Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 13/15

I, Barry Paul King, Coroner, having investigated the death of ***James Anthony Stanczyk*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***31 March and 25, 26 and 27 May 2015****, find that the identity of the deceased person was* ***James Anthony Stanczyk*** *and that death occurred on* ***23 September 2012*** *at* ***Sir Charles Gairdner Hospital*** *from* ***ligature compression of the neck (hanging)*** *in the following circumstances:*

Counsel Appearing:

Mr J T Bishop assisting the Coroner
Mr P D Quinlan SC (instructed by DLA Piper) appearing on behalf of Joondalup Hospital Proprietary Limited and its employees
Ms R Hartley (State Solicitor's Office) appearing on behalf of Sir Charles Gairdner Hospital, Graylands Hospital and the Chief Psychiatrist
Ms B E Burke (Australian Nursing Federation) appearing on behalf of James McLay CNC
Mr T M Andrews (Mark Andrews Legal) appearing on behalf of Jacmah Enterprises Pty Ltd trading as X-Men Security Services

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SUPPRESSION ORDER

No report of any evidence that could lead to the identification of the deceased's ex-partner or of the patient in Bay 13 may be published.

INTRODUCTION

1. On 22 September 2012, James Anthony Stanczyk (the deceased) presented at the Joondalup Health Campus emergency department (JHC-ED) following a suicide attempt in which he gassed himself with carbon monoxide in his vehicle and took an overdose of diazepam.

2. At the JHC-ED the deceased was treated for carbon monoxide poisoning, pending assessment by a psychiatrist in relation to his mental health. During the evening of that day the deceased became agitated and distressed. Medical staff calmed him down. They arranged for a security guard who was responsible for a nearby patient to keep an eye on the deceased because they were concerned that the deceased had a high risk of suicide and should not leave the JHC-ED.

3. On the morning of 23 September 2012 the deceased was assessed by a psychiatric registrar. The registrar was concerned about the deceased's level of risk of self-harm, so she asked emergency staff to arrange for a security guard to watch the deceased on a one-to-one basis.

4. Before there was time for a one-to-one guard to arrive, the patient near the deceased became aggressive and violent. The guard responsible for him, as well as emergency medical and nursing staff, had to deal with him. In the commotion that ensued, the deceased was able to leave without being immediately noticed.

5. The deceased made his way to his home in North Perth where that afternoon he committed suicide by hanging. He was 31 years old.

6. On 25, 26 and 27 May 2015 I held an inquest into the deceased's death. The focus of the evidence was on the arrangements made by staff at the JHC-ED to have the deceased monitored to ensure that he did not abscond from the hospital.

7. The documentary evidence adduced at the inquest was primarily a comprehensive report with relevant attachments[1] prepared by First Class Constable Serena Culliford of the Coronial Investigation Unit of the Western Australian Police. Further documentary evidence comprised:

   (a) a request form and a policy document, both related to special care requests at the JHC-ED;[2]

   (b) a letter and statements respectively from three witnesses employed at JHC: Dr Rhoanna McNeill,[3] Gaena O'Brien RN[4] and Vanessa Tran CN;[5]

   (c) a bundle of copies of photographs obtained from video recordings at the JHC-ED;[6]

   (d) a Department of Health document containing policy and practice guidelines in relation to patient flow of mental health patients to acute and non-acute care facilities;[7]

   (e) two documents containing statistics relating to the attendance of mental health patients in the JHC-ED and other emergency departments in Western Australia;[8] and

   (f) a supplementary bundle of medical records relating to the patient being treated in the bed beside the deceased at the JHC-ED.[9]

[1] Exhibit 1, Volumes 1 and 2
[2] Exhibits 2 and 3
[3] Exhibit 4
[4] Exhibit 5
[5] Exhibit 11
[6] Exhibit 6
[7] Exhibit 7
[8] Exhibits 8 and 10
[9] Exhibit 9

8. Oral testimony was provided (in order of appearance) by:

(a) Constable Culliford;[10]

(b) the following security guards employed by Jacmah Enterprises Pty Ltd trading as X-Men Security Services (X-Men Security), a business which was contracted with the proprietor of Joondalup Health Campus (JHC):

i. Imran Abbas,[11]
ii. Mohammed Faheem Malik,[12]
iii. Saqib Khan,[13]
iv. Gupreet Singh Bhullar,[14] and
v. Fraidoon Jabarkhil;[15]

(c) Dr Nathan Gibson, the Chief Psychiatrist of Western Australia;[16]

(d) Charlie Bertolami, the director/manager of X-Men Security Services;[17]

(e) James McLay, a clinical nurse consultant who was a psychiatric liaison nurse at the JHC-ED;[18]

(f) Edie O'Connor, a registered nurse at the JHC-ED;[19]

(g) Michelle Meinen, a registered nurse at the JHC-ED;[20]

(h) Ms O'Brien RN, a night shift co-ordinator at the JHC-ED;[21]

(i) Mandy Chilkott, a clinical nurse who was a day shift co-ordinator at the JHC-ED;[22]

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[10] ts 8-11
[11] ts 11-38
[12] ts 39-59
[13] ts 59-77
[14] ts 78-92
[15] ts 93-132
[16] ts 136-166
[17] ts 166-189
[18] ts 189-204
[19] ts 204-214
[20] ts 214-226
[21] ts 226-236

(j) Dr Cameron Burrows, a duty consultant at the JHC-ED in 2012 and the current director of emergency medicine at JHC;[23]

(k) Dr Catherine Morgan, a senior medical officer at the JHC-ED;[24]

(l) Dr McNeill, a psychiatric registrar in the mental health unit at JHC (JHC-MHU);[25]

(m) Dr Asha Juniper, another psychiatric registrar at the JHC-MHU;[26]

(n) Ms Tran CN, the clinical nurse manager at the JHC-ED;[27] and

(o) Dr Simon Wood, the director of medical services at JHC and the previous director of the JHC-ED.[28]

9. If the deceased had been an involuntary patient under the *Mental Health Act 1996* (*MHA*) at the time of his death, he would have been a 'person held in care' under section 3 of the *Coroners Act 1996*.

