Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 54/12

I, Barry Paul King, Coroner, having investigated the death of ***Aaron Luke Prisgrove*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***25 February 2014*** *find that the identity of the deceased person was* ***Aaron Luke Prisgrove*** *and that death occurred on* ***12 July 2011*** *at* ***Graylands Hospital*** *from* ***ligature compression of the neck*** *in the following circumstances:*

Counsel Appearing:

Ms M Smith assisting the Coroner
Ms R Hartley (State Solicitors Office) appearing for the Department of Health, Graylands Hospital, Royal Perth Hospital, Broome Hospital, Dr Min Zhu, Bernard Lee Tong MHNC, Moira Heddle EN, Wei Shyong Kok RN, Philip Ibbertson RMHN and Dr Francisco Rosell
Ms B Burke (Australian Nursing Federation) appearing on behalf of Janet Johnson

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INTRODUCTION

1. Aaron Luke Prisgrove (**the deceased**) died on 12 July 2011 when he hanged himself shortly after he was admitted into Graylands Hospital (**Graylands**).

2. As the deceased was an involuntary patient under the *Mental Health Act 1996* at the time of his death, he was a 'person held in care' under section 3 of the *Coroners Act 1996*.

3. Section 22 (1)(a) of the *Coroners Act 1996* provides that a coroner who has jurisdiction to investigate a death must hold an inquest if the death appears to be a Western Australian death and the deceased was immediately before death a person held in care.

4. An inquest to inquire into the death of the deceased was therefore mandatory.

5. 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.

6. The death of the deceased was investigated together with the deaths of nine other persons who immediately before they died had been persons held in care as involuntary patients at Graylands under the *Mental Health Act 1996*.

7. The joint inquest commenced before Coroner D.H. Mulligan in the Perth Coroner's Court on 27 August 2012. Evidence specific to the deceased was received on 27 March 2013. Evidence relevant to other deceased persons and general evidence about Graylands was provided to the Court until the hearings were completed on 22 April 2013.

8. Coroner Mulligan became unable to make findings under s.25 of the *Coroners Act 1996* so I was directed by Acting State Coroner Evelyn Vicker to investigate the deaths.

9. To remove any doubt of my power to make findings under s.25, on 25 February 2014 I held another inquest into the death of the deceased and the other nine persons. The evidence adduced in that inquest was that which had been obtained by Coroner Mulligan, including exhibits, materials and transcripts of audio recordings of the inquests. Interested parties who were present at the inquests before Coroner Mulligan were invited to make fresh or further submissions. All of the parties indicated their agreement with the appropriateness of the procedure I had adopted.

10. I should note that there was a great deal of evidence adduced at the inquests that was related to general or systemic issues pertinent to Graylands. That evidence was adduced to investigate whether those issues had a bearing on any or some of the deaths and to allow the coroner to comment on the quality of supervision, treatment and care of the deceased patients. For example, evidence of the condition of the buildings at Graylands containing wards was provided in order to allow the Court to investigate whether the physical environment of the wards would have been more therapeutic had the buildings been refurbished.

11. That general evidence was useful in providing an overview of the context in which the deceased persons were treated for their mental illnesses; however, in my view many of the issues the subject of that evidence were not sufficiently connected with all the respective deaths for me to comment on those issues under s.25 (2) or (3) of the *Coroners Act 1996* generally as if they did.

12. I have therefore not addressed those general issues separately from a consideration of each death. Rather, where I have come to the view that the issues were connected with the death or were potentially relevant to the quality of the supervision, treatment and care of the deceased, I have addressed them in the respective findings.

