Coroners Act 1996
[Section 26(1)]

Coroner's Court of Western Australia

RECORD OF INVESTIGATION INTO DEATH

Ref: [2020] WACOR 9

I, Sarah Helen Linton, Coroner, having investigated the death of ***Nualla Christine REILLY*** *with an inquest held at the* ***Perth Coroner's Court, Court 55, CLC Building, 501 Hay Street, Perth*** *on* ***24 to 25 February 2020*** *find that the identity of the deceased person was* ***Nualla Christine REILLY*** *and that death occurred on* ***9 June 2017*** *at* ***Carlisle Train Station*** *as a result of* ***multiple injuries*** *in the following circumstances:*

Counsel Appearing:

Ms F Allen assisting the Coroner.
Ms B Burke appearing on behalf of Nurse Kaitlyn Lucy.
Ms R Panetta and Ms G Mullins (State Solicitor's Office) appearing on behalf of the East Metropolitan Health Service and South Metropolitan Health Service.

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INTRODUCTION

1. Nualla Christine Reilly was a 74 year old woman who had never married or had children. Ms Reilly had a long history of mental health issues, including a longstanding personality disorder that made it difficult for her to form and maintain new relationships. Ms Reilly did, however, come from a large family and she had good family support from her siblings.

2. Ms Reilly had lived alone in Redcliffe with her dog until shortly before her death. In the middle of 2016 Ms Reilly experienced a significant relapse of her mental health conditions, in part due to her beloved pet dog coming towards the end of its life. Ms Reilly's psychiatric conditions became increasingly difficult to manage and she had a number of hospital admissions in late 2016 and early 2017 related to her deteriorating mental state, which included suicidal thoughts and attempts.

3. Ms Reilly's last hospital admission at the Bentley Older Adult Mental Health Service (Bentley Hospital) was for an extended period from 25 January 2017 to 2 June 2017. It was decided by medical staff and her family during that admission that she was no longer safe to live at home on her own. It was intended that she would move from hospital to a nursing home facility near family.

4. While looking for a suitable nursing home placement, Ms Reilly was transferred to a transitional care facility, Amana Living's Bull Creek Transition Care facility, on 2 June 2017. Ms Reilly was unhappy at the transitional care facility and on 9 June 2017 she attempted suicide by dropping her mechanical bed on to her head. She was taken to Fiona Stanley Hospital Emergency Department for medical review. Ms Reilly indicated to hospital staff that she had attempted suicide as she felt it was the only way to resolve her current crisis. She was assessed as still being still actively suicidal.

5. Ms Reilly was adamant during psychiatric assessment that she didn't want to return to the Amana facility, nor to Bentley Hospital. She said she wanted to go home, but this was not an option. After undergoing review in the Emergency Department, a plan was made by a Psychiatric Registrar to transfer Ms Reilly to Bentley Hospital, where they knew her well, for further psychiatric review. Ms Reilly declined to go there voluntarily, so she was placed on forms under the *Mental Health Act 2014 (WA)* that required her to be transported to Bentley Hospital and assessed by a psychiatrist to determine whether she should be made an involuntary patient.

6. While the relevant paperwork was being completed by the psychiatric staff, there was some confusion amongst Emergency Department nursing staff as to what was happening with Ms Reilly. In the confusion, Ms Reilly was mistakenly permitted to leave the hospital unaccompanied. She immediately got in a taxi outside the hospital and travelled to Victoria Park Train Station, where she caught a train to Carlisle Train Station. After arriving at Carlisle Train Station, Ms Reilly left the platform and shortly after walked on to the train tracks, where she was hit by an oncoming train. Ms Reilly suffered fatal injuries and died at the scene. I am satisfied that her death was an intentional act of suicide.

7. Ms Reilly's death was treated as a death of a 'person held in care' for the purposes of the *Coroners Act 1996* (WA), as she was absent without leave from Fiona Stanley Hospital under s 97 of the *Mental Health Act 2014 (WA)*, after being 'detained' on a Form 1A and Form 4A. Although no specific detention order was completed, I note this was the form of words used by the Psychiatric Registrar, Dr Wood, when she spoke to a nurse in the Emergency Department, advising that Ms Reilly was "now detained on a Form 1A."[1] It was Dr Wood's intention that Ms Reilly would be supervised by hospital staff until her transfer to Bentley Hospital was arranged, but unfortunately this was not put in place before Ms Reilly left Fiona Stanley hospital.

8. Under s 25(3) of the *Coroners Act*, 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. The inquest focused primarily on the circumstances around how Ms Reilly was able to abscond from Fiona Stanley Hospital after being placed on forms.