10. Under s25(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.

11. While the deceased was not an involuntary patient under the *MHA* at the time of his death, I have considered the supervision, treatment and care provided to the deceased, and I have found that his supervision was inadequate due to a failure of the system then in place. I have not concluded that the deceased would likely have been stopped from leaving the JHC-ED if he had been monitored by a one-to-one guard.

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[22] ts 237-252
[23] ts 260-285
[24] ts 286-300
[25] ts 300-314
[26] ts 314-320
[27] ts 321-333
[28] ts 333-342

THE DECEASED

12. The deceased was born on 3 February 1981, making him 31 years old at the time of his death.

13. According to a statement obtained by police from the deceased's father, as a boy the deceased was cheerful and made friends easily. He was very artistic and did well in high school. The deceased's mother died from an aneurysm when he was 17 years old, which hit him quite hard.[29]

14. Contrary to his father's statement, the deceased reported to mental health professionals that his childhood was unhappy, his parents were both alcoholics and his mother physically abused him.[30] He self-harmed by cutting and hair-pulling as a teenager and made several suicide attempts.[31]

15. There is evidence to indicate that the deceased had a family history of mental illness, with his grandfather suffering from bipolar affective disorder leading to suicide and his grandmother having schizophrenia.[32]

16. The deceased started using drugs when he was 16. He reported that in the time leading up to his death he was spending approximately $100 a week on cocaine and methylamphetamine but did not use drugs intravenously. He had presented to Royal Perth Hospital (RPH) in 2000 with chest pain purportedly relating to cannabis overdose, but by 2012 he reported that he did not use cannabis regularly.[33] He drank alcohol in binges,[34] but the quantity is unclear. He was a heavy smoker.

17. After high school the deceased went to university where he studied for a psychology degree for a year. He then became self-employed in a landscaping business.[35]

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[29] Exhibit 1, Volume 1, Tab 8
[30] Exhibit 1, Volume 1, Tab 11
[31] Exhibit 1, Volume 2, Tab 50
[32] Exhibit 1, Volume 1, Tab 12
[33] Exhibit 1, Volume 1, Tab 11
[34] Exhibit 1, Volume 2, Tab 50
[35] Exhibit 1, Volume 1, Tab 50

18. The deceased had a supportive older sister and a younger sister who was in prison for drug and fraud offences. One or two years before his death the deceased had attempted suicide by hanging after an argument with his younger sister.[36]

19. The evidence indicates that, as an adult, the deceased had at least two serious partners. He was with his latest partner for about seven years, with the relationship coming to an end around July 2012. The break-up of that relationship appears to have precipitated an onset of deterioration of the deceased's mental health.[37]

20. The deceased lived in a two storey unit in North Perth.

JULY 2012

21. During the course of his breakup with his recent partner, the deceased became severely depressed, stopped eating and sleeping and did not work. On 26 July 2012 the deceased attended Dr Debbie Cohen-Jones, a general practitioner in Subiaco, to whom he admitted having attempted suicide by overdose three weeks previously.[38]

22. Dr Cohen-Jones referred the deceased to Sir Charles Gairdner Hospital (SCGH) where he was diagnosed with anxiety and depression within the context of situational crisis, mainly relationship breakdown and financial stress. He was also noted to have borderline cluster B personality traits and had a history of poly-substance abuse.[39] A person who is a cluster B personality type often has poor emotional regulation, does not tolerate distress well, can have aggressive outbursts, and can be quite impulsive and unpredictable.[40]

23. The deceased was admitted to Sir Charles Gairdner Hospital's mental health unit overnight as a voluntary patient. The next day he was discharged with follow up

[36] Exhibit 1, Volume 1, Tab 50
[37] Exhibit 1, Volume 1, Tab 50
[38] Exhibit 1, Volume 1, Tab 9
[39] Exhibit 1, Volume 1, Tab 12
[40] ts 301 per McNeill, R

by Doctor Cohen-Jones and a referral to a drug and alcohol counselling service and a clinical psychologist.[41]

24. The deceased returned to Dr Cohen-Jones on 31 July 2012. He was feeling better and was keen to obtain help from a psychiatrist. Dr Cohen-Jones referred him to a private psychiatrist and a psychologist. She prescribed an anxiolytic and an antidepressant and arranged for a review in a fortnight.[42]

AUGUST 2012

25. On 6 August 2012 the deceased attended the emergency department of SCGH with a laceration to his finger from punching a picture frame. At the hospital it was noted that he had made suicide attempts, including ingesting all his antidepressants over the previous five days, but he was mistakenly discharged without psychiatric review.[43]

26. Following contact with SCGH by Dr Cohen-Jones, the deceased was taken back to SCGH on 7 August 2012 where he underwent a psychiatric review. He was assessed to be at risk of suicide and on 8 August 2012 he was transferred to Graylands Hospital (Graylands) for assessment under the *MHA*.[44]

27. The deceased was admitted to Graylands and remained there as an involuntary patient until 20 August 2012.[45]

28. On 13 August 2012 the deceased was informed by his treating psychiatrist and doctor at Graylands that his partner had been diagnosed with HIV. He was shocked and distressed by the news. That evening he was given overnight leave in the care of a friend as his psychiatrist thought that keeping him in a locked ward might increase his risk of suicide.[46]

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[41] Exhibit 1, Volume 1, Tab 12
[42] Exhibit 1, Volume 1, Tab 9
[43] Exhibit 1, Volume 1, Tab 12
[44] Exhibit 1, Volume 1, Tab 12
[45] Exhibit 1, Volume 2, Tab 50
[46] Exhibit 1, Volume 2, Tab 50