THE DECEASED

13. The deceased was born in Alice Springs on 18 July 1978. His father was an ambulance paramedic and his mother was a nurse. He had two brothers, one older and one younger. He described his childhood as happy at times.[1]

14. The deceased's father described the deceased as a helpful, friendly, hard working young man who had been a healthy child. The deceased had played sport and had a good relationship with his family, especially his maternal aunt, Ruth Rowan.[2]

15. When the deceased was in his late teens he began to experiment with cannabis though it seems that he stopped after less than a year.[3]

16. After school the deceased spent time in the Australian Army Reserve. When he started, he appeared to fit in well, but after a stint at a facility in Singleton, New South Wales where he underwent training as a heavy vehicle driver, he became rebellious and his mental state appeared to change. At one stage, a non-commissioned officer rang the deceased's father to express concern about the deceased's welfare.

[1] Ex 1, Vol 2, Tab 3, p27
[2] Ex 1, Vol 1, Tab 9
[3] ts 22

17. The deceased eventually abandoned the Army Reserve and began to work in a small restaurant as kitchen staff.

18. In 2001 and or 2002 the deceased began to self-harm. He attempted suicide by hanging and overdosing diazepam, resulting in admission as an involuntary patient at a hospital in Melbourne.[4] He was diagnosed with depression and discharged after a week following treatment. The deceased then went to live with his Aunt Ruth, and he recovered well from this episode.[5]

19. The deceased obtained work in the transport industry in Melbourne in 2002/2003 before deciding to move to Western Australia to work in the mining industry from 2005 to 2007.[6] He went to Kalgoorlie and worked near the Superpit but then moved to Darwin where he worked at a mine near Hayes Creek in the north of the Northern Territory.[7]

20. About this time, the deceased was showing more and more signs of acromegaly, a condition caused by a growth hormone disorder. In 2007 he returned to his family for a visit and they noticed that his body was changing. In 2008 he was visiting his aunt in the Gold Coast when he was diagnosed with acromegaly by a general practitioner. He began to receive treatment from an endocrinologist.[8]

21. In about 2009 while working at Hayes Creek, the deceased began a serious relationship with Bianca Griffiths, a young woman from the Darwin area who worked for the same company as the deceased.[9]

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[4] ts 25
[5] ts 24, 26
[6] Ex 1, Vol 1, Tab 9
[7] ts 27
[8] ts 28, 30
[9] Ex 1, Vol 1, Tab 9

22. In about 2010 the deceased underwent an operation to remove a tumour from his pituitary gland, following which the symptoms associated with acromegaly eased.

23. When the company for whom the deceased worked terminated in, it appears, the first half of 2011, he and Ms Griffiths moved to Perth and began to work on a fly-in fly-out basis, each at a different location. The deceased was working in the Pilbara while Ms Griffiths was working in Kalgoorlie as a chef.[10]

24. In mid-2011, after a short time living in Perth, the deceased and Ms Griffiths ended their relationship. The deceased later told his father that it was his decision.

25. The deceased returned to Melbourne in late June 2011 where he stayed with his parents. At first he talked at length to his parents but he became withdrawn. After a week, he returned to Perth to go back to work in the Pilbara, but he had made arrangements to return to Melbourne for his birthday on 18 July 2011.

TOM PRICE HOSPITAL

26. Over the next few weeks the deceased began to drink alcohol heavily and experienced significant symptoms of depression. He lost six kilograms of weight over three weeks and suffered sleep disturbance.

27. On 8 July 2011 he called Ms Griffiths to say goodbye.

[10] ts 27,28

28. That day the deceased was admitted into Tom Price Hospital after presenting at the emergency department following an overdose of panadeine and panadeine forte tablets. He was seen by a locum medical practitioner, Dr Lynne Davies, who noted that the deceased had no social support, had signs of significant depression and regretted that he had not succeeded in ending his life.

29. Dr Davies diagnosed the deceased with depression and alcohol abuse. She considered him to be as a high risk of self-harm. She spoke with the Mental Health Emergency Line and the triage nurse at Graylands, which resulted in Graylands agreeing to accept the deceased as a patient.

30. Dr Davies arranged for the Royal Flying Doctor Service to transfer the deceased to Perth, and she completed the necessary forms under the *Mental Health Act 1996*.

ROYAL PERTH HOSPITAL

31. On arrival in Perth in the late afternoon of 8 July 2011, the deceased was taken to Royal Perth Hospital (**RPH**) where he was admitted from the emergency department into the psychiatric ward, Ward 2K, as a voluntary patient. It is likely that he was taken to RPH instead of directly to Graylands because of the availability of emergency department facilities at RPH or because of a lack of available beds at Graylands.[11]

32. While being interviewed in the emergency department by psychiatrist Dr Allet on 9 July 2011, the deceased denied suicidal ideation or

[11] ts 105

plans and indicated that he wanted to be admitted for help. He was spontaneous and pleasant and displayed no psychotic symptoms or hopelessness. Dr Allet considered that the deceased had experienced a depressive episode in the context of alcohol misuse.[12]

33. As the deceased was a voluntary patient, he could leave the ward for up to an hour, but it was explained to him that drinking alcohol while he was admitted was not allowed.[13]

34. On the early afternoon of 10 July 2011 Ms Griffiths called the deceased's father to inform him that the deceased was in a pub and drinking beer. The deceased's father called Ward 2K to express his concerns for the deceased's safety.[14]

35. A short time afterwards, the deceased returned to the hospital and was confronted about drinking alcohol while admitted. He told staff that if he wanted to do something, he would do it. Due to his impulsivity, the deceased was asked not to leave the ward and was placed on 15 minute observations despite his guarantee not to self-harm.

36. While on Ward 2K at RPH, the deceased was seen four times by a senior medical officer, Dr Min Zhu. Dr Zhu told the Court that the number of times was unusual but that the deceased was quite a disturbed young man.[15] The deceased was also seen by psychiatrist Dr Kostov as well as an intern, Dr Petrescu.

37. On the morning of 11 July 2011 the deceased told Dr Zhu and Dr Petrescu that he had a flight booked to Melbourne on 20 July 2011, that he

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[12] Ex 1, Vol 2, Tab 3, p42
[13] ts 80, 81
[14] Ex 1, Vol 2, Tab 3, p49
[15] ts 103, 109

felt safe on the ward and that he would inform nursing staff if he experienced self-harm or suicidal ideation.[16]

38. That afternoon, the deceased was reviewed by Dr Kostov and Dr Petrescu while Dr Zhu observed the review.[17] The deceased told them that he wished that he had ended it all previously and that he had experienced active suicidal ideation on the previous day, but that he had told nurses about it immediately.[18] He said that he was looking forward to visiting his parents and that he intended to stay in Melbourne until he was better. He said that he had changed his plane ticket to leave on 12 July 2011, the next evening.

39. Dr Kostov advised the deceased that he should remain in Perth for a week, but the deceased expressed his preference to travel to Melbourne and he denied suicidal ideation.

40. Dr Kostov diagnosed the deceased with adjustment reaction and suicidal attempt in the context of alcohol abuse and the breakup of his relationship, alcohol abuse and dependency, and illicit drug use with a past history of significant abuse and dependency. He assessed the deceased's risk of self-harm to be low while in hospital and supportive environments and placed him on normal hourly observations.

41. A plan was made to review the deceased the next morning and, if his improvements continued, to discharge him.

42. That evening the deceased left the ward temporarily. When he returned, he informed nurses that he had visited the chapel where he attempted to hang himself with his belt while

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[16] Ex 1, Vol 2, Tab 3, p42
[17] Ex 1, Vol 2, Tab 3, p54-56
[18] Ex 1, Vol 2, Tab 3, p54

feeling angry and upset. He was unable to carry it out, and had made a second attempt in a men's toilet near the chapel.[19]

43. Overnight the deceased was allocated a one-to-one nurse, known as specialling or being on a one-to-one special, and the next morning a multi-disciplinary meeting concluded that he was unsafe in hospital.[20] Dr Kostov, Dr Zhu and Dr Petrescu saw the deceased and informed him that he would be made an involuntary patient and be transferred to Graylands. In the meantime he would remain on a one-to-one special.

44. The deceased was transferred to Graylands by ambulance and police at about 5.15pm that evening.

GRAYLANDS

45. At Graylands the deceased was received at Smith Ward, a closed ward for acute male patients, at about 5.50pm on 12 July 2011. There he was briefly assessed as to his mental state by an experienced triage nurse, Bernard Lee. Nurse Lee had already been provided with information about the deceased by way of faxed notes from RPH.[21] The deceased appeared cooperative and softly spoken but low in mood and withdrawn.[22]

46. Nurse Lee assessed the deceased's overall risk as high, based on the two self-harm attempts at RPH and the overdose before that.[23] He was aware that the deceased was on a one-to-one special at RPH, but his understanding was that one-to-one specials are utilised on Ward 2K at RPH because it is an open ward; once it has been

[19] Ex 1, Vol 2, Tab 3, p58
[20] Ex 1, Vol 2, Tab 3, p58
[21] ts 162
[22] ts 166
[23] ts 168

determined at RPH to make a patient involuntary, it is necessary for the patient to be monitored constantly. [24] Nurse Lee discussed the situation with the nurse coordinator and put the deceased on 15 minute observations.

47. The nurse coordinator on duty was Mental Health Nurse Clinician Philip Ibbertson. He explained that he did not think that a one-to-one special was needed in the deceased's case because the deceased was calm and cooperative, had stated that he would approach nursing staff if he felt distressed, and had no significant evidence of bruising from previous hanging attempts. Nurse Ibbotson said that the deceased was sitting quietly in the day area virtually with someone, and that in the normal course of things would be seen by a doctor before they had to worry about the issue of observations.[25]

48. Upon the deceased's arrival at Smith Ward, Nurse Ibbertson had performed a cursory physical check and property search of the deceased with the help of Enrolled Nurse Moira Heddle. During that process the deceased appeared to be calm and cooperative.[26]

49. The deceased had brought with him a large military-style holdall bag with handles on each side of the length-wise opening. After removing items which Nurses Ibbotson and Heddle considered to be a risk to the deceased, they gave the bag back to him. One item they removed was a long strap that would attach to the bag.

50. Nurses Ibbotson and Heddle did not consider the bag to present a risk to the deceased. Nurse Ibbotson said that in 25 years he had never

[24] ts 180
[25] ts 211
[26] ts 219

removed that style of bag from patients.[27] Nurse Heddle stated that she had returned 'loads of bags' to patients.[28] Nurse Lee also stated that he had not thought that the bag could present a risk of self-harm.[29]

51. Dr A Rosell, the admitting duty doctor, had been notified of the deceased's arrival. He had earlier been called by Dr Zhu at RPH so was aware of the deceased's circumstances there. At the time that the deceased was being received into Smith Ward, Dr Rosell was admitting another patient on another ward. He had to complete that process before admitting the deceased.

52. The deceased was given a place to sit in the day room near the nurses' station and was given something to eat.

53. The ward was particularly busy and noisy with patients in a high state of emotional arousal. The ward did not have a safety room or another place where the deceased could wait.

54. At about 6.25pm the deceased had complained of feeling anxious, so was given a small dose of diazepam after authorisation from Dr Rosell was obtained by telephone. Nurse Heddle gave the deceased a Safety Plan to look at over her break from 6.30pm to 7.00pm. The deceased completed the safety plan and handed it in.[30]

55. A short time later, the deceased approached Nurse Ibbertson and asked for an extra dessert, which Nurse Ibbertson provided. The deceased said that he was tired and wanted to lie down. Nurse Ibbertson called triage to ask how long it would be before Dr Rosell attended.

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[27] ts 216
[28] ts 251
[29] ts 172
[30] ts 249

56. Nurse Ibbertson decided to allow the deceased to go to his room on the ward to lie down while waiting for Dr Rosell. The usual practice was to leave a patient sitting in the day area where they could be seen, but in this case Nurse Ibbertson considered that the unusually high unruliness in the ward was adversely affecting the deceased and that the deceased's presentation was such that the deceased would not be at immediate risk.[31]

57. The deceased's room was remote from the nurse station, making visual monitoring of the deceased impossible, but the nurses had no other practicable option at the time if the deceased was to be allowed to lie down to rest. There was another room that would be available close to the night nurse station when the nurses moved there later.[32] Incidentally, Nurse Ibbertson understood that the cupboard and all the other furnishings in Smith Ward had been configured to be ligature-minimised.[33] This appears to have been correct.[34]

58. Nurse Ibbertson also relied on the 15 minute observations of the deceased that were being carried out and by the fact that other patients would be present near the deceased's room.[35]

59. The staff member charged with carrying out observations of patients on Smith Ward at the time was Registered Nurse Wei Shyong Kok, who was on a rotation at Graylands as part of a graduate nurse program.[36] Nurse Kok was made aware that the deceased was a high risk patient.[37]

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[31] ts 222
[32] ts 221
[33] ts 217
[34] ts 177 22/4/13; General Brief Vol 1, Tab 6, p9
[35] ts 222, 223
[36] Ex 1, Vol 1, Tab 35
[37] ts 268

60. Nurse Kok checked on the deceased in the day area every 15 minutes from 6.00pm. At about 6.45pm Nurse Kok handed the deceased his bag and showed him to his room at the end of the corridor when so requested by Nurse Ibbertson. He checked on the deceased again at 7.00pm, 7.15pm, 7.30pm and 7.45pm and saw that the deceased was in his bedroom in a calm state.[38]

61. Dr Rosell arrived in Smith Ward at about 7.45pm. He went to the nurses' station and read the notes for the deceased for five or ten minutes. He then asked Nurse Ibbertson to send a nurse to bring the deceased to an interview room so that he could interview him.[39]

62. Nurse Ibbertson gave the job to Nurse Kok who went to get the deceased. When Nurse Kok entered the deceased's room, he saw the deceased in the corner of the room with one of the handles of his holdall bag around his neck and the other handle looped onto the top corner of a door-less cupboard.[40]

63. Nurse Kok tried to get the bag off the deceased's neck but was unable due to the weight of the deceased. He activated his duress alarm and ran to the night nurses' station nearby to get some cutters.[41] There he found Nurse Ibbertson and Nurse Heddle and told them that the deceased was hanging in his room.[42]

64. The nurses ran to the deceased's room, lifted him off the cupboard and, with Dr Rosell who had run to the room within seconds of hearing the duress alarm,[43] administered cardiopulmonary resuscitation. Another nurse, Ben Boland, came

[38] Ex 1, Vol 1, Tab 35, Annexure 3
[39] ts 287-288
[40] Ex 1, Vol 1, Tab 35
[41] Ex 1, Vol 1, Tab 35
[42] Ex 1, Vol 1, Tab 38
[43] ts 289

from Montgomery Ward. He had emergency department experience.[44] The Medical Emergency Team attended and became involved with the resuscitation until ambulance paramedics arrived. Ambulance paramedics continued to attempt to resuscitate the deceased but to no avail.[45]

CAUSE AND MANNER OF DEATH

65. On 15 July 2011 forensic pathologist Dr D. M. Moss examined the deceased. He found a ligature mark to the front of the neck with underlying soft tissue damage and excess fluid in the lungs. A toxicology analysis showed therapeutic levels of prescription-type medication but no alcohol or other common drugs.

66. Dr Moss concluded that the deceased died from ligature compression of the neck (hanging) and I so find.

67. I find that the manner of death was suicide.

QUALITY OF SUPERVISION, TREATMENT AND CARE

68. The deceased's family have provided written submissions in which they raise a number of points relevant to the care received by the deceased. I shall address them by reference to, and in order of, their appearance in the summary of the family's written submissions:

[44] Ex 1, Vol 1, Tab 38
[45] Ex 1, Vol 1, Tab 3

a. *The deceased was transferred with notice as to his risk and instability.*

This was clear on the evidence, and all the relevant personnel were aware of his risk of self-harm.

b. *It appears that not all of the medical records reached Graylands at the time of admission.*

As I understood the evidence, the records from RPH were faxed to Graylands by Dr Zhu. The Graylands medical file for the deceased contains RPH documents including progress notes and medical charts.[46] As mentioned, Graylands staff were aware of the deceased's risk.

c. *Graylands took the deceased off 1:1 specialling without an independent assessment or a clear authorisation for it.*

As noted above, Nurse Lee and Nurse Ibbertson discussed the monitoring requirements for the deceased and considered that 15 minute observations were appropriate because of the deceased's presentation as not being an immediate risk and because it was anticipated that the deceased would remain in the day area until he was seen by Dr Rosell. That appears to have been a reasonable decision at the time, though the circumstances changed somewhat once the deceased had been allowed to go to a room that was difficult to monitor from the nursing station.

It should be noted that keeping the deceased on a one-to-one special until he saw Dr Rosell would not have guaranteed that the

[46] Ex 1, Vol 2, Tab 1

deceased would not have attempted suicide after seeing him. Dr Rosell might well have ordered that the deceased be placed on 15 minute observations after he had assessed him.[47]

However, following the deceased's death, Graylands implemented a policy of keeping newly admitted patients on the same level of observations as was in place at the transferring hospital.

d. *The deceased was administered medication without an independent assessment or clear authorisation for it.*

This submission is substantially supported by the Root Cause Analysis. As a result, an audit of the documentation of PRN medications was implemented.[48]

Nurse Ibbertson did complete the S4R record of drugs received,[49] but his failure to document the authorisation by Dr Rosell properly left him open to the accusation that no authorisation was obtained. Irrespective of that recording failure, there was no evidence to indicate that the administration of the diazepam or the failure to ensure that appropriate records were kept had a deleterious effect on the deceased.

e. *The deceased demonstrated responsibility when he filled in his Safety Plan in which he requested communication with staff.*

This submission may be based on a misconception of the entry which the deceased made in the Safety Plan. On the

[47] ts 287
[48] Ex 1, Vol 1, Tab 29
[49] Ex 1, Vol 1, Tab 5

Safety Plan the deceased was asked, 'How would you communicate to staff when you may be struggling?' in reply to which he wrote, 'Talk to them'.[50] While that does show responsibility, it seems to me to be an indication that the deceased would take steps to seek help if he were struggling, rather than a request for communication.

f. *The deceased was taken to the most remote and isolated room in the ward.*

This was clear. The layout of the ward was such that observation of the deceased was not possible from the nursing station. Allowing the deceased to go to his room occurred because of a combination of factors as described above.

There was general agreement among witnesses that the ward was poorly laid out. Graylands Acting Program Manager from 2007 to 2012, Mark Anderson, who was also a clinical nurse, stated that the ward was appalling for observation, although improvements had been made with mirrors and cameras.[51]

The Chief Psychiatrist of Western Australia, Dr Nathan Gibson, added that in his view there were too many patients for that type of ward. He went on to say that Smith Ward was an acute ward that was being considered for closure once new facilities were available in Osborne Park.[52]

[50] Ex 1, Vol 1, Tab 20
[51] ts 72-73
[52] ts 160

g. *The deceased was not attended upon in accordance with the Safety Plan.*

I am not sure about which part of the Safety Plan is said to have not been followed. However, the Root Cause Analysis suggests that a Safety Plan should be used to engage with the patient and used to formulate a collaborative risk management plan, and the evidence suggests that that use of the Safety Plan had not taken place.

It must be noted, however, that the timing and the circumstances of the deceased requesting, and being allowed, to go to his room did not leave much time for much interaction between the deceased and staff with respect to the Safety Plan. Other steps directed towards managing the deceased appeared to be awaiting Dr Rosell's interview of the deceased in order to admit him to the ward. The unusual unruliness on the ward was also likely to have been a factor.

In considering this issue, the Root Cause Analysis recommended a review of the model of care for nursing.[53]

h. *The deceased was left to his own devices and provided with the very article/s that he used to bring about his death.*

This is partially correct. The deceased was not in the constant company of another person and he used his bag to hang himself. However, the pertinent question is whether these facts indicate anything about the quality of the supervision, treatment and care of the deceased. I shall address this question in greater detail below.

[53] Ex 1, Vol 1, Tab 29

i. *The staff did not take all reasonable steps to render assistance to the deceased after the duress alarm at 19.58.*

In my view, it is difficult to see what more could have been done by staff, and the written submissions do not identify the steps that could have been taken.

Nurses and doctors arrived in response to the duress alarm within seconds.[54] Cardiopulmonary resuscitation and oxygen was administered by doctors and nurses and attempts were made to administer adrenaline.[55] Suction was used to clear the deceased's airways, a defibrillator was attached and a call was made for an ambulance.

j. *After the duress alarm at 19.58 it took a further 18 minutes for St John Ambulance to arrive before they could even make any viable assessment to assist the deceased, including the use of adrenaline.*

I am not in a position to comment on the timeliness of the ambulance response since this issue was not raised in the evidence.

The ambulance notes indicate that St John Ambulance received the call at 8.07pm and that the ambulance arrived at the scene at 8.17pm.[56] The assessment by ambulance paramedics was recorded as taking place at 8.20pm.

[54] ts 289
[55] ts 274, 293
[56] Ex 1, Vol1, Tab 32

k. *The evidence of the staff on the whole was deflective of responsibility, demonstrated a lack of insight into the foreseeable risk to the deceased, and failed to acknowledge their complete inattention to the deceased after 6.45pm whilst he was in their protective care.*

This submission reflects, in particular, allegations in the written submissions with respect to the actions of Nurse Kok. The Prisgrove family submit that Nurse Kok's evidence was inconsistent, and in particular submit that his entries on a Visual Observation Record indicating observations after 6.45pm were false because a statement he made following the deceased's death included the sentences:

> My first contact with the patient was when I introduced myself to the patient & handed him his belongings & showed him his room
>
> My last contact with the patient was when I showed him to his room.

The Prisgrove family's submission is that those sentences show that Nurse Kok had not made any observations of the deceased after he showed him his room at 6.45pm.

In my view the natural meaning of 'contact' in the second of the two sentences given the use of the word in the first sentence is 'interaction'. As Nurse Kok's later observations were carried out from outside the deceased's room, he had no contact with the deceased at those times. He explained that in answers to questions by Corner Mulligan.[57] I can see no basis for a finding that the record of observations was false.

[57] ts 271

69. With the benefit of hindsight, it is possible to identify decisions made at Graylands which, had they been different, could have resulted in a different outcome.

70. It is important to keep in mind that the possibility of a different outcome is just that: a conjectural possibility.

71. As noted by Nurse Heddle, not returning the bag to the deceased, keeping him in the day area and keeping him on one-to-one special until seen by a doctor are matters that could, in hindsight, have been done.[58] I understand that these procedures have now become instituted at Graylands as policies.[59]

72. However, having those procedures in place at the time may not have led to a different conclusion. For example, not having his bag would not mean that the deceased could not have used another ligature, for example one fashioned from an article of clothing, with which to hang himself.

73. It must also be noted that the tragic result in the deceased's case does not necessarily reflect adversely on the standard of treatment and care provided to him. It would be difficult to fault the quality of care provided to the deceased at RPH, yet the deceased attempted suicide while a patient there. Had he succeeded, in hindsight it would have been apparent that he should not have been kept on an open ward or that he should have been on a one-to-one special.

74. At Graylands the deceased was assessed by experienced nursing staff who were aware that he was at high risk of self-harm. They took steps which, in the circumstances of the deceased's

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[58] ts 254
[59] ts , 280

presentation and in the context of their considerable experience, the policies under which they operated and the facilities in which they worked, were reasonable to protect the deceased from that risk.

75. There is no evidence to support a conclusion that the deceased was simply placed in his room and ignored thereafter.

76. That is not to say, however, that the changes to policies that have implemented since the deceased's death have not been beneficial or that further systemic improvements will not be necessary in future. It is clear that understanding mental illness and how best to manage it are evolving areas of medical knowledge and practice.

77. A review of the evidence pertaining to 10 deaths of involuntary mental health patients has shown that medical and nursing staff at mental health facilities such as Graylands must deal with the continuous dilemma of managing very difficult and unpredictable patients in the least restrictive manner possible while protecting them from self-harm. It is difficult to see how it can be possible to do both successfully all the time with the resources available.

78. The circumstances of the death of the deceased provide a distressing reminder of how mental illness can lead its sufferers to impulsive and improbable acts of self-destruction. In my assessment of the evidence, the staff at Graylands were clearly aware of that fact and acted in what they as experienced mental health professionals considered to be in the best interests of the deceased in the context of what was available to them.

79. In my view, the quality of supervision, treatment and care of the deceased provided by staff at Graylands was reasonable in the circumstances.

CONCLUSION

80. As a result of his mental illness, the deceased took his own life while young and otherwise generally healthy. This was a terrible tragedy.

81. Suffering from mental illness is a tragedy in itself. Recent statistics suggest that it is frighteningly widespread in our society. In his report of 2012, Professor Bryant Stokes noted that:

    a. in the context of limited resources, the mental health system is under considerable stress, particularly in relation to staff already stretched;

    b. demand for services is outstripping provision of acute inpatient facilities, step-down units and rehabilitation services;

    c. in Australia, one-third of the population experience mental illness at some time of their lives; mental illness accounts for 13 per cent of the total burden of disease and is the largest single cause of disability;

    d. currently mental illness in WA ranks as the fourth highest burden of disease for men and the second highest for women, but by 2016 these rankings are expected to be reversed with mental disorders accounting for the greatest burden;

    e. mental health clinicians are dedicated and committed to work in often-complex scenarios and volatile environments;

f. the current mental health workforce was inadequate to meet the mental health needs of WA; and that

g. mental health clinicians are severely overworked in almost all areas.[60]

82. Professor Stokes made over 100 recommendations aimed at improving the provision of services to mental health patients throughout Western Australia. Dr Gibson told the inquest that there were challenges attached to implementing the recommendations and that one of the principal issues was to determine the priorities of the recommendations so that resources could be allocated to them accordingly.[61]

83. While I have found that the quality of supervision, treatment and care of the deceased by staff at Graylands was reasonable in the circumstances, one of those circumstances was the unsuitability of Smith Ward for the purpose for which it was being used.

84. It appears from the Mental Health Commission's website that steps are underway to address the lack of appropriate facilities for mental health patients. This is welcome.

85. Families such as the Prisgrove family will no doubt hope and expect that their mental health-related tragedies will lead to improvements in the level of care and treatment available to other families' loved ones.

[60] General Vol 1, Tab 9
[61] ts 125-126

86. I encourage those who decide the nature and the level of resources that are allocated to the provision of mental health services in Western Australia to give this area of public health the priority it requires.

B P King
Coroner
11 April 2014