9. For the sake of clarity, I note that if for some reason my interpretation of Ms Reilly as a person held in care is incorrect, I indicated at the commencement of the inquest that I would in any event have exercised my discretion under s 22(2) of the Coroners Act to hold an inquest into the death and I would have given consideration to the same issues.[2]

BRIEF BACKGROUND

10. Ms Reilly was born in Busselton into a large family, with six children in total. She left school at 14 years of age and worked in a factory and later as a shop assistant and a cleaner.[3] Ms Reilly remained single and for many years she lived with her mother and acted as her mother's carer. After her mother passed away Ms Reilly obtained her own Department of Housing accommodation in 1996.[4]

11. Ms Reilly spent a lot of time alone, and when she did socialise, it was with her brothers and sister. She would regularly meet her family each week to play cards. Ms Reilly also enjoyed walking her dog twice a day, where she would interact with other dog walkers.[5]

12. A psychiatrist who treated Ms Reilly explained that Ms Reilly's personality disorder made it difficult for her to form and maintain relationships, although this did not apply to her family. However, even her family relationships worked better when she was able to live independently. Unfortunately, as set out below, her ability to do so changed over time.

[1] Exhibit 1, Tab 28 [37].
[2] T 6 – 7.
[3] Exhibit 1, Tab 2, p. 2; Exhibit 2, Tab 5.
[4] Exhibit 1, Tab 2, p. 2; Exhibit 2, Tab 5.
[5] Exhibit 1, Tab 2, p. 2; Exhibit 2, Tab 5.

DETERIORATION IN MENTAL HEALTH 2016 - 2017

13. Ms Reilly had been diagnosed with borderline personality disorder, anxiety and depression. She also suffered from type 2 diabetes (and was insulin dependent), peripheral neuropathy, hypertension (high blood pressure) and dyslipidaemia (high cholesterol). She was prescribed a number of medications for her health conditions, including the antidepressants Amitriptyline and Brintellix, as well as a number of medications for her diabetes, including insulin.

14. Ms Reilly's family described her as a worrier with low self-esteem and they were aware she suffered from depression, anxiety and diabetes. They had noticed that over the last 18 months of her life that Ms Reilly's capacity to manage her anxiety and depression had decreased. She had retreated from her usual activities and become more isolated.[6]

15. Ms Reilly's GP, Dr Arthur Devlin, advised that Ms Reilly experienced a significant relapse of her mental health condition around July 2016. Her condition became increasingly difficult to manage, which led to her admission to hospital. Ms Reilly was admitted to the psycho-geriatric ward of Bentley Hospital on 17 October 2016 as a voluntary patient. She reported suicidal thoughts and had taken an overdose of her insulin. She was diagnosed with a relapse of her generalised anxiety disorder. Ms Reilly was commenced on antipsychotic medication and her antidepressant medications were changed. She responded well to treatment and her anxiety and suicidal thoughts settled. She was discharged home on 3 November 2016.[7]

16. On 7 December 2016 Ms Reilly was admitted to the Emergency Department of Armadale-Kelmscott Memorial Hospital due to ongoing depression, fleeting suicidal thoughts, and an attempt to commit suicide by strangling herself with monitor cords. She also reported she had stopped eating three days before and ceased taking her insulin in an attempt to end her life. There is a reference to Ms Reilly having made attempts to abscond from the ward. It was felt that her symptoms might be due to a sudden change in her antidepressants. She initially was treated for physical health issues and after she was medically cleared she was admitted to the Psychiatric Unit and later discharged.

17. On 22 December 2016, Ms Reilly presented to Royal Perth Hospital (RPH) and reported feeling low, having panic attacks and being worried about her physical health. She also admitted taking another insulin overdose. Ms Reilly was transferred to Bentley Hospital on 23 December 2016 as a voluntary patient and was commenced on the antipsychotic medication quetiapine. Her mood improved and she denied any further suicidal plans. She was discharged home on 9 January 2017. Arrangements were made on discharge for Ms Reilly's insulin to be kept in a locked box and administered to her by Silver Chain nurses. Ms Reilly appeared agreeable to this arrangement.[8]

[6] Exhibit 1, Tab 2, p. 2; Exhibit 2, Tab 5.
[7] Exhibit 2, Tab 11.
[8] Exhibit 1, Tab 17, p. 2; Exhibit 2, Tab 9.

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18. Ms Reilly saw Dr Devlin three days later on 12 January 2017 with generalised panic and agitation. She refused to go to Bentley Hospital and denied suicidal intent. He gave her an injection of Valium and increased her Seroquel dose. The next day she was much improved but Dr Devlin told Ms Reilly and her sister that while this crisis had resolved, she must engage with the specialist psychiatric services again as he had grave concerns for her long term symptom control.[9]

19. Ms Reilly presented to RPH the next day after taking an overdose of her medication the previous evening. She complained of constant suicidal thoughts and had left a suicide note after ingesting the contents of her Webster Pak and drinking whiskey. It was noted that her pet dog was ill with cancer and was probably going to have to be put down, which had led to her current crisis. She reluctantly agreed to a voluntary admission but constantly expressed a desire to die as she saw no light at the end of the tunnel.[10] Ms Reilly apparently struggled on the first ward she was placed on, as she felt it was a 'young person's place'. Arrangements were made to transfer her to the Bentley Hospital Older Adults Unit.