29. That night his friend rang Graylands to say that the deceased had drunk two bottles of wine, was distraught and was looking at old photos and smashing ornaments.[47]

30. The next day the deceased returned to Graylands. At about 12.30 pm he met with his treating staff who informed him that he tested positive to HIV. Counselling with an HIV clinical nurse specialist from RPH was arranged for the following day. His involuntary status was maintained and he was kept in a secure ward due to a high risk of suicide associated with the HIV diagnosis.[48]

31. On 15 August 2012 the deceased met with the HIV clinical specialist nurse, following which he appeared appreciative and settled. He was given unescorted ground access twice a day without incident. The next day he appeared calm and relaxed and denied thoughts of self-harm or suicide. He was keen for follow-up support from the Inner City Mental Health Clinic following discharge until a private psychiatrist could be arranged.[49]

32. On the afternoon of 16 August 2012 the deceased was visited by his ex-partner. They had a long talk and afterwards the deceased was settled and said that he was relieved and was sure that the relationship was over.[50]

33. Over the next three days the deceased was stable. He was given day leave without incident and appeared to be much happier. He was joking with staff and was often seen smiling while talking on his phone. He had bought vitamins and fruit and had exercised well.[51]

34. On 20 August 2012 the deceased was discharged from Graylands. He told his treating doctors that he accepted the break-up of the relationship. He said that his manual labour days were over and that he would be looking for future jobs. The discharge summary from Graylands indicated that the deceased had an adjustment disorder

[47] Exhibit 1, Volume 2, Tab 50
[48] Exhibit 1, Volume 2, Tab 50
[49] Exhibit 1, Volume 2, Tab 50
[50] Exhibit 1, Volume 2, Tab 50
[51] Exhibit 1, Volume 2, Tab 50

relating to the HIV diagnosis and that he had borderline cluster B personality traits.[52]

JOONDALUP HEALTH CAMPUS EMERGENCY DEPARTMENT - 22 SEPTEMBER 2012

35. On the early afternoon of 22 September 2012 the deceased was taken to the JHC-ED by ambulance after he was found by passers-by in bush in Two Rocks in his utility vehicle with a garden hose running from the exhaust pipe to the vehicle's interior. He had taken 12 diazepam tablets and had drunk a quarter of a bottle of wine.[53]

36. At the JHC-ED the deceased was placed in Bay 12 in the treatment area,[54] which was effectively a bed with curtains available to separate it from Bay 13 and to provide privacy from the rest of the treatment area.[55]

37. In Bay 13 was another patient who was experiencing mental health problems. He had presented at the JHC-ED on the evening of 20 September 2012 with drug-induced psychosis and the next evening had been made subject to orders under the *MHA* that he be taken to an authorised hospital for assessment. At that time there were no secure places available in any psychiatric facility in the Perth metropolitan region, so there was no place to which he could be sent. Due to his *MHA* status and his threatened and actual violence to staff, he was being guarded by an employee of X-Men Security.[56]

38. The role of X-Men Security guards used at the JHC-ED to watch patients was to keep an eye on the patients to which they were allocated and to alert medical or nursing staff of any indication that the patients required attention or assistance; for example, when patients became agitated or when they tried to leave the hospital while they were at risk of self-harm. The guards' presence

[52] Exhibit 1, Volume 2, Tab 50
[53] Exhibit 1, Volume 2, Tab 49
[54] Exhibit 1, Volume 1, Tab 20
[55] Exhibit 1, Volume 2, Tab 45
[56] Exhibit 1, Volume 2, Tab 49

acted as a deterrent and they provided another set of eyes to watch for patients in need of attention.[57]

39. Guards would also take part in a procedure known as a 'Code Black' in which several staff members from different areas would attend the JHC-ED urgently to deal with a patient who had become disruptive or aggressive, or who tried to leave the hospital.[58]

40. At about 2.00 pm on 22 September 2012 the deceased was seen by Dr Morgan. He told Dr Morgan about his admission to Graylands, so she arranged for the psychiatry liaison nurse, Mr McLay CN, to obtain electronically the deceased's medical records from Graylands. The deceased was still drowsy and was not yet suitable for psychiatric review.[59]

41. A blood test indicated that the deceased had mild carbon monoxide poisoning of 16% carboxyhaemoglobin. He was given high flow oxygen therapy with a plan to keep him overnight.[60]

42. Upon reviewing the Graylands discharge summary, Dr Morgan made an entry in the deceased's integrated progress notes indicating that he needed psychiatric input. She considered that he was at a high risk of suicide, so she informed the JHC-ED nurses and made the comment 'not to leave' in the 'Emergency Department Information System' with respect to the deceased.[61]

43. At about 3.00 pm the deceased had a sandwich and a drink, and after that he generally slept.

44. At 8.00 pm Dr Morgan discussed the deceased's situation with the duty psychiatry registrar, Dr McNeill, who made a note in the deceased's integrated progress notes that the deceased was at high risk of suicide. Dr McNeill also requested a guard. As a result, the guard who was

[57] ts 261-262 per Burrows, C
[58] ts 265-266 per Burrows, C; ts 167-168 per Bertolami, C
[59] Exhibit 1, Volume 1, Tab 20
[60] Exhibit 1, Volume 1, Tab 20
[61] Exhibit 1, Volume 1, Tab 20

watching the patient in Bay 13 at that time, probably Mr Abbas, moved his chair to a position where he could also watch the deceased.[62]

45. Dr Morgan had presumed that the deceased would be given his own guard, also known as a one-to-one guard, and was a bit uncomfortable with the fact that the guard who was watching him would also be watching the patient in Bay 13.[63]

46. At 10.00 pm that evening the deceased was given a sandwich and some orange juice. At 10.20 pm he got up, got dressed and tried to leave, saying to staff that he felt fine. Dr Morgan was called.[64]

47. When Dr Morgan attended, the deceased told her of his recent diagnosis of HIV, which he blamed on his ex-partner. He was nihilistic and felt futile about it. She tried to reassure him that modern treatments could be successful, at which stage he became angry, agitated and tearful. He expressed hopelessness and suicidal thoughts. Dr Morgan became very concerned.[65]

48. Dr Morgan considered that the deceased was clearly at a high risk of suicide and required intervention. In oral evidence she said that he was the highest risk patient she had ever seen in her 20 years of practice.[66] She spoke to the psychiatric liaison nurse on duty to ask if the deceased could be admitted to the locked section of the JHC-MHU. The nurse told her that there were no beds, but arranged for Dr McNeill to attend.[67]

49. Dr McNeill saw the deceased at about 11.30 pm. There was a guard near his bed, who Dr McNeill assumed was a one-to-one guard for the deceased. The deceased was highly distressed. He ventilated for about 20 minutes about how his ex-partner had infected him with HIV and how he received no support from friends or family, whom

[62] Exhibit 1, Volume 1, Tab 20; ts 290 per Morgan, C
[63] ts 291 per Morgan, C
[64] Exhibit 1, Volume 2, Tab 49
[65] Exhibit 1, Volume 1, Tab 20
[66] ts 295, 299 per Morgan, C
[67] Exhibit 1, Volume 1, Tab 20

had been told by his ex-partner that it was the deceased who had infected him.[68]

50. Dr McNeill was unable to assess the deceased due to his distressed state, but she was able to calm him down and get him to agree to remain in the JHC-ED until he could be reviewed in the morning. She got him to accept an oral sedative.[69]

51. Dr McNeill made an entry in the integrated progress notes of a plan for a psychiatric review in the morning when the deceased was more settled. The deceased was to remain as a voluntary patient until then. He had accepted medication and had agreed to remain for review.[70]

52. In her entry Dr McNeill re-confirmed the need for a guard and indicated that the *MHA* could be used to compel the deceased in hospital if necessary. She considered that her entry made it clear that the deceased should not be allowed to leave the hospital.[71] Her experience at the JHC-ED was that all guards were one-to-one, so she did not think it necessary to write 'one-on-one'.[72]

53. Dr McNeill informed the psychiatric liaison nurse of the information she had entered into the integrated progress notes.[73]

54. For the rest of the night the deceased slept while observed by the guard who was also watching the patient in Bay 13.

JOONDALUP HEALTH CAMPUS EMERGENCY DEPARTMENT - 23 SEPTEMBER 2012

55. When Ms Chilkott CN came on duty as shift co-ordinator at 7.00 am on 23 September 2012, she received a handover from Ms O'Brien RN to the effect that the guard

[68] ts 302 per McNeill, R
[69] Exhibit 4; ts 302 per McNeill, R
[70] Exhibit 1, Volume 2, Tab 49; Exhibit 4
[71] Exhibit 4
[72] ts 303 per McNeill, R
[73] Exhibit 4

assigned to the patient in Bay 13 was also keeping an eye on the deceased. She understood that the deceased was awaiting psychiatric review and that he was not the subject of a form under the *MHA* but that he was not to leave the department.[74]

56. At about 7.45 am the deceased awoke and ate breakfast. He was co-operative and was contrite for his behaviour the previous night.[75]

57. At about 8.25 am the deceased went outside with a guard in order to smoke cigarettes. At about 10.00 am he complained of nausea and abdominal pain. Dr Burrows saw him and prescribed intravenous ondansetron.[76]

58. By 10.15 am the deceased was again distressed. He asked Ms Meinen RN about HIV issues and told her about his ex-partner and the lack of support from his friends. He was crying throughout their conversation.[77]

59. Ms Meinen RN contacted Mr McLay CN who attended Bay 12 and spoke to the deceased for about 10 minutes. The deceased was anxious and depressed. He was angry that his ex-partner would not tell him about his HIV test results and that a friend had accused him of abusing his ex-partner. He denied any ongoing thoughts of suicide and said that he would be all right, but Mr McLay CN thought that his demeanour was inconsistent with his assurances and that his level of anxiety and ongoing emotional distress put him at risk.[78]

60. Mr McLay CN located the psychiatric registrar on duty, Dr Juniper, and informed her of his impressions.[79]

61. Dr Juniper went to the deceased in Bay 12 at about 10.30 am. When she arrived there, the deceased was making to leave the bay. She did not notice a guard in his bay but saw two guards in Bay 13. She was

[74] ts 237-238 per Chilkott, M
[75] Exhibit 1, Volume 2, Tab 49
[76] Exhibit 1, Volume 2, Tab 49, Exhibit 1, Volume 1, Tab 19
[77] Exhibit 1, Volume 1, Tab 26
[78] Exhibit 1, Volume 1, Tab 23
[79] Exhibit 1, Volume 1, Tab 23

concerned that the deceased may attempt to leave the hospital so she did not leave his presence in order to speak to another staff member about the guard.[80]

62. Dr Juniper reviewed the deceased and considered that he was modifying his answers in order to give her the impression that he was safe to discharge. She assessed his risk of attempted self-harm or suicide to be moderate to high. She told him that she was concerned about his capacity to manage his feelings without harming himself and that she felt that he needed inpatient psychiatric treatment. The deceased was adamant that he did not want or need inpatient treatment and that he just wanted to stay with his older sister.[81]

63. Dr Juniper told the deceased that she wanted to discuss the deceased's management plan with her supervising psychiatrist and asked him if he could guarantee that he would remain where he was until she returned. He guaranteed that he would.[82]

64. As Dr Juniper left the deceased's bay, she saw Dr Burrows, the duty emergency medicine consultant, close by. She told him that she was concerned about the deceased and that she required that he be watched. Dr Burrows asked her if a guard should be organised and she replied, 'Yes, I think so.' She saw Dr Burrows turn to the shift co-ordinator, Ms Chilkott CN, to arrange for a guard.[83] Dr Juniper then went to the psychiatric liaison office at the other end of the JHC-ED to speak to her supervisor by phone.[84]

65. A short time after Dr Juniper left Dr Burrows, the patient in Bay 13 became aggressive towards his guard, Mr Khan, and rushed at him as though to hit him. When Mr Khan backed away, the patient picked up a plastic bottle of hand gel and threw it at him, striking him in the neck. A Code Black emergency was called by nursing staff.[85]

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[80] ts 317 per Juniper, A
[81] Exhibit 1, Volume 1, Tab 27
[82] Exhibit 1, Volume 1, Tab 27
[83] ts 318 per Juniper, A
[84] ts 319 per Juniper, A
[85] Exhibit 1, Volume 1, Tab 28

66. Dr Burrows, Ms Chilkott CN, Ms Meinen RN and Mr McLay CN were nearby. They as well as guards and other staff members attended the patient in order to defuse the situation. There was considerable commotion. The patient eventually calmed down and Mr McLay CN and Ms Meinen RN led him outside for a cigarette.[86]

67. During the brief time in which the patient in Bay 13 became aggressive and the Code Black emergency took place, the deceased took advantage of the distraction in order to leave the JHC-ED without being noticed.[87]

68. The precise time at which the events occurred following Dr Juniper's conversation with Dr Burrows about a guard for the deceased is not clear. Dr Juniper said that some ten minutes after she left Dr Burrows she was informed that the deceased had absconded from the hospital.[88]

69. The video recording of the interior of the JHC-ED shows the deceased leaving the patient treatment area in the JHC-ED at 11.23:03 and Mr Khan leaving the area near Bay 13 after being struck with the bottle of hand gel at 11.23:10. Mr Jabarkhil is seen entering the JHC-ED outside doors at 11.24:58. The patient in Bay 13 is seen leaving the hospital with Mr McLay CN and Ms Meinen RN at 11.31:44.[89]

70. Mr Jabarkhil's role at the JHC-ED was that of a roving guard. He was the senior security guard with X-Men Security and would arrange for guards to monitor patients at the request of JHC-ED staff.

71. There was an inconsistency between the evidence of Ms Chilkott CN and that of Mr Jabarkhil as to whether she had called him to organise a guard after Dr Juniper had requested one.

72. Ms Chilkott CN's evidence was that after Dr Juniper requested a guard, she called the roving guard, whom

[86] Exhibit 1, Volume 1, Tab 26
[87] Exhibit 1, Volume 1, Tab 26
[88] ts 319 per Juniper, A
[89] Exhibit 1, Volume 2, Tab 35

I infer was Mr Jabarkhil, to organise one. She testified that she spoke to him and filled in a request form at the same time.[90] Her evidence was supported by, among others, Ms O'Conner RN who recalled that she overheard Ms Chilkott CN speaking on the phone at the relevant time and asking for a guard.[91]

73. However, Mr Jabarkhil said that he had not received a call to request a guard for the deceased. He said that, if he had received a call, he would have had no problem in organising a guard. He said that he had not seen a written request for a guard for the deceased that day.[92] He said that he had entered the JHC-ED at around 11.25 am because he was responding to a notice on his phone of the Code Black.[93]

74. This inconsistency appears immaterial to me in circumstances where the JHC-ED staff were aware that the deceased was without a guard while awaiting Mr Jabarkhil.

75. This was particularly clear from the evidence of Ms O'Connor, who said that she was concerned for the deceased when the Code Black was called because she knew of his risk of self-harm from speaking with Ms Meinen RN, and she knew that he was not supposed to leave because he was to be put on MHA forms. She was standing where she could watch the deceased in Bay 12 and took it upon herself to observe him because she was aware that the guard for the patient in Bay 13 was not responsible for him.[94]

76. Unfortunately but not surprisingly, Ms O'Connor RN was distracted by the commotion caused by the patient in Bay 13 long enough for the deceased to leave without her noticing.[95]

[90] ts 241 per Chilkott, M
[91] ts 212 per O'Conner, E
[92] ts 131 per Jabarkhil, F
[93] ts 97 per Jabarkhil, F
[94] ts 205-206 per O'Connor, E
[95] ts 205-206 per O'Connor, E

77. Upon discovering that the deceased had left, Ms O'Connor RN began searching for him in toilets and in the JHC-ED waiting room.[96] When she was unable to find him, she notified her colleagues. Dr Juniper called police and requested that the deceased be apprehended and returned to the JHC-ED.[97]

THE EVENTS LEADING UP TO DEATH

78. The deceased left the JHC-ED through doors near the ambulance bay, walked through the hospital carpark and made his way to his home. At about 1.40 pm,[98] he called an old friend, Leigh Healy, who at the time was having lunch at a pub in Mullaloo with his partner. The deceased told Mr Healy that he was on his way home and asked Mr Healy to meet him there. Mr Healy agreed to do so.[99]

79. When Mr Healy arrived at the deceased's unit, the deceased's older sister, Josephine Stanczyk, was already there. She had received a phone call informing her that the deceased absconded from the JHC-ED.[100] The deceased's unit was locked but Ms Stanczyk and Mr Healy could see through a window that the deceased was hanging by the neck with a thick ribbon tied to the top balustrade of the upper level balcony.[101]

80. Ms Stanczyk and Mr Healy broke into the unit through the kitchen window.[102] They cut the deceased down and called police.[103]

81. Ambulance paramedics attended and administered cardiopulmonary resuscitation, including adrenaline and defibrillation, before taking the deceased to the emergency department at SCGH.[104] Further resuscitation was

[96] Exhibit 1, Volume 1, Tab 25
[97] Exhibit 1, Volume 1, Tab 27
[98] Exhibit 1, Volume 1, Tab 15
[99] Exhibit 1, Volume 1, Tab 2
[100] Exhibit 1, Volume 1, Tab 3
[101] Exhibit 1, Volume 1, Tabs 2 and 3
[102] Exhibit 1, Volume 1, Tabs 2 and 3
[103] Exhibit 1, Volume 1, Tab 15
[104] Exhibit 1, Volume 2, Tab 43

administered by emergency doctors, but the deceased could not be revived.[105]

THE CAUSE OF DEATH AND HOW DEATH OCCURRED

82. Forensic pathologist Dr J White conducted a post-mortem examination on 25 September 2012. Dr White found an evident ligature mark to the neck, congested lungs, an enlarged spleen and several small, superficial incised wounds to the inner aspect of the left wrist.[106] A toxicological analysis detected methylamphetamine and benzodiazepines in the blood and urine. Alcohol was not detected.[107]

83. Dr White formed the opinion that the cause of death was ligature compression of the neck (hanging), [108] and I so find.

84. On the basis of the circumstances described above, I find that death occurred by way of suicide.

ISSUES FOR CONSIDERATION

85. On the relatively narrow question of whether the deceased was properly monitored at the JHC-ED, the evidence raised the following issues:

    (a) whether the deceased could have been detained lawfully at the JHC-ED;

    (b) whether the deceased should have been so detained;

    (c) whether adequate steps were taken to detain him;

    (d) if not, what steps should have been taken;

[105] Exhibit 1, Volume 1, Tab 12
[106] Exhibit 1, Volume 1, Tab 6
[107] Exhibit 1, Volume 1, Tab 7
[108] Exhibit 1, Volume 1, Tab 6

(e) if those steps had been taken, whether the deceased would have absconded when he did; and

(f) changes implemented at the JHC-ED since the death.

86. The evidence also raised for consideration the lack of suitable alternatives in which to place the deceased while awaiting transfer to an authorised hospital.

COULD THE DECEASED HAVE BEEN DETAINED LAWFULLY?

87. There was evidence indicating that members of the JHC-ED staff held mixed views as to the source of power to detain the deceased.

88. The Office of the Chief Psychiatrist had produced a Clinician's Guide to the *MHA*[109] which, though to my mind is somewhat ambiguous, indicates that a person who has been made the subject of a Form 1 under the *MHA* but is not at an authorised hospital may only be detained if there is clear evidence of a real, significant and urgent risk to the person or to others unless the person is detained. While the language used is in the negative and relates to patients who, unlike the deceased, are under Form 1, the Clinician's Guide describes a common law power to detain patients under what was called by witnesses employed at the JHC-ED to be 'the duty of care'.

89. Dr Gibson agreed with Mr Quinlan SC's proposition that the 'duty of care' was a reference to the duty of care that a medical practitioner or a hospital may have to a patient to take reasonable steps to prevent immediate risk to that patient.[110]

90. In line with Mr Quinlan SC's definition, I am more familiar with a duty of care being used as a threshold issue for tortious liability rather than as a concomitant

[109] Exhibit 1, Volume 2, Tab 52
[110] ts 157 per Gibson, N

power, but I have no doubt that, in a general sense, hospital staff have power to protect patients from self-harm and that the power extends to detaining for a reasonable time and in a reasonable way acutely suicidal patients who are not under the *MHA*.

91. That latter notion also seemed to be the consensus of the staff members who gave evidence. However, due to a lack of an applicable statutory power due to a failure of the *MHA* to address that situation, some staff members felt unsure of the lawfulness of their actions. Ms O'Brien RN put it this way:

> I mean, it's one of these grey areas where we never know whether we're acting within the law or not by holding these patients against their will. We don't have many real laws to govern that. Even if they are on a form, we still – you know, we do it because we want to keep the patient safe but whether we're doing it lawfully or not – who knows.[111]

92. Dr McNeill said that she made reference to the *MHA* in her entry to the integrated notes for the deceased because:

> Over the years it has become apparent to me that nurses do have some difficulty in using detention and restraint unless they feel that we can use the Mental Health Act because I think that they're fearful of being charged with assault or some such thing.[112]

93. The current situation with respect to this 'grey area' is clearly unsatisfactory. Dr Gibson indicated that the situation is expected to be rectified when the *Mental Health Act 2014* takes effect, possibly later this year.[113]

94. Despite the legal uncertainties generally facing emergency clinicians with acutely suicidal mental health patients,

[111] ts 231 per O'Brian, G
[112] ts 305 per McNeill, R
[113] ts 146 per Gibson, N

there is no evidence to suggest that those uncertainties led to the care provided to the deceased at the JHC-ED being adversely affected.

95. In my view, no issue arises about whether the deceased should have been forcibly restrained or detained in some way in the JHC-ED prior to the time when he absconded. The open nature of the JHC-ED precluded a secure environment, and personal physical restraints would not have been reasonable given the deceased's general compliancy and lack of aggression.

96. In any event, the evidence suggests that, if the deceased had been more effectively monitored and a nurse or doctor had been able to speak with him in time, it is unlikely that physical restraint would have been required to detain him if he tried to leave.[114]

SHOULD THE DECEASED HAVE BEEN DETAINED?

97. The evidence of Dr Morgan, Dr McNeill and Dr Juniper leave me in no doubt that on 23 September 2012 the deceased was at a heightened risk of self-harm and that appropriate steps should have been taken to stop him from leaving the JHC-ED.

WERE ADEQUATE STEPS TAKEN?

98. The procedure then in place at the JHC-ED for a patient at risk of self-harm was to assign a one-to-one guard whose role was to watch the patient and to notify emergency staff if the patient became agitated or tried to leave. If the patient tried to leave, staff members would attempt to talk the patient into returning to his or her bay. If talking was not successful, the ultimate method was to call a Code Black and physically or chemically restrain the patient.

[114] ts 217 per O'Connor, E; ts 307 per McNeill, R

99. Each of Dr Morgan, Dr McNeill and Dr Juniper expected that the deceased would have been provided with a one-to-one guard at the relevant times. Dr Burrows said that when a doctor requested a guard for a patient, that was usually a one-to-one guard.

100. In my view, the evidence establishes that a guard was requested by Dr McNeill by way of an entry in the integrated progress notes at 8.00 pm on 22 September 2012 and that the request was confirmed at 12.30 on 23 September 2012.

101. Dr McNeill said that her decision was that the deceased 'should not leave no matter what' and that her expectation was that her decision would not be overridden until the deceased was next reviewed psychiatrically.[115] To paraphrase Dr Gibson, once a psychiatric registrar has determined that a patient should be kept in, the rest of the staff should effect that determination.[116]

102. It appears that a one-to-one guard was not provided because of either a lack of available resources during night shift or a lack of a system providing clear communication of what was expected, or both. Instead, the guard for the patient in Bay 13, who Dr McNeill had assumed was a one-to-one guard for the deceased, moved his chair to watch over the deceased as well.

103. When the shifts changed at 7.00 am the next morning, the effect of the miscommunication was carried over and no one-to-one guard was arranged for the deceased prior to the time he absconded.

104. On the face of the evidence, there was a failure to put in place a reasonable step to protect the deceased from anticipated self-harm in accordance with the JHC-ED's usual procedure.

[115] ts 308 per McNeill, R
[116] ts 163-165 per Gibson, N

WOULD A ONE-TO-ONE GUARD HAVE MADE ANY DIFFERENCE

105. The deceased was able to abscond unnoticed from the JHC-ED because the attention of staff and guards was distracted by the actions of the patient in Bay 13.

106. It is clearly arguable that the distraction caused by the patient in Bay 13 was such that, if a guard had been with the deceased in Bay 12, the guard would also have been distracted and may not have seen the deceased leave until it was too late.[117]

107. That argument is supported by Ms O'Connor's commendable but unsuccessful attempt to keep an eye on the deceased during the Code Black. She was standing directly opposite the deceased in Bay 12, yet she was distracted by the noise and commotion caused by the patient in Bay 13 and did not see the deceased leave. I note, however, that her attention was also diluted by concern for her own patients.[118]

108. While the evidence of Mr Jabarkhil was that a guard's responsibility is to focus on his patient, he also agreed that, if the patient for whom an X-Men Security guard is responsible is sleeping or settled, the guard could leave the patient to assist another guard.[119] That possibility appears to accord with X-Men Security's standing orders.[120]

109. As the deceased was apparently settled, especially in comparison with the patient in Bay 13, a guard assigned to him might well have left him in order to support his colleague in the next bay.

110. In addition, it is likely that a Code Black already in progress would have diverted the attention of other staff members away from the deceased, so if the guard had seen the deceased attempting to leave, the guard would

[117] ts 263 per Burrows, C
[118] ts 205 per O'Connor, E
[119] ts 109, 123 per Jabarkhil, F
[120] Exhibit 1, Volume 2, Tab 39

have been left to act alone to convince the deceased to stay. There was a clear and sensible policy for staff and guards not to attempt to act alone to detain a patient physically, so if the deceased was determined to leave, it is likely that he would not have been stopped by the guard.

111. In these circumstances, I cannot conclude to any level of certainty that the precaution of providing a one-to-one guard for the deceased would have stopped him from leaving when he did.

CHANGES AT THE JHC-ED SINCE THE DEATH

112. Following the deceased's death, a team of medical and nursing staff from JHC conducted an internal investigation, known as a root cause analysis, into the deceased's absconding from the JHC-ED on 23 September 2012.

113. The root cause analysis team identified several contributing factors to the event, including: [121]

(a) a lack of available beds at mental health facilities in the Perth metropolitan area;

(b) inadequate resources available in the JHC-ED to care for multiple psychiatric patients;

(c) an apparent failure to assess and communicate the appropriateness of a shared guard; and

(d) a lack of a documented plan for the deceased, including the requirement for a one-to-one nurse (also known as a special).

114. The team recommended actions, which included the following: [122]

[121] Exhibit 1, Volume 2, Tab 54. The findings have been paraphrased.
[122] Exhibit 1, Volume 2, Tab 54. The findings have again been paraphrased.

(a) to review the Code Black system to ensure a co-ordinated management of code black situations to ensure safety of patients and staff; and

(b) to review and to update the guard policy to ensure that appropriate guards or carers are assigned to patients with clear understanding and description of their roles.

115. Relevant changes made at the JHC-ED following the deceased's absconding have included:[123]

(a) employment of internal security staff to deal with aggression or violence and to respond to Code Black calls;

(b) an updated form to request special care for patients. Special care can be a security guard, a nurse special where a dedicated nurse attends the patient on a one-on-one basis, or a patient care assistant where that patient does not need psychiatric clinical care but has a risk of absconding or is confused and may wander. The updated form complements an updated patient special care policy, which provides guidance on determining the level of special care required by a patient;

(c) an updated mental health patient nursing observation form which clearly sets out a mental health plan; and

(d) the establishment of a Code Black response team specific to the JHC-ED, comprising five people plus the duty emergency medicine consultant and the shift co-ordinator. This team responds to Code Black emergencies in seconds and allows other staff to continue to attend to their own patients.

116. These changes appear reasonable and appropriate. However, it seems clear that the potential for mental health patients to abscond from the JHC-ED still exists,

[123] Exhibit 11

even when the patients are under the *MHA* and even when they are guarded. For example, a patient who has been in the JHC-ED for days and has become frustrated may go out with a guard for a smoke and simply walk away. Even calling a Code Black is ineffective to stop the patient because, once a patient is in the car park, staff consider that there is nothing they can do.[124]

ALTERNATIVES TO THE JHC-ED

117. The first of the contributing factors identified in the root cause analysis mentioned above was the lack of beds at mental health facilities in the Perth metropolitan area.

118. Rather startling statistics provided by the Minister for Health to the Legislative Council of the Western Australian Parliament on 2 May 2012[125] and further, even more startling, statistics relating to 2013 and 2014 provided to the inquest by JHC[126] indicated that the JHC-ED and other emergency departments in the Perth metropolitan area have been regularly forced to accommodate for several days patients experiencing mental health complaints because of the lack of places available at appropriate facilities.

119. For example, in 2014 the lengths of stay at JHC-ED of a total of 749 mental health patients was: one to two days for 460 patients, two to three days for 188 patients, three to four days for 63 patients, four to five days for 28 patients and more than five days for 10 patients. The statistics necessarily include patients who must receive treatment for acute medical conditions such as drug overdoses or, as in the deceased's case, the effects of self-harm.[127]

120. Those figures occurred despite protocols to transfer mental health patients from emergency departments to appropriate clinical environment within 24 hours, and a

[124] ts 331 per Tran, V
[125] Exhibit 8
[126] Exhibit 10
[127] ts 141, 152, per Gibson, N

more recent 4 hour rule protocol applying to all patients who present at emergency departments.[128]

121. It is clear on the evidence that the accommodation of acutely mentally ill patients in an emergency ward for an extended period of time is likely to be detrimental to the patients, to create a risk to staff and other patients, and to prevent staff from treating other patients with acute medical conditions.[129]

122. The patient in Bay 13 was an example of such a patient. He presented at the JHC-ED on the evening of 20 September 2012, was placed under the *MHA* on 21 September 2012 and acted aggressively on the morning of 23 September 2012. He was not transferred out of the JHC-ED into the JHC-MHU until late in the afternoon of 24 September 2012.[130]

123. The number of mental health patients in similar circumstances has increased from September 2012 to the date of the inquest despite the creation of more places in authorised hospitals and the use of non-police officers to transfer patients who have been made involuntary under the *MHA*.[131]

124. A longer term solution to this unsatisfactory situation from a medical/mental health management perspective would be the provision of a sufficient number of places in mental health facilities where mental health patients can be managed and treated appropriately.[132]

125. In other jurisdictions, notably Queensland and New South Wales, facilities known as mental health observation areas or psychiatric emergency care centres have been created at hospitals to provide specialised emergency care to patients with mental health disorders and behavioural risk such as aggression or self-harm requiring acute intervention.

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[128] ts 150-151 per Gibson, N
[129] ts 150-155 per Gibson, N ts 279-280 per Burrows, C; ts 339 per Wood, S
[130] Exhibit 9
[131] ts 282-283 per Burrows, C; ts 159-162 per Gibson, N; Exhibits 8 and 10;
[132] ts 150, 159 per Gibson, N;

126. Dr Wood said that the Royal Brisbane Hospital was the first hospital in Australia to have a psychiatric emergency care centre and that there are some 13 mental health observation areas/psychiatric emergency care centres in New South Wales.[133] My on-line research revealed that the facility at the Royal Brisbane Hospital was created in 1983.[134]

127. Dr Wood testified that JHC wants to provide a similar facility for high risk patients because of community demand. As the JHC-ED is a public emergency department, it is the State's responsibility to provide the infrastructure for such a facility if one is to be created there. JHC has made a submission to Treasury about the necessary capital funding, but as at the date of the inquest Dr Wood did not know if the State had acceded to the request.[135]

128. It appears to me that the creation of such facilities in Western Australia would provide the benefit of reducing the identified problems facing emergency departments in managing mental health patients, as well as providing specialised emergency medical care to patients at high risk before they are transferred to facilities where on-going psychiatric care can be provided.

COMMENTS ON THE QUALITY OF TREATMENT AND CARE

129. The evidence established that the professionalism and commitment of the staff at the JHC-ED and the JHC-MHU who cared for the deceased was of a uniformly high standard and was characterised by compassion and personal concern.

130. However, it is apparent from the foregoing that, as a result of a number of coincidental factors relating to systemic communication issues, the deceased was allowed to leave the JHC-ED while he was known by all relevant staff to be at a high risk of suicide. A step which

[133] ts 341 per Wood, S
[134] Australian Psychiatry Vol 13, No 3 September 2005 p.266
[135] ts 340-431 per Wood, S; Exhibit 11

could have been taken to ensure so far as practicable that he not be allowed to leave was not taken, so from a purely objective perspective, it follows that the quality of care provided was, to that limited but important extent, inadequate.

131. Since the time of the deceased's death, the systemic failures leading to the deceased absconding from JHC-ED have been addressed though, in the absence of a place and means of keeping high risk patients in a secure environment before they can be placed in an authorised facility, there remains a concern that mental health patients kept in emergency departments for extended periods are still able to abscond.

CONCLUSION

132. The deceased was a profoundly troubled young man facing significant stressors. Competent and experienced medical and psychiatric professionals at the JHC-ED identified his risk of self-harm or suicide to be high, but systemic issues relating to communication failures led to him being allowed to abscond from the hospital. He went to his home where he committed suicide as was feared.

133. The evidence in this inquest initially focused on an apparent failure by the JHC-ED to ensure that the deceased was appropriately monitored while he was awaiting assessment by a psychiatrist to determine whether he should be placed under the *MHA*.

134. While that issue was closely investigated, the issue was overshadowed by evidence showing that, due to an inadequate number of places at appropriate mental health facilities to provide for the demand, a growing number of acute mental health patients were, and are, being kept in emergency departments for days while they await a place. This is unsatisfactory for the reasons discussed above.

135. In addition, while this situation continues, it is likely that more at-risk patients will abscond from emergency departments, with the potential for similar tragic results.

136. I encourage those who determine the allocation of resources for mental health services in Western Australia to consider the need for a timely solution.

Barry King
Coroner
16 July 2015