite reporting she had genital bleeding as a result of sexual assaults.[25]

18. Nurse Harwood concluded there were risks to the deceased's physical health (not eating or drinking; reports of physical symptoms), safety risks related to her living in her car and her expressed desire to fight off the neighbours, and risks to her reputation, as the neighbours were complaining about her anti-social behaviour.[26] There were also some potential risks to the safety of others related to an expressed desire by

[22] Exhibit 1, Tab 9, 2; Exhibit 2, Tab 36, 1.
[23] Exhibit 1, Tab 9, 2.
[24] T 34.
[25] T 34.
[26] T 35; Exhibit 1, Tab 29.2.

the deceased to kill her sister if she saw her (and she often misidentified others as her sister).[27] The deceased was, however, adamant that she would not harm herself, as she believed she needed to be around to protect her son.[28]

19. Nurse Harwood and Ms Sarra returned to the Community Mental Health Clinic and Nurse Harwood discussed the deceased's case with the multi-disciplinary team to formulate a plan to assist the deceased. The team agreed with Nurse Harwood's assessment that the deceased's symptoms and circumstances warranted her being referred for an examination by a psychiatrist under the Act. At about 2.30 pm, Nurse Harwood completed a 'Form 1' (referral for examination by a psychiatrist pursuant to s 29 of the Act) and specified Albany Hospital as the place of referral.[29] This was necessary, as the deceased had refused voluntary treatment.[30]

20. Given the deceased did not want to come into hospital for medical treatment, Nurse Harwood also completed a Transport Order and Mental Health Transport Risk Assessment Form the following morning requesting police assistance to transport the deceased to hospital.[31] Nurse Harwood attended the deceased's home with police later that morning and the deceased was safely transported to hospital just after midday on 9 November 2010.[32]

LAST ADMISSION TO ALBANY HOSPITAL

21. The deceased was seen first in the Emergency Department at Albany Hospital and then admitted to C-ward (a general ward) under guard because there were no beds available in G- ward. At that time, G-ward was the approved area or 'authorised facility' in Albany Hospital that could hold involuntary patients under the Act. An enquiry was made as to whether the deceased could be transferred to Graylands Hospital in Perth, but no beds were available in Graylands at that time.

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[27] T 35.
[28] T 35; Exhibit 1, Tab 29.2.
[29] T 35; Exhibit 1, Tab 29.3.
[30] Exhibit 1, Tab 29.3.
[31] T 35 – 36; Exhibit 1, Tabs 29.4 and 29.5.
[32] T 37.

22. Although the Form 1 had been completed, it was not activated until the deceased arrived in an 'authorised facility,' which in this case was the G-ward at Albany Hospital. Therefore, the 24 hours allotted for a psychiatrist to review the deceased did not start until the deceased was received into G-ward.[33]

23. Nevertheless, the psychiatrist on call was notified that the deceased was on C-ward and was due to have a review with the psychiatrist the following morning.[34]

24. In the interim, the deceased was seen by a Senior Medical Practitioner, Dr Clyne, at 5.45 pm on 9 November 2010. He charted some medications to be provided to the deceased, as and when required, but noted she was refusing medications at that time.[35] Dr Clyne saw the deceased again the following morning, as she was refusing fluids and food due to her fears of poisoning.[36] Dr Clyne noted the psychiatrist was aware she was on C-ward awaiting review. It was for the Consultant Psychiatrist to admit an involuntary patient.[37]

25. Dr Clyne saw the deceased again at 4.15 pm and the situation had not improved. He discussed her management over the phone with the Psychiatric Consultant, Dr Subash Bhargava, and a treatment plan was formulated including dispensing Olanzapine as a PRN medication until she was assessed by a psychiatrist.[38] Dr Clyne noted that the deceased would not be transferred to G-ward that day, and a note was also made by the Mental Health Liaison Nurse that there was no bed available at Joondalup Hospital at that time either.[39]

26. The deceased remained on C-ward overnight and still had not been seen by a psychiatrist in the morning of 11 November 2010. Dr Clyne noted there was still no bed available in G-ward and indicated that there had not been any psychiatric consult at that stage.[40]

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[33] Exhibit 2, Tab 32 [42].
[34] Exhibit 2, Tab 31 [9]; Exhibit 3.
[35] Exhibit 3, Integrated Progress Notes, 9.11.2010, 17:45.
[36] Exhibit 2, Tab 31 [10]; Exhibit 3.
[37] Exhibit 2, Tab 32 [16].
[38] T 45 - 46; Exhibit 2, Tab 31 [11].
[39] Exhibit 3.
[40] Exhibit 2, Tab 31.

27. The deceased was eventually admitted to G-ward at 2.20 pm that day when a bed became available.[41] This activated the Form 1, so the 24 hours for assessment began to run.[42]

28. The deceased was initially placed in the secure ward but she complained that the bed was uncomfortable. She was moved to Room 4 in the open ward following her assurance that she would remain on the ward. It is indicated in the notes that an occupational therapist went to the deceased's home and collected some of the deceased's belongings and brought the deceased's motor vehicle back to the hospital.[43]

29. The deceased was not assessed by a psychiatrist pursuant to the Act until the following day. The deceased was assessed by Dr Bhargava on the morning of 12 November 2010. At that time, she was evasive and guarded and she wanted all of the conversation to be tape-recorded. She told Dr Bhargava about her belief she had been stalked by one man for 35 years, and also her belief that one of her sons had been murdered and the other was being held hostage.[44] No more detailed history could be obtained.

30. Dr Bhargava diagnosed the deceased as suffering from a delusional disorder with persecutory delusions and formed the view that the deceased was a significant risk to herself, in terms of risk to her reputation and her safety, as she was likely to become homeless due to her delusions. [45] The deceased lacked insight into her illness and her need for treatment, so voluntary admission was not an option. Accordingly, Dr Bhargava made the decision that the deceased should be detained in G-ward as an involuntary patient under the Act and completed a Form 6 'Involuntary Patient Order' pursuant to s 43 of the Act.[46]

31. Dr Bhargava hoped that following treatment in hospital they would be able to eventually discharge the deceased on a CTO to continue to manage her in the community with depot medication, given her previous non-compliance with medication and outpatient clinic attendance when she was

[41] Exhibit 2, Tab 32 [49]; Exhibit 3, Integrated Progress Notes.
[42] Exhibit 2, Tab 32 [49].
[43] Exhibit 3, Integrated Progress Notes.
[44] Exhibit 2, Tab 32 [22] – [24].
[45] Exhibit 2, Tab 32 [27] – [30].
[46] Exhibit 2, Tab 32 [32].

discharged on the last occasion.[47] However, to achieve this they needed to get the deceased to agree to start taking her medication in some form, either oral or depot injection, again.[48]

32. While on the ward, the deceased was mostly cooperative but remained reluctant to eat or drink because she was afraid of being poisoned. Her mental state fluctuated between being settled and pleasant, to being delusional, to irritated and agitated.[49] She was encouraged to take a regular oral dose of the antipsychotic medication Risperidol but she refused. She would only accept the antipsychotic Olanzapine and took it as a PRN (as needed) medication when she was feeling distressed.[50]

33. The deceased's refusal to accept medication was problematic, as she had a poor prognosis in the absence of treatment.[51] Accordingly, the management plan was to develop a therapeutic alliance to gain her confidence so she would agree to take her antipsychotic prescription medication voluntarily. In the meantime, an injectable depot antipsychotic medication was administered on 18 November 2010 and was repeated on 2 December 2010.[52] The plan was to wait for the deceased to improve and then discharge her on a CTO. The CTO was necessary to ensure she continued to comply with her medication regime.[53]

LEAVE FROM HOSPITAL

34. To those unfamiliar with the *Mental Health Act*, the term 'involuntary patient' gives the impression that the patient is detained at the hospital and cannot leave until that status changes. The reality is somewhat different, as the term 'involuntary' relates more directly to the patients' treatment and not their permanent detention against their will.[54] So while an involuntary patient can be detained in hospital against his or her will, this is not inevitably the case.

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[47] T 46 – 47.
[48] T 51.
[49] Exhibit 2, Tab 32 [33] – [35].
[50] Exhibit 2, Tab 32 [36] – [37].
[51] Exhibit 2, Tab 32 [38] – [39].
[52] Exhibit 1, Tab 28, 2; Exhibit 2, Tab 32 [39].
[53] Exhibit 2, Tab 32 [38] - [40].
[54] Exhibit 1, Tab 3, 6.

35. Leave of absence for an involuntary patient being treated in hospital can be approved by the patient's psychiatrist and is often used as an incentive for treatment.[55] Sometimes the leave is approved with an escort and sometimes the patient is allowed to be unescorted.[56] At Albany Hospital in 2010, it did not generally include permission for involuntary patients to drive their own motor vehicles, although there does not appear to have been a clear policy governing this issue.[57]

36. An involuntary patient is still considered to be detained in the hospital while on approved leave of absence, despite the fact that they have been granted freedom of movement outside the hospital confines.[58]

37. This is consistent with the provisions relating to a patient released on a CTO, which allow for the treatment of an involuntary patient in the community.[59]

38. The flexibility offered by the Act to allow involuntary patients some freedom of movement within the community when possible is in line with the stated objects of the Act to ensure that persons having a mental illness receive the best care and treatment, with the least restriction of their freedom and the least interference with their rights and dignity that safety permits.[60]

39. In accordance with the Act, involuntary patients are permitted leave from the G-ward of Albany Hospital. In 2010, leave for G-ward patients would usually be discussed at the team meeting held each Tuesday. The meeting was attended by Dr Bhargava, as the Consultant Psychiatrist, the psychiatry Registrar, nursing staff, the occupational therapist and the social worker.[61] A decision to grant leave to patients on the G-ward would normally be made by Dr Bhargava, based on an assessment of the patient and information from nursing staff.[62] However, it also seems from the evidence that patients could make requests directly to Dr Bhargava if he met with them, and he would often

[55] Exhibit 2, Tab 32 [50] – [52], [61]; s 59 *Mental Health Act*.
[56] Exhibit 2, Tab 32 [64].
[57] Exhibit 2, Tab 32 [64], [67].
[58] S 61 *Mental Health Act*.
[59] Part 3, Division 3 of the *Mental Health Act*.
[60] S 5 *Mental Health Act*.
[61] Exhibit 2, Tab 32 [50].
[62] Exhibit 2, Tab 32 [51].

make a decision at that time which would be communicated to other staff. It does not appear to have been Dr Bhargava's practice at that time to formally document his decision-making process.

40. It was apparently unusual at the time for an involuntary inpatient to have access to a motor vehicle at Albany Hospital, both due to the risk of absconding and because particular psychopathology may make driving a motor vehicle risky. However, use of a motor vehicle by an involuntary patient is not prohibited by the Act, nor was it prohibited by Albany Hospital policy at the time. It was considered a matter for clinical judgment as to whether it was appropriate for a patient to have access to a motor vehicle and to use a motor vehicle during a leave of absence.[63]

41. The deceased asked for leave for the first time on 15 November 2010 when Dr Bhargava met with her. She indicated she wanted to go to the shops, pay bills and attend her unit to collect her belongings, as Homeswest had issued her with an eviction notice.[64] Dr Bhargava was aware the deceased had been allowed leave during her previous admission at the hospital in February that year without incident.[65]

42. Based upon her previous behaviour and her reasons for requesting leave on this occasion, Dr Bhargava authorised leave for the deceased the following day, being 16 November 2010. Leave at this point was seen as part of the strategy to develop a therapeutic alliance with the deceased. No formal risk assessment was documented and Dr Bhargava cannot recall the precise details of the leave he granted. He confirmed in his evidence that he did not consider whether she would be driving her car.[66] Dr Bhargava recalled that during the deceased's previous admission, she had been given access to her car only after she was made a voluntary patient.[67] She had been happy when that occurred, as she considered her car a safe haven.[68]

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[63] Exhibit 1, Tab 28, 5.
[64] Exhibit 2, Tab 32 [55].
[65] Exhibit 2, Tab 32 [61].
[66] Exhibit 2, Tab 32 [56] – [63].
[67] T 53.
[68] T 53.

43. Dr Bhargava did not recall the question of access to her car being raised with him during this admission.[69] However, Dr Bhargava's evidence was that if he had been asked, he would have allowed the deceased to drive, as there was no hospital policy prohibiting it and he believed there were no obvious risks associated with her driving.[70]

44. It is apparent that the deceased did have access to her vehicle during this admission when taking leave of absence, although it is not mentioned in her records.[71] The deceased went on leave a number of times, often because she was upset by other patients or because she wanted to go to the beach.[72] She always returned from leave as scheduled and without incident. She was noted to be cheerful and reactive on her return to the hospital each time.[73] The deceased's attitude towards eating and drinking markedly improved after each period of leave, so the general observation was that the leave was beneficial to her.[74]

EVENTS LEADING UP TO THE DECEASED'S LEAVE OF ABSENCE ON 6 DECEMBER 2010

45. Towards the end of November 2010, Dr Bhargava and the treating team were moving towards releasing the deceased on a CTO, as part of her treatment plan.[75]

46. On 2 December 2010, the deceased's son contacted Dr Bhargava and expressed his concern about the deceased's discharge plans, as the deceased had telephoned his partner the day before and made threats to come to Perth and find her on her release. The threats appeared to relate to her persistent delusion that her son was being held against his will.[76]

47. Although the deceased was not generally known to act out any of her threats,[77] Dr Bhargava thought it was best to keep her in hospital for another couple of days, noting that

[69] T 53.
[70] Exhibit 2, Tab 32 [68] – [70].
[71] T 53.
[72] Exhibit 2, Tab 32 [59, [63]].
[73] Exhibit 2, Tab 32 [60].
[74] T 54 - 55.
[75] T 51.
[76] T 48, 51; Exhibit 1, Tab 9; Exhibit 2, Tab 32 [73].
[77] T 48.

the involuntary order was still valid until 10 December 2010.[78] The new plan was to keep the deceased in hospital until that date and then review her and decide whether to extend the order or discharge her on a CTO.[79]

48. On 6 December 2010, Dr Bhargava met with the deceased in company with the psychiatric intern and a nurse to inform her that she was not being discharged yet.[80] When Dr Bhargava told the deceased she would not be discharged yet, she became irate and distressed but was not threatening or aggressive. It did not take her long to settle and she then asked for a second opinion. Dr Bhargava reassured her that he would arrange a second opinion as soon as possible.[81]

49. At the end of the interview, the deceased asked for permission to go on leave from the ward. According to Dr Bhargava, the deceased appeared to have settled down and was not distressed at the time she made the request.[82] Dr Bhargava was concerned that if he did not agree to her request it might be perceived by the deceased as a kind of punishment for her reaction to the news that she was not being discharged, which might harm the therapeutic relationship. On his assessment, she was not at risk of suicide or harming anyone else at that point in time, although she still held her delusional beliefs about the man stalking her and her son being held hostage.[83] Dr Bhargava was aware that she usually benefitted from going on leave as she would come back relaxed and happy. For those reasons, Dr Bhargava granted the deceased's request.[84] He did not document those reasons, although his permission was given in front of a junior doctor and a nurse and that permission was documented.[85]

50. There is no suggestion from the evidence that any change was observed in the deceased's presentation by any other hospital staff after Dr Bhargava gave permission for the deceased to take leave that day. No specific details of the

[78] T 51.
[79] T 51 – 52.
[80] Exhibit 2, Tab 32 [71] – [74].
[81] Exhibit 2, Tab 32 [76].
[82] Exhibit 2, Tab 32 [77].
[83] T 56; Exhibit 3, Integrated Progress Notes, 6.12.2010.
[84] T 56.
[85] T 57; Exhibit 3, Integrated Progress Notes, 6.12.2010.

leave (e.g. where she was going, how she would get there, etc.) were discussed.[86]

51. The general practice was that a risk assessment would be done by the staff if there was a concern about escalating risk, before a patient was allowed to go on leave.[87] Therefore, if something significant had occurred, the staff would have raised it with Dr Bhargava. That did not occur.[88]

52. There is no contemporaneous note in the deceased's medical records as to when the deceased left the hospital that day although there is an entry made at 2.30 pm indicating that she left the ward at approximately 11.30 am.[89]

WHAT HAPPENED AFTER THE DECEASED LEFT THE HOSPITAL?

53. It's not known where she went immediately after leaving the hospital, but what is known is that at about 12.45 pm that day the deceased attended Albany Police Station. She approached a customer service officer at the station and asked to speak to a police officer. The customer service officer went and got the supervisor on duty, Sergeant Robert Dixon.[90]

54. Sergeant Dixon went to the front counter and spoke to the deceased. He asked her how he could assist her and she responded by asking if he was a real policeman or was just going to fob her off like every other person that she told about her son's murder. Sergeant Dixon had not immediately recognised the deceased but he quickly recalled that he had met her earlier in the year in similar circumstances and had made some attempt at that time to investigate her claims. He had found she had a history of making similar reports to police.[91]

55. The deceased was known to a number of the staff at the police station, as she regularly attended to make reports

[86] T 57.
[87] Exhibit 2, Tab 32 [53].
[88] T 57.
[89] Exhibit 3, Integrated Progress Notes, 6.12.2010, 14:30.
[90] Exhibit 1, Tab 3 and Tab 19.
[91] T 23 24; Exhibit 1, Tab 22 and Tab 23.

prompted by her delusions. They were aware she was receiving psychiatric treatment at Albany Hospital and the deceased confirmed to Sergeant Dixon on 6 December 2010 that she was resident in the G-ward at Albany Hospital.[92]

56. As he was aware of the deceased's history, Sergeant Dixon asked the deceased to wait in the foyer while he went inside and telephoned the hospital. Sergeant Dixon spoke to Clinical Nurse and authorised mental health practitioner Nicolo Germinario, who at that time was the clinical nurse manager of the Albany Mental Health Unit (G Ward) at Albany Hospital.[93]

57. There is some dispute as to whether Sergeant Dixon was told by Nurse Germinario that the deceased was a voluntary patient or an involuntary patient in G-ward at that time. Sergeant Dixon thought he had been told the deceased was a voluntary patient, but conceded it was possible Nurse Germinario had said the deceased was an involuntary patient and he had misheard what was said.[94] There was no dispute that Nurse Germinario told Sergeant Dixon that the deceased was on approved leave.

58. Sergeant Dixon asked Nurse Germinario whether the deceased was a risk to herself and Nurse Germinario reassured him that she was no risk to anyone.[95] Nurse Germinario had formed the opinion that the deceased was not a risk to herself or others at that time based on his knowledge that the claims she made to Sergeant Dixon were not out of the ordinary and the deceased had been granted leave immediately after being reviewed by her doctors.[96]

59. Nurse Germinario asked Sergeant Dixon whether the deceased was "being a nuisance and if she was not could he take down her complaint?"[97]

60. Based on his conversation with Nurse Germinario and his own assessment that she did not appear to be a threat to herself or to anyone else, Sergeant Dixon's plan at the end of the telephone call was to pacify the deceased by taking down

[92] Exhibit 1, Tab 20 and Tab 21.
[93] T 78.
[94] T 18.
[95] T 22.
[96] Exhibit 1, Tab 26 [33] – [36],
[97] Exhibit 1, Tab 26 [36].

her complaint. He hoped she would then be happy to leave the police station.[98]

61. Unfortunately, things didn't go as planned. When Sergeant Dixon tried to placate the deceased, she became agitated and said to him, "you're just like all the rest. No one believes me." She then swung her handbag, hitting Sergeant Dixon on the shoulder, and walked out of the police station.[99] Sergeant Dixon described the deceased as 'in a bit of a huff"[100] but no more than that. The incident was witnessed by other people at the police station, who described the deceased as "agitated" and "frustrated"[101] and Sergeant Dixon as "calm" and "professional."[102]

62. By striking Sergeant Dixon with her handbag, the deceased had potentially committed an offence. However, Sergeant Dixon did not take the act seriously and at no stage did he think her behaviour warranted arresting the deceased, particularly given her known mental health problems.[103]

63. Sergeant Dixon offered to give the deceased a lift home to the hospital but she told him she didn't need one.[104] It didn't occur to him that she had a vehicle, so he assumed she was going to walk home.[105]

64. The evidence reveals that the deceased did have a vehicle with her. Minutes after she left the police station, the deceased was driving her van along Princess Royal Drive in Albany. She had travelled only a short distance from the station when she drove across a bridge and into the path of an oncoming truck loaded with grain.

65. The truck driver was cresting an incline when he first saw the deceased's van and he noted that the van was travelling on the incorrect side of the road, directly towards him. He was travelling 10 kilometres under the posted 70 km/hr speed limit at the time and immediately braked as hard as he could. The heavy braking caused the wheels of the truck

[98] T 22 – 23; Exhibit 1, Tab 22.
[99] T 25 – 27; Exhibit 1, Tab 22 and Tab 23.
[100] T 26.
[101] Exhibit 1, Tab 20 and Tab 21.
[102] Exhibit 1, Tab 21.
[103] T 25; Exhibit 1, Tab 22.
[104] T 23.
[105] T 23.

to lock but he managed to keep the truck travelling in a straight line in the correct lane. This was important, as the location where this occurred was on a bridge with a single lane in each direction and barriers on either side, leaving no room to veer out of the lane to the side of the road.[106]

66. Although the truck driver had seen the deceased approaching and tried to brake, the evidence suggests the deceased did not do the same. The truck driver stated that when he first saw the driver of the van she appeared to be looking down to her right, as if she was trying to find something on the floor.[107] He then saw her look up and it appeared to him she saw the truck and seemed shocked, "as if she could not believe what she was seeing."[108] The deceased did not attempt to steer away from the truck, but instead took her hands off the steering wheel and put them over her face, as if to protect herself.[109] The lack of tyre marks from the van and the observations of the truck driver also suggest she did not attempt to brake.[110]

67. Given the deceased did not brake or change direction to move out of the incorrect lane and the truck remained in the correct lane, a collision was inevitable. The truck and the deceased's van collided head on.

68. The deceased's van sustained major structural damage in the crash and the deceased was trapped in the driver's seat. Two witnesses to the crash rushed to her aid and found she was semi-conscious and obviously seriously injured. While they tried to comfort and reassure her, the deceased quickly lapsed into unconsciousness and died shortly afterwards.[111]

69. Police officers investigated the crash and found that the truck driver was not in any way at fault for the collision.[112] Fault for the crash lay with the deceased, who was driving on the incorrect side of the road (for an unknown reason) and made no attempt to avoid the collision.[113]

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[106] Exhibit 1, Tab 2.
[107] Exhibit 1, Tab 10 [14].
[108] Exhibit 1, Tab 10 [15].
[109] Exhibit 1, Tab 10 [16] – [17].
[110] Exhibit 1, Tab 2 and Tab 10 [18].
[111] Exhibit 1, Tab 2.
[112] Exhibit 1, Tab 2.
[113] Exhibit 1, Tab 2 and Tab 3.

CAUSE OF DEATH

70. A post mortem examination was conducted on 9 December 2010. At the conclusion of the examination, the forensic pathologist, Dr White, formed the opinion the cause of death was multiple injuries.[114]

71. I accept and adopt the conclusion of Dr White as to the cause of death.

MANNER OF DEATH

72. The evidence before me raises the possibility that the deceased was attempting to commit suicide when she drove head on into the truck. This is suggested by the deceased's objective driving behaviour; namely driving on the incorrect side of the road and failing to take any evasive action to avoid the collision. However, the remainder of the evidence does not point to the deceased having any suicidal intent leading up to the collision.

73. Dr Bhargava confirmed in his evidence that at no time during her stay on G-ward did the deceased indicate that she had any suicidal thoughts or in any way posed a risk to herself. The deceased consistently indicated that she wanted to live to protect her son, which was considered an important protective factor.[115] Dr Bhargava's assessment of the deceased immediately before she went on leave on the day of her death remained that it was unlikely she would take her own life.[116]

74. Dr Victoria Pascu, a Consultant Psychiatrist who conducted a review of the deceased's psychiatric history and care, noted that there was a documented impulsive suicide attempt by overdose many years before, but nothing similar in the deceased's more recent contact with mental health services.[117] Most notably, there was no documented evidence of the deceased having any thoughts, intent or plan to harm herself during her last admission in November 2010.[118] In her evidence at the inquest, Dr Pascu indicated

[114] Exhibit 1, Tab 7.
[115] T 53.
[116] T 59.
[117] Exhibit 2, Tab 36, 3 – 4.
[118] Exhibit 2, Tab 36, 7.

that she was not convinced the deceased was suicidal and thought that if she presented a risk at all at the time of her death, it was more likely to have been to another person than to herself.[119]

75. The deceased's conduct at the police station shortly before the crash demonstrated she continued to maintain the delusional belief that one son had been murdered and her other son was in danger, and she was trying to get help and justice for them. As noted above, her persistence with these beliefs was generally considered to work against any suicidal thoughts.

76. The truck driver's observations of the deceased looking away from the road ahead when he first saw her supports the conclusion that she may have moved onto the incorrect side of the road due to inattention, rather than a deliberate steering of the car. It is possible that her agitated mental state following her encounter with Sergeant Dixon contributed to her distraction, but that is mere speculation and I do not make such a finding.

77. The truck driver's description of the deceased's behaviour when she looked up and apparently saw him for the first time is also consistent with the deceased not realising that she had put herself in the path of oncoming traffic until that moment. Her failure to then take evasive action by steering away or braking is equally consistent with panic rendering her immobile, as opposed to any desire to harm herself.

78. Taking into account all of the evidence before me, I do not find the evidence supports the conclusion that the deceased intended to take her life at the time of the crash. The evidence points more strongly towards the deceased failing to pay due care and attention while driving and inadvertently putting herself in the path of an oncoming truck.

79. It follows that I find that the manner of death was accident.

[119] T 125.

QUALITY OF SUPERVISION, TREATMENT AND CARE

80. Under s 25(3) of the *Coroners Act 1996*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care.

81. The deceased's son also raised specific concerns about the hospital procedures and staff decisions that allowed the deceased to be on day release and to have access to her van on the day of her death.[120]

82. As noted above, to assist the coronial investigation, Dr Pascu completed a review of the psychiatric treatment of the deceased during her last admission to Albany Hospital.[121]

83. Dr Pascu noted that the deceased was initially admitted to a general ward due to a lack of beds in the mental health ward and she acknowledged that this is not uncommon even today for metropolitan and country mental health patients.[122] Dr Pascu noted in her report that there was a proposed expansion to the Albany Mental Health Unit, which was likely to alleviate this problem in Albany, and evidence was given at the inquest that this has now occurred and has had a positive effect.[123]

84. The current situation at Albany Hospital is that they have 16 beds, 4 of them secure, and they are all being used.[124] This is more than double the number of total beds that were available in 2010.[125] Although the situation still arises where all the beds are full and patients have to wait in a bed on the general ward for assessment, Dr Bhargava indicated that it is definitely less common now that they have more beds.[126]

85. In this case, there do not appear to have been any particular issues or problems with the deceased's care while on the general ward, but it is reassuring to know that it is more

[120] Exhibit 1, Tab 9.
[121] Exhibit 2, Tab 36.
[122] Exhibit 2, Tab 36, 8.
[123] Exhibit 2, Tab 36, 8.
[124] T 43.
[125] T 43.
[126] T 46.

likely in the present day that a patient such as the deceased will be admitted straight to the mental health unit.

86. As well as changes to the size of the mental health unit, the shared care model that allowed a general practitioner to care for the deceased while she waited in the general ward for a bed has also changed. Under the new model, every patient with a primary mental health diagnosis is admitted under a psychiatrist.[127] As there is no area of concern in relation to the deceased's care while she was on the general ward, I do not propose to go into any further detail about the new system for admission of mental health patients on the general ward.

87. The two main areas of concern raised by Dr Pascu in her review were:

    i. the general lack of documentation of risk assessments and management plans for the deceased once admitted to G-ward;[128] and
    ii. the lack of a specific documented risk assessment of the deceased by a psychiatrist after she was informed by Dr Bhargava that she was not going to be discharged. Dr Pascu suggested this review should have encompassed consideration of closer monitoring of the deceased's mental state and review of her risks regarding community access and driving.[129] These concerns echo the expressed concerns of the deceased's son.[130]

88. Dr Neil Cock, the Clinical Director of the Great Southern Mental Health Service, gave evidence at the inquest and he acknowledged that the documentation was "not as good as it should have been at the time."[131] Dr Cock advised that since the time of the deceased's death procedures have changed in that regard. Dr Cock also advised that Albany Hospital had implemented changes to the policy pertaining to involuntary patients' vehicle access in hospital in the wake of the deceased's death.[132]

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[127] T 99.
[128] Exhibit 2, Tab 36, 8, 10, 11.
[129] Exhibit 2, Tab 36, 8.
[130] Exhibit 1, Tab 9, 9.
[131] T 100.
[132] T 100.

Documentation

89. Dr Bhargava gave evidence that he did perform a clinical risk assessment of the deceased when she arrived on the ward, but did not document this himself. His general expectation was that the junior doctor attending a patient interview with him would make the entry in the inpatient notes recording his observations.[133] He also made ongoing risk assessments, as did other staff, but again they were not regularly documented.[134]

90. Dr Pascu noted the absence of documentation of these assessments and recommended that there should be a policy at Albany Hospital Mental Health unit relating to documentation of medical information in the patient's file, emphasising the benefits of contemporaneous documentation through the shifts and at the time of patient reviews.[135]

91. Dr Cock concurred with Dr Pascu's view about the importance of documentation and acknowledged there were failures in the way matters were documented at the time of the deceased's admission. In particular, Dr Cock indicated that it would have been appropriate for any decisions to grant the deceased leave and the conditions of that leave to be documented in the medical record, even though there was no specific leave form.[136] This lack of documentation in the deceased's case prompted a change in procedure at Albany Hospital.

92. Dr Cock explained at the inquest that a new policy implemented at Albany Hospital requires that a risk assessment is not only made at the time of admission, prior to any leave from hospital and on discharge, but on each occasion that risk assessment must be properly documented.[137] To assist in that regard, the Department of Health introduced a Risk Assessment and Management Plan protocol in November 2011[138] and Albany Hospital has recently started using the Mental Health Risk Assessment and Management Plan form (the RAMP form), as it is

[133] T 64 – 65.
[134] T 64 – 65.
[135] Exhibit 2, Tab 36, 11.
[136] Exhibit 2, Tab 33 [38] – [39].
[137] T 96.
[138] T 102.

thought to be the best instrument to record that process.[139] The form provides prompts to consider general risk factors, specific suicide factors and signs of violence/aggression, both in the patient's background and at the time of the current assessment.[140] Dr Cock indicated that the hospital conducts regular audits to ensure compliance with the policy.[141]

93. In addition, there is also now a specific patient leave procedure for the Albany Hospital Mental Health Unit. This procedure was published on 6 September 2013.[142] There are separate procedures outlined for granting leave for voluntary and involuntary patients and the procedure specifies how the leave is to be documented in the medical record.[143] All treating team clinicians are required to comply with this procedure.[144]

94. These new procedures should hopefully avoid some of the problems that arose in this case as a result of the lack of documentation of decision-making processes.

95. The lack of documentation available in the deceased's medical record gave the impression the deceased was told that she would not be discharged as she anticipated, she became "very irate" and referred to her continuing delusional beliefs about dangers faced by her son and that hospital staff were "poisoning her through the water."[145] The clinical impression was that she remained "unchanged,"[146] thus indicating she remained delusional. Despite all of those observations, the note then records the deceased was able to have leave without further explanation.[147]

96. Dr Cock acknowledged in his report that the entry in the medical notes made it hard, without more information, to understand the decision to grant leave at that stage. Dr Cock subsequently sought further information from Dr Bhargava about his decision-making process, and was

[139] T 96; Exhibit 6.
[140] Exhibit 6.
[141] T 96.
[142] Exhibit 2, Tab 33 [40] and Attachment 8.
[143] Exhibit 2, Tab 33 [40] and Attachment 8.
[144] Exhibit 2, Tab 33 [40].
[145] Exhibit 3, Integrated Progress Notes, 6.12.2000.
[146] Exhibit 3, Integrated Progress Notes, 6.12.2000.
[147] Exhibit 3, Integrated Progress Notes, 6.12.2000.

informed that the deceased's anger was transient, she settled quickly and, on that basis, Dr Bhargava considered that it was appropriate to grant the deceased leave at that time.[148] Based on that additional information, Dr Cock expressed his opinion that Dr Bhargava was faced with a very difficult situation at that time, as he was doing his best to engage the deceased in treatment. Even with the benefit of hindsight, Dr Cock considered that Dr Bhargava's decision to grant the deceased leave was a reasonable one.[149] Dr Pascu also agreed that Dr Bhargava's decision was a reasonable one in all the circumstances.[150] Dr Pascu did give evidence that she might have tried a more aggressive treatment regime with the deceased than was attempted, but this did not change her view about the appropriateness of granting the deceased a leave of absence at the time she was seen by Dr Bhargava.[151]

Vehicle Access

97. The next question is the appropriateness of the deceased having access to her vehicle while on that leave of absence.

98. As noted above, there is no legislative prohibition on involuntary inpatients having access to motor vehicles and, at the time, there was no documented policy at Albany hospital in that regard for either voluntary or involuntary patients in G-ward.[152] According to Dr Cock, the practice was that the decision was left to the clinical judgment of the treating psychiatrist or another medical practitioner.[153] However, that does not appear to have occurred in the case of the deceased, as she apparently had regular access to her motor vehicle without the knowledge of Dr Bhargava. Dr Bhargava's evidence was that he gave neither a blanket approval nor any date-specific approval for the deceased to have access to her motor vehicle. There is also no record of anyone else making an assessment of the deceased's fitness to use a motor vehicle during that time.[154]

[148] Exhibit 2, Tab 33 [41].
[149] T 100.
[150] T 122.
[151] T 122 – 123.
[152] Exhibit 1, Tab 28, 5.
[153] T 97; Exhibit 2, Tab 33, 6.
[154] Exhibit 2, Tab 33 [37].

99. The medical records do record the deceased's campervan had been brought to the hospital by an occupational therapist, and it was ward practice to hold onto keys, purses and mobile phones and provide them to patients on request when appropriate. Therefore, for the deceased to have had access to her vehicle, some hospital staff must have given her the keys and hence been aware she was using her vehicle while on leave.[155] There appear to have been no reported concerns by those staff about the deceased's vehicle use prior to 6 December 2010 and no reports from any concerned members of the community who might have come across the deceased.

100. Dr Bhargava acknowledged that there are some circumstances in which a treating psychiatrist would have an obligation to inform the police or Department of Transport that a patient is not capable of driving, but it did not arise in the deceased's case.[156] Dr Bhargava stated that the depot injections of Risperidol would not have been expected to affect the deceased's ability to drive a car safely[157] and Dr Cock confirmed that Risperidone depot is not a contraindication to driving.[158] Dr Bhargava also considered the deceased was alert and generally able to focus, despite her delusional disorder, and if he had been asked at the time, he would have considered her fit to drive a vehicle.[159]

101. This is consistent with the deceased's driving history. Despite the deceased's long history of mental illness, police traffic records confirm that the deceased was not involved in any reported traffic crashes prior to the day of her death. She had a good driving history, with no traffic offences recorded for more than two decades.[160] This suggests that the deceased's delusional disorder did not generally compromise her driving ability in a significant way.

102. Nevertheless, it is important to consider specifically whether the events prior to the deceased's leave of absence on 6 December 2010 suggested that her ability to drive was compromised at that particular time. As noted above,

[155] Exhibit 1, Tab 28, 4 – 5.
[156] T 62.
[157] T 60 - 61.
[158] Exhibit 1, Tab 28, 5.
[159] T 61, 63.
[160] Exhibit 5.

looking back in hindsight, Dr Bhargava believes that the deceased was still fit to drive at that time. Dr Pascu expressed the view that the deceased's driving ability might have been compromised, but more as a result of her obvious increased frustration after her encounter with Sergeant Dixon, rather than her behaviour prior to leaving the hospital.[161] However, Dr Pascu did not place great emphasis on this point. In Dr Pascu's opinion, the only real risk that could have been predicted at that time was the risk the deceased presented to her son's partner.[162]

103. Therefore, although it is concerning that the deceased was able to access her vehicle without any considered risk assessment by her treating psychiatrist, the weight of the evidence points to the conclusion that there was nothing about the deceased's mental state at the time of her leave of absence that contraindicated allowing her to drive her vehicle. There was nothing in her previous history, her medication regime or her presentation on the morning to suggest that she was not fit to drive a vehicle.

104. Nevertheless, the death of the deceased prompted a review of the hospital's policies to try to reduce the risk of similar accidents in the future.[163] This has ultimately led to the introduction at Albany Hospital of a policy effectively prohibiting the use of a private motor vehicle whenever possible while an inpatient in the Mental Health Unit.[164] This Patient Vehicle Access Procedure came into effect on 28 August 2014.[165] Dr Pascu considered this blanket restriction to be an overreaction, as at Graylands they still make such decisions based on clinical judgment in each individual case.[166] Dr Cock seemed to accept that the policy was a strong reaction, but indicated the hospital has taken what they consider to be the safest possible position, while acknowledging that it will restrict the rights and freedoms of the patient.[167]

105. If not for the new policy being implemented, I would have considered making recommendations in relation to the need

[161] T 125 – 126.
[162] T 126.
[163] T 103.
[164] Exhibit 2, Tab 33 [42] – [43].
[165] Exhibit 4.
[166] T 120 - 121, 127.
[167] T 96.

for a specific, documented assessment of an involuntary patient's fitness to drive before each leave of absence where access to a vehicle was likely. However, given that Albany Hospital's new Patient Vehicle Access Procedure effectively precludes that from occurring, there is no purpose to such a recommendation arising from this case.

106. I do, however, express my concern that the earlier procedures in 2010 were apparently not followed, resulting in the deceased being allowed to have regular access to her vehicle without any risk assessment being made by a medical practitioner. I would expect that the new procedure is followed much more rigorously.

Events at the Police Station

107. When the deceased presented to the police station and it became apparent the deceased was a patient in G-ward, Sergeant Dixon acted appropriately by telephoning Albany Hospital. Whether he was told by Nurse Germinario that the deceased was a voluntary or involuntary patient makes little difference in this case, as he understood correctly the important fact that she was on approved leave from the hospital and was not considered to be a risk to herself or others.[168]

108. Dr Bhargava was asked whether he considered Nurse Germinario's response to Sergeant Dixon's telephone call was appropriate in relation to the deceased at that time. He expressed the opinion that the response was appropriate.[169]

109. Nurse Germinario's evidence was that he would perhaps have changed his view if he had been informed by Sergeant Dixon that the deceased had hit him with her handbag after their conversation, as it suggested an increased level of agitation and might have warranted some further medical review.[170] Dr Pascu agreed that this might have been beneficial, but also observed that it's not a "black and white" [171] answer as "psychiatry has lots of greys."[172] Dr Pascu agreed that the deceased's behaviour with

[168] T 82 - 83.
[169] T 63.
[170] T 83 – 85.
[171] T 125.
[172] T 125.

Sergeant Dixon may have been a sign that her frustration was escalating, which might have affected her ability to control her psychotic symptoms and warranted further psychiatric review. However, Dr Pascu emphasised that the main concern would be the risk she might then present to others, particularly her son's partner, rather than any specific risk to herself or unusual impairment of her driving ability (beyond how any ordinary person's driving ability would be affected by stressors and frustrations).[173]

110. Dr Bhargava indicated that he would have been concerned if the deceased had included Sergeant Dixon in her delusional system but, given what he had been told about her presentation at the station, the deceased's behaviour was consistent simply with an expression of frustration and it did not suggest she was at risk of harming herself or others at that time.[174]

111. Taking into account all of the circumstances, I do not make any criticism of Sergeant Dixon's or Nurse Germinario's conduct. What occurred shortly after the deceased left the police station was clearly not anticipated by either of them and, considering the expert evidence before me, it was not an easily predictable event.

Final Comment

112. The events of 6 December 2010 rightly raised concerns about the level of supervision and care of the deceased by the staff in the Mental Health Unit at Albany Hospital. The deceased's son wrote to the Coroner's Court to ask for a review of the hospital procedures and the doctors involved to enable him to understand how she could be an involuntary patient and yet be allowed to drive a motor vehicle on day release.[175] Hopefully, this inquest has now answered some of his questions.

113. The evidence before me reveals that it was not unusual for an involuntary patient at Albany Hospital at that time to be given leave of absence from hospital and, on occasion, access to their private vehicle to use on that leave. This was, and remains, permitted under the *Mental Health Act.*

[173] T 126.
[174] T 63.
[175] Exhibit 1, Tab 9.

114. The deceased was granted regular leave in the hope that it would be beneficial to her, which it apparently proved to be, and in the hope that it would forge a therapeutic relationship that would encourage the deceased to continue to engage with treatment when she was eventually released back into the community. I am satisfied this was a reasonable approach for her treating team to pursue.

115. However, there were clear failings in the documentation of the decision-making process surrounding the deceased's leave of absences and her ability to access her vehicle on those occasions. I am reassured by the evidence provided at the inquest that these failings have been remedied and that Albany Hospital has implemented procedures that ensure that risk assessments are regularly conducted and appropriately documented, and leave of absences are more closely regulated and documented.

116. I have found that the deceased's actions just prior to her death were not consistent with an intention to harm herself, but rather the evidence supports the conclusion she was distracted and inattentive to the road ahead. Such behaviour may well have been the product of the deceased's frustration and an escalation of her psychotic symptoms. They may, on the other hand, have simply been an example of the lapses in attention all drivers are capable of at times. If a proper, documented risk assessment had been conducted that morning before the deceased commenced her leave, with specific consideration given to her fitness to drive, it might be easier to reach a conclusion on the matter. Unfortunately, that was not done in this case.

117. In my view, the implementation of a policy to restrict the use of private vehicles to inpatients in the Mental Health Unit wherever possible is a positive step and certainly reduces the risk of a similar death occurring. However, I accept it may not be seen so by the patients. Nevertheless, from a coronial point of view, it is the most risk averse and safest position to take for both the patients and members of the community.

CONCLUSION

118. The deceased was a troubled woman with a long history of chronic delusions which greatly affected her ability to live a happy and safe life in the community. Efforts to treat her disorder were hampered by her sporadic compliance with her treatment regime each time she was released from hospital. Her treatment was also complicated by her incorporation of police and medical practitioners into her delusions, which made her distrustful of the people who tried to help her.

119. At the time of her death, the deceased was an involuntary inpatient in the Mental Health Unit at Albany Hospital. This was necessary, given her declining mental health at that time, which put her physical health at risk and made it impossible for her to live safely and peacefully in the community.

120. While remaining an involuntary inpatient, the deceased was granted repeated leaves of absence from hospital, with a view to eventually releasing her as an involuntary patient on a CTO to ensure she continued to comply with her medication regime. This was an appropriate aim and the repeated leave of absences appeared to be working positively towards achieving this aim. As part of her leave of absence, the deceased was given access to her private car by hospital staff. No one appears to have turned their mind to whether this was a safe option or not for the deceased on each occasion, although her previous history suggests her driving ability was not generally impaired by her mental illness or medications.

121. On the day of her death, the deceased drove to a police station to make a report, based upon her delusional beliefs. This was not an unusual event for the deceased and hence did not alarm the police or the hospital staff who were aware of it. However, shortly after the deceased left the police station, she was involved in an accident that suggests she was in a distracted state of mind at the time. It is difficult to determine whether her distraction was a result of her mental disorder, but it would clearly have been a safer option if she had not been able to drive her car that day.

122. As a result of the deceased's death, Albany Hospital has put in place stricter procedures to ensure more comprehensive risk assessments are done and to prevent psychiatric patients' access to cars. Their aim is to hopefully prevent a similar event occurring. This may be small comfort to the family of the deceased, who had taken steps to ensure the deceased remained in hospital in the belief that this would ensure both her safety and the safety of others. Nevertheless, they are positive steps from the community's perspective and the fact that the WA Country Health Service has taken a proactive approach has removed the necessity for me to make recommendations in that regard.

S H Linton
Coroner
25 November 2015