20. Ms Reilly was transferred back to Bentley Hospital on 25 January 2017, where she remained for an extended admission of many months.[11]

21. Consultant Psychiatrist Dr Gary Budrikis worked as a consultant in charge of the inpatient unit in Older Adult Psychiatry at the Bentley Mental Health Service at the time. Ms Reilly was a patient under Dr Budrikis' care from 25 January to 2 June 2017, as well as some previous admissions. He had known her as a patient with the service since August 2016.[12]

22. Dr Budrikis provided a very detailed report in relation to Ms Reilly's care at Bentley Hospital and he also gave evidence at the inquest. Dr Budrikis summarised Ms Reilly's background as recording a longitudinal history that suggested she suffered from a personality disorder throughout her life, characterised by emotional instability and recurrent impulsive self-destructive behaviour that is sometimes called borderline personality disorder. Her personality disorder was complicated by recurrent depressive episodes.[13] Dr Budrikis explained at the inquest that the personality disorder and depression compounded each other, in the sense that having a depressive illness will make it more difficult for the person with an underlying personality disorder to behave in a way that's normal and in their best interests.[14] Ms Reilly was prescribed an antidepressant medication.[15]

[9] Exhibit 1, Tab 12.
[10] Exhibit 1, Tab 18, p. 3; Exhibit 2, Tab 8 and Tab 12.
[11] Exhibit 1, Tab 8.
[12] Exhibit 1, Tab 15.
[13] T 134 – 135.
[14] T 135.
[15] Exhibit 1, Tab 15.

23. Ms Reilly's physical ailments included type 2 diabetes, neuralgic pain related to her diabetes, hypertension, high cholesterol levels, vitamin D deficiency and magnesium deficiency.[16]

24. Dr Budrikis explained that Ms Reilly's diabetes was a further complicating factor for her mental health conditions. Type 2 diabetes is often associated with frontal lobe impairment in later life, due to cerebrovascular disease. On top of that, Ms Reilly had made several suicide attempts by taking insulin, which can cause brain injury.[17] It was also suspected Ms Reilly took overdoses of another medication, a tricyclic agent, which has a high mortality if taken in overdose. Dr Reilly observed that "it can certainly be suspected that she may have sustained hypoxic brain injuries during one or more of these overdoses."[18]

25. Therefore, at the time of her admission in June 2017, Ms Reilly had three factors at play: the lifelong personality disorder, the recurrent depression and her medical problems, which together caused her to have sufficient difficulty in terms of thinking and decision-making that she had need of a guardian to help her make important life decisions, such as where she should live.[19]

26. During her lengthy admission from January to June 2017, Dr Budrikis concluded there was clinical evidence of impaired frontal lobe function, resulting in impairment of impulse control, judgment and decision making capacity. He noted that this is a common enough scenario in older adults who have sustained brain injuries, and is sometimes termed 'organic personality disorder', but it can be easily missed even by experienced clinicians who are not specifically trained in the recognition of the disorder as the persons affected are often still well groomed, fluent and coherent.[20] This was consistent with the reports of Ms Reilly on the day she died, as she was well dressed and not visibly thought disordered or agitated.[21]

27. Although Ms Reilly was single, it was apparent that she had a close, supportive family, consisting first and foremost of her siblings. Ms Reilly's siblings were consulted and they willingly attended family meetings with the medical staff.[22]

28. Ms Reilly had voiced concerns to a social worker, in the presence of her sister, that she did not feel safe at home anymore and had said she would like to go to a nursing home or to live with her sister. However, when spoken to separately, Ms Reilly's sister told the social worker that historically Ms Reilly would live with her for two weeks and then would want to return home. Ms Reilly's sister did not want Ms Reilly to return home, but also did not want to place her in a nursing home. Ms Reilly's sister eventually signed an aged care assessment form and a family meeting was scheduled.[23]

[16] Exhibit 1, Tab 15.
[17] T 135.
[18] T 135; Exhibit 1, Tab 15, p. 2.
[19] T 135.
[20] T 136; Exhibit 1, Tab 15.
[21] T 136.
[22] Exhibit 1, Tab 2, p. 2 and Tab 15.
[23] Exhibit 1, Tab 17, p. 4.

29. Dr Budrikis acknowledged that Ms Reilly's response to treatment for depression during her lengthy stay at Bentley Hospital was by no means a full response. This fact, combined with the evidence of impaired frontal function and the history of recurrent suicide attempts, gave rise to concerns that Ms Reilly was no longer capable of safely living at home, especially alone. Ms Reilly's brother, who was her guardian, and other members of her family, had discussion with the treating team and it was agreed it was not in her best interests to return home. Dr Budrikis described it as a "consensus decision" that the time had come for Ms Reilly to go into residential care.[24]

30. There was some difficulty working out the level of care Ms Reilly required, as she had low physical care needs but high behaviour management issues. Ms Reilly was consulted and she seemed agreeable to moving to some sort of aged care facility, but indicated she was worried about restrictions on her independence and freedom in a high care facility. She was given some reassurance and told that the level of freedom she would be given would depend on her assessment. A plan was formulated to begin applying for a place at suitable nursing homes near family. It was felt by a social worker that Ms Reilly might be difficult to place and it was going to be necessary for her to go to transitional care while waiting for a place to become available at an appropriate aged care facility.[25] Ms Reilly indicated she would prefer to leave Bentley Hospital and was agreeable to moving to transitional care until a permanent placement became available.[26]

31. A referral was forwarded for transitional care on 20 April 2017 and applications were also sent to various nursing homes. Dr Budrikis had indicated there needed to be a family meeting about whether Ms Reilly required a secure or non-secure facility as she had tried to abscond from the ward on 19 April 2017 while barefoot and with no money, apparently with the plan to go home using public transport as she was having trouble sleeping. Eventually a place was found at a transitional aged care facility run by Amana Living in Bullcreek, which Ms Reilly and her family accepted.[27]

32. Dr Budrikis advised that while Ms Reilly acquiesced to this placement arrangement, he clearly recalled that there was a contingency plan in place in case she refused aged care placement. The contingency plan involved seeking guardianship orders with the State Administrative Tribunal on the basis that Ms Reilly lacked the capacity to refuse recommendations of aged care placement. Dr Budrikis was relatively certain that Ms Reilly would have been aware of the contingency plans, as they would have been discussed at family meetings in her presence.[28]

33. Ms Reilly was transferred to Amana Living's Bull Creek Transitional Care facility on 2 June 2017, to await a residential care home placement.[29] There was a three month window for a placement to be found.[30] In the care transfer summary she was assessed as a medium risk of absconding.

[24] T 136.
[25] Exhibit 1, Tab 17, p. 4 - 5 and Tab 29.
[26] Exhibit 1, Tab 17, p. 5 and Tab 29.
[27] Exhibit 1, Tab 2, p. 2 and Tab 15 and Tab 17 and Tab 29.
[28] Exhibit 1 Tab 15.
[29] Exhibit 1, Tab 17, p. 7.
[30] T 138.

TRANSFER TO AMANA LIVING

34. Upon her arrival at Amana Living on 2 June 2017 Ms Reilly appeared unsettled, and she continued to complain of feeling unhappy and having thoughts of suicide. Dr Budrikis explained that Ms Reilly's frontal lobe impairment left her with poor coping skills, so when she was unhappy and under stress she decompensated and acted out rather than being able to think rationally about her situation.[31]

35. On 6 June 2017 a social worker met with Ms Reilly's sister and the social worker explained that Ms Reilly would require a secure nursing home placement due to her risk of "overdose, self-harm, absconding risk and longstanding anxiety disorder."[32]

36. The next day Ms Reilly told a nurse that she had telephoned a friend to ask them to take her away from the facility so that she could kill herself. She was placed on 30 minute observations.[33] Her response to the increased observations was to ask staff why they were "spying on her all night."[34]

37. On 8 June 2017 a multidisciplinary team meeting recorded that Ms Reilly was on 30 minute observations and she continued to voice suicidal thoughts.

38. At 2.50 am on 9 June 2017 an entry in the notes records that Ms Reilly claimed she had attempted suicide by dropping her bed on to her head. She was said to have placed a couple of books on the floor, placed her head on the books and then lowered the bed on her head in an attempt to crush it.[35] Ms Reilly had done something very similar when admitted as a patient at Bentley Hospital a few months prior, and had also threatened to do it again while still at Bentley.[36]

39. She was examined and found to have a haematoma on the left side of her head and a small laceration to her left ear lobe. Care staff liaised with Fiona Stanley Hospital staff and a decision was made that she should be sent to hospital for further management. Transfer by ambulance to Fiona Stanley Hospital was arranged.[37]

40. The SJA Patient Care Record indicates the ambulance officers were told Ms Reilly did not want to live in the nursing home anymore and the staff at the facility could not cope with her, so she was being sent to the Fiona Stanley Hospital Emergency Department (FSH ED). A note was also made that Ms Reilly had allegedly self-harmed with an intent to kill herself.[38]

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[31] T 137.
[32] Exhibit 2, Tab 5, iCareHealth p. 3 of 7, entry 6.6.17 15:23.
[33] Exhibit 2, Tab 5, iCareHealth p. 1 of 7, entry 7.6.17 16:45.
[34] Exhibit 2, Tab 5, iCareHealth p. 7 of 8, entry 8.6.17 06:00.
[35] Exhibit 2, Tab 5, iCareHealth p. 4 of 8, entry 8.6.17 02:50.
[36] Exhibit 1, Tab 15, Annexure A, p. 2.
[37] Exhibit 1, Tab 2, p. 3; Exhibit 2, Tab 5.
[38] Exhibit 1, Tab 19, SJA Patient Care Record – 16370468.

FIONA STANLEY HOSPITAL ATTENDANCE

41. Ms Reilly arrived at the Fiona Stanley Hospital (ED) by ambulance at 3.25 am. She was triaged as a Category 3 patient, so examination was not considered to be urgent. She had bruising to her left forehead and an abrasion to her left ear, but her primary medical need was for a Mental Health Assessment. She was placed in Bay 37 of Fiona Stanley Hospital ED to await assessment.

42. Ms Reilly was initially reviewed by the ED intern and notes were made of this review at 5.35 am (although the review appears to have occurred sometime earlier). Ms Reilly was reported to be still actively suicidal in the ED. She said she had nothing to live for anymore and that her accommodation was making her feel worse. She was crying during the assessment and was assessed as a current risk to herself. The plan was for the psychiatric liaison nurse (PLN) to review her.

43. A Mental Health Assessment was completed by the PLN on duty, Clinical Nurse Specialist Tim Smith. There is some discrepancy as to when this occurred, but Nurse Smith believes the assessment began around 4.45 am.[39] Nurse Smith had not met Ms Reilly before but he was able to access Ms Reilly's history of multiple hospital presentations over the last 12 months for impulsive self-harm and suicide attempts, including her recent lengthy admission to Bentley Hospital. Nurse Smith was able to access this information via PSOLIS, the mental health electronic records system.[40]

44. The purpose of Nurse Smith's assessment of Ms Reilly was to perform a risk assessment.[41] It is the usual practice for the PLN to review a mental health patient in the ED first, and then to refer the patient to the Psychiatric Registrar if required.[42]

45. When he went to see her in the ED, Nurse Smith recalled that Ms Reilly was lying in bed and appeared calm and very happy to talk. She told Nurse Smith that her mood was "terrible"[43] and she said to him, "I'm suicidal."[44] Ms Reilly told him that she had tried to kill herself by lowering the bed onto her head. Nurse Smith documented that Ms Reilly's main issue was her living arrangements. She said she was very unhappy living at the Amana facility and "wanted to go to a nursing home."[45] She felt that most of the people at Amana were below her level of functioning and "she was unable to socialise with them in a meaningful manner."[46] She said the other residents were "old and demented and they did not know how to play bingo."[47] Ms Reilly also reported difficulty sleeping at night due to the other residents calling out and walking about at night and a light in the corridor outside her bedroom that kept her awake.[48]

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[39] T 9.
[40] T 9; Exhibit 1, Tab 16 [24].
[41] T 11.
[42] T 8.
[43] T 12.
[44] T 12.
[45] Exhibit 1, Tab 16 [23].
[46] Exhibit 1, Tab 16 [24].
[47] Exhibit 1, Tab 16 [24].
[48] T 10 - ; Exhibit 1, Tab 16 [24].

46. Ms Reilly was adamant she did not want to return to the Amana transitional facility and she was also adamant that she did not want to go back to Bentley Hospital, as she did not like "being locked up."[49] Ms Reilly stated that she had decided to end her life as it was the only way she could see out of her situation.[50] Ms Reilly asked Nurse Smith if she could stay at Fiona Stanley Hospital instead, but he explained to her that this was obviously not a long term option. She then asked him if she could go straight to a nursing home, but he understood this was not a possibility as there was no available placement for her at the time. Nurse Smith understood the only real options for Ms Reilly were to return her to Amana or send her to back to Bentley Hospital again but he needed to explore the options further. Nurse Smith confirmed with Ms Reilly that she was "quite happy to stay in hospital"[51] while he did that.

47. Nurse Smith believed that he spent approximately one hour with Ms Reilly, although he accepted in evidence it may have been closer to 45 minutes.[52] As indicated above, Ms Reilly reported she had attempted suicide as she felt it was the only way to resolve her current crisis, but she denied having any other plans to end her life at the time of the assessment. She did, however, "admit to having tried to think of other ways to commit suicide but had been unable to come up with any plan."[53]

48. At the end of the assessment, Nurse Smith considered Ms Reilly required psychiatric review. He checked with her to make sure she was happy to stay and told her the psychiatric doctor would come and see her. At no stage did Nurse Smith form the impression that Ms Reilly was going to get up and try to leave the hospital. She had told him that she wanted to stay at Fiona Stanley Hospital and when he explained to her that her options were to probably go back to Amana or Bentley Hospital, she had said to him, "I will refuse to leave"[54] the hospital.

49. Nurse Smith was not aware of an entry in the handwritten medical notes which was timed at 5.12 am. The note recorded that Ms Reilly had attempted to leave the ED and was observed walking down the assessment corridor heading towards the triage area. When stopped, she informed staff that she wanted to leave. Ms Reilly was advised that she needed to finish being assessed and security would be called if she tried to leave again. Ms Reilly was then easily re-directed back to Bay 37 and the treating ED Junior Medical Officer was informed. A further entry in the notes at 5.30 am indicated she was settled in her bay and clinical staff searched her belongings to make sure she had no medications or harmful objects in her possession.[55]

50. I note that the timing of these entries does not marry up well with the chronology given by Nurse Smith. Nurse Smith explained in his evidence that the 4.45 am time is the time that he began his assessment and the timestamp

[49] Exhibit 1, Tab 16 [26].
[50] Exhibit 1, Tab 16 [27].
[51] T 10.
[52] T 25.
[53] Exhibit 1, Tab 16, Mental Health Assessment, Mental State Assessment.
[54] T 13.
[55] Exhibit 1, Tab 2, p. 3 and Tab 21; Exhibit 2, Tab 4, Continuation Notes.

at the bottom of the mental health assessment plan indicated 5.33 am, which was when he saved the document. He believes it would have taken 10 to 15 minutes to complete. He then filled in the mental health risk assessment, which is time stamped 5.42 am.[56]

51. Based on the above, at 5.12 am Nurse Smith would still have been seeing Ms Reilly. Nurse Smith was certain he was not aware of the fact Ms Reilly had tried to leave at the time he saw her and he indicated he would normally read the handwritten notes when he came into the bay. Nurse Smith felt it was possible the entry was made at the same time that he was seeing Ms Reilly, and recorded an earlier event.[57] It would seem by the time of the 5.30 am note, Nurse Smith had probably returned to the psychiatric office.

52. Nurse Smith gave evidence that if he had been aware of the absconding incident, it would have led him to add a line of questioning of Ms Reilly about her absconding. He said he would have asked her directly, "Do you want to leave or are you going to try and leave?" However, Nurse Smith said the information may not have changed anything in terms of his plan from that point on, depending on how she answered. If she answered 'yes', then he would have looked at different options available from that point forward in terms of asking for a 'one-to-one nursing special' to be arranged and making sure that people were more aware of her, as well as whether she might need to be placed under the *Mental Health Act* because she was posing a more heightened risk and might not be cooperative.[58]

53. As it was, Ms Reilly had told him that she had suicidal thoughts but no specific plans or intent to act on them while in the ED. Unlike in some cases, the ED environment itself was not making Ms Reilly feel more anxious or more suicidal and Nurse Smith was comfortable that she was settled when he left her and she gave no indication she might act impulsively.[59]

54. Nurse Smith did not see Ms Reilly again after this assessment as he finished his shift soon after, but he did arrange for a psychiatric registrar to review her.[60] He explained that he arranged the review as she was refusing the options of returning to Bentley Hospital and Amana and it was clear she would need an admission, which required a medical review to be conducted first.[61] He spoke to the psychiatric registrar on shift, Dr Margaret Wardrop, and explained the situation and gave her his assessment before she went and reviewed Ms Reilly. Nurse Smith also spoke to Dr Wardrop after her review so he could do a verbal handover for the next shift.[62]

55. His genuine belief at the time was that Ms Reilly was happy to wait in the ED and was not at risk of absconding. Nurse Smith gave evidence that he was very surprised when he was informed at home that afternoon that Ms Reilly had left the hospital, and was also very surprised at the elevation of lethality in her actions to jumping in front of a train. He said that he would never have

[56] T 24 – 25; Exhibit 2, Tab 4,
[57] T 15 – 16.
[58] T 16.
[59] T 21 - 23.
[60] Exhibit 1, Tab 16 [28] – [29], [31].
[61] T 17 - 18.
[62] T 18.

thought that was going to happen, based upon his assessment of her that morning.[63]

56. An entry at 7.05 am by Psychiatric Registrar Dr Wardrop documented that Ms Reilly remained suicidal and had asked Dr Wardrop for an "injection to kill her so that she could stop suffering". Ms Reilly indicated that if she was in a nursing home she felt she would no longer be suicidal and she would be in a more comfortable environment. Ms Reilly also indicated that she did not want to go back to a hospital as she felt she had spent too long "locked up" and needed time to redevelop skills at living by herself, away from an institution. She expressly indicated that she did not want to return to the transitional care facility or Bentley Hospital.[64]

57. Dr Wardrop's impression was of an adjustment disorder with situational crisis and chronic risk of suicide. The plan was to discuss her case with a consultant and leave her in the ED in the interim.[65]

58. At 7.30 am Ms Reilly refused breakfast. She was noted to speak to her sister about 20 minutes later, at 7.50 am.[66]

59. The next PLN, Clinical Nurse Specialist Jacqueline Spinks, had commenced her shift at 7.00 am. Nurse Spinks recalled seeing Ms Reilly during her walkaround after handover and noting Ms Reilly was well-dressed, but she did not speak to her. Nurse Spinks understood that the task for Ms Reilly that morning was to make a decision about where she was going to be sent.[67]

60. Nurse Spinks spoke to Amana Living during the morning and they advised they could not take Ms Reilly back as she had been difficult to manage and she was obviously not happy there, so they were concerned about the acuity of her risk to herself at that time and felt they could not manage her behaviour.[68] Nurse Spinks was aware that Ms Reilly had been waitlisted for Bentley Hospital and Bentley Hospital had been faxed over information about Ms Reilly in the early hours of the morning. Nurse Spinks was waiting for an indication from Bentley that they had a bed available and they were able to receive Ms Reilly by transfer.[69]

[63] T 19 - 20.
[64] Exhibit 1, Tab 21; Exhibit 2 Tab 4, Medical Progress note, 9.6.17, 7.05 am.
[65] Exhibit 2 Tab 4, Medical Progress note, 9.6.17, 7.05 am.
[66] Exhibit 1, Tab 21; Exhibit 1, Tab 22 [10].
[67] T 100.
[68] T 103 - 105; Exhibit 1, Tab 27.
[69] T 101 – 102.

61. Nurse Spinks and the Psychiatric Registrar now on duty for the day shift, Dr Isabelle Wood, went to see Ms Reilly at approximately 11.00 am in her assessment bed in the ED to tell her what the plan was going to be for her transfer.[70]

62. Dr Wood had earlier received a handover from the night shift Psychiatric Registrar, Dr Wardrop. Dr Wood recalled that she had been told Ms Reilly's history and that Ms Reilly had been assessed and the PLN Nurse Smith had deemed Ms Reilly to be a medium risk of suicide and deliberate self-harm and Dr Wardrop had then reviewed her. Ms Reilly had requested an injection to end her life and indicated "suffering stemmed from not being able to live where she wanted."[71] Dr Wardrop felt that Ms Reilly was suffering an adjustment disorder with situational crisis and was at chronic risk of self-harm. Dr Wood had also read the mental health assessment completed by Nurse Smith and the BOSSnet digital medical record entries completed by the PLN team overnight.[72]

63. Dr Wood understood that her task that morning was to confirm where Ms Reilly was to be sent. She couldn't stay in the ED and she could not go home or back to the transitional care facility, so the only option was a mental health bed, and Bentley Hospital was the most appropriate place and had a bed available. Dr Wood indicated she felt her task was a bit unusual on this day, as she was not conducting a mental health assessment of Ms Reilly, but instead was required to have a discussion with Ms Reilly, in effect to see if she would go to Bentley Hospital voluntarily or not.[73]

64. When Nurse Spinks and Dr Wood saw Ms Reilly at 11.00 am, Ms Reilly was sitting in the ED cubicle. Ms Reilly was not agitated and although she had some cognitive impairment, she was "very well turned out"[74] with red lipstick on and appeared well kempt. Ms Reilly was informed of the situation and told that a bed was available at Bentley Hospital. Dr Wood asked her if she was happy to go there and Ms Reilly was very insistent that she did not want to go back to Bentley Hospital. She said she wanted to return to her actual home, although she was told this was not possible. Ms Reilly was not agitated and remained relatively calm but she was quite adamant that she would not go voluntarily to Bentley Hospital.[75] Nurse Spinks recalled that Ms Reilly told them she had spent four months at Bentley hospital and "she hated it."[76] Ms Reilly made it clear that she would not change her mind.[77]

65. Dr Wood and Nurse Spinks felt Ms Reilly needed further assessment and lacked the capacity to make informed decisions, so it was decided Ms Reilly would need to be sent to Bentley Hospital for psychiatric assessment on a Form 1A.[78] Nurse Spinks said she felt it was a joint decision between her and Dr Wood, as they had tried the least restrictive option, but Ms Reilly was not

[70] T 105.
[71] Exhibit 1, Tab 24.
[72] Exhibit 1, Tab 28 [25].
[73] T 82 – 84.
[74] T 84.
[75] T 84 – 85, 95.
[76] T 105.
[77] T 107.
[78] Exhibit 1, Tab 28 [36].

willing to go voluntarily, she presented a risk to herself and there were no other appropriate facilities available.[79]

66. Nurse Spinks and Dr Wood explained to Ms Reilly that they were going to keep her under the *Mental Health Act* and she would have to remain in the ED until they could arrange her transfer to Bentley.[80]

67. When Nurse Spinks and Dr Wood left Ms Reilly, she was still in her cubicle, sitting on the bed and dressed in her own clothes. She did not try to leave before they left, and gave them no obvious indication that she intended to leave after they left. Dr Wood gave evidence that she was aware that sometimes patients would "make a dash for an exit" in such circumstances, but there was nothing about Ms Reilly's behaviour that suggested she was at immediate risk of doing so.[81]

68. Similarly Nurse Spinks gave evidence at the inquest that she was very surprised at the escalation of Ms Reilly's behaviour as she had given no indication that she would act so impulsively. Nurse Spinks agreed that Ms Reilly's behaviour must have been prompted by the information that she was going to be sent to Bentley Hospital, after she had made it clear she didn't want to go there, but she did not show any outward sign that she had suddenly changed to extreme high risk of suicide.[82]

69. In any event, Dr Wood's understanding was that once the decision had been made for Ms Reilly to be referred on a Form 1A to Bentley Hospital, she would be allocated a one-to-one nursing special to supervise her, so that the risk of her leaving was low. Dr Wood understood that a one-to-one nurse might not be allocated immediately, depending on staffing availability, but Dr Wood was also reassured that Ms Reilly was in a very high visibility bed right near the nursing station and the coordination computer.[83]

70. Dr Wood indicated that after they left Ms Reilly in her cubicle Dr Wood immediately informed a nurse at the computer opposite the bay, which she believed was the ED Nursing Coordinator's computer, although other evidence would suggest it was the Assessment Lead's computer (which is on wheels and is located directly oppose Bay 37). Dr Wood could not remember the identity of the nurse she spoke to, other than it was a female nurse and she had a vague recollection the nurse had blonde hair.[84] Nurse Spinks saw Dr Wood stop and speak to a nurse, but could not say who Dr Wood spoke to, nor whether it was the assessment lead or the nurse coordinator. Nurse Spinks was able to confirm that the nurse Dr Wood spoke to was standing at the Assessment Lead computer.[85]

71. Dr Wood spoke to the unidentified nurse at the Assessment Lead computer and told the nurse that Ms Reilly was now detained on a Form 1A under the

[79] T 106.
[80] Exhibit 1, Tab 21 and Tab 27.
[81] T 85.
[82] T 120.
[83] T 85, 94.
[84] T 86.
[85] T 108 - 109.

Mental Health Act and had been accepted to Bentley Older Adult Mental Health Service.[86] As per her understanding of the hospital procedure, Dr Wood assumed that this information would prompt someone to organise a one-to-one nursing special, although she did not make the specific request.[87] Dr Wood explained at the inquest that this had been her experience while working in the hospital ED for the previous year, and her expectation was based on that experience.[88] Dr Wood confirmed the conversation was very brief but her impression was that the nurse she spoke to understood why she was passing on the information and there was nothing to suggest the nurse would not take the usual action.[89]

72. Dr Wood states she then went to the Psychiatric Liaison Office to complete the relevant paperwork, being a hard copy paper version of the Form 1A (Referral for examination by a psychiatrist) and a Form 4A (Transport Order) under the *Mental Health Act*. She signed these at 11.30 am.[90] A little while later, recorded at 12.22 pm, Dr Wood also completed BOSSnet notes relating to Ms Reilly. She then continued on with the other work of the day.[91]

73. Nurse Spinks states she had returned to the Psychiatric Liaison Office with Dr Wood to complete the relevant paperwork. While in the Psychiatric Liaison Office, Nurse Spinks telephoned Ms Reilly's sister to inform her that they were detaining Ms Reilly under the *Mental Health Act* and that she would be going to Bentley. Ms Reilly's sister was reportedly content with the plan and understood the need to send Ms Reilly back to Bentley Hospital. Ms Reilly's sister also informed Nurse Spinks that Ms Reilly's former home had been a Homeswest unit and had been re-allocated, so she could not return there in any event.[92]

74. If Ms Reilly had been transferred to Bentley Hospital that day, her review would have been undertaken by Dr Budrikis, and based on his knowledge of Ms Reilly and the clinical scenario, he believes it is extremely likely he would have made her an involuntary patient and detained her at Bentley Hospital to provide medication and psychological therapy while exploring the possibility of securing more secure discharge accommodation and revisiting the issues of guardianship. Despite her desire to go home, Dr Budrikis thinks it is most unlikely this would have ever formed part of her discharge plan on safety grounds.[93] However, this never came to be assessed, as Ms Reilly did not make it to Bentley Hospital as shortly after the forms were completed, she disappeared.

75. Dr Budrikis, who had been the Consultant Psychiatrist in charge of Ms Reilly's mental health care for a long period and who knew Ms Reilly's history and

[86] Exhibit 1, Tab 28 [37] and Tab 28A [37].
[87] T 86.
[88] T 94.
[89] T 98.
[90] Exhibit 1, Tab 21 and Tab 27 and Tab 28.
[91] T 88; Exhibit 1, Tab 28 [38] and Tab 28A [38].
[92] T 109; Exhibit 1, Tab 27 [27].
[93] Exhibit 1, Tab 15.

issues well, believes that Ms Reilly would have "known the score"[94] and anticipated that she was probably going to be made an involuntary patient.[95]

76. A Behavioural Observation Form was commenced by Nurse Spinks at 11.45 am, after Dr Wood had completed the *Mental Health Act* forms. The Behavioural Observation Form records the patient's behaviour. Nurse Spinks gave evidence that the forms purpose was for the nursing special she assumed would be allocated to Ms Reilly.[96] Nurse Spinks described the need for the Nurse Special as being "somebody to make sure that she remained in the department."[97] Similarly to Dr Wood, Nurse Spinks gave evidence that in her experience the allocation of a Nurse Special was standard in the ED for all patients under the *Mental Health Act*.[98]

77. Nurse Spinks recorded on the Behavioural Observation Form that Ms Reilly required advanced observation due to her risk of harm to herself and her impaired cognition/mental state. Nurse Spinks stated that these levels indicated that she was "to be kept within arm's length and within eyesight at all times."[99] Nurse Spinks explained further in her statement that this did not mean she had to have a nurse sitting with her, but she did need "someone to observe her."[100]

78. Before Nurse Spinks had the opportunity to hand over the Behavioural Observation Form to the Nursing Shift Coordinator, Ms Reilly absconded, so no nursing special was allocated to Ms Reilly and no entries were made on the Behavioural Observation Form.

ESCAPE FROM Fiona Stanley Hospital

79. Registered Nurse Joel Parke had commenced work in the ED at 7.00 am that day and was allocated the role of Assessment Lead. Nurse Parke explained that the Assessment Lead Nurse works between the nurses on the floor and specialty services, such as the psychiatric team, receiving information either directly or through Emergency Department Information System (EDIS) on the patient and the plan going forward. Nurse Parke used the analogy of 'traffic control', with his role to ensure that the patients in his allocated area are kept moving through the system, either to discharge home or admission into another area, in order to keep beds free in the ED.[101]

80. He was given a verbal handover and recalled he was told Ms Reilly had been seen by the PLN and the Registrar and she was to remain in the ED while discharge planning was occurring or her admission was arranged. He was not told she required a Nurse Special and there was nothing in particular that stuck out in terms of supervision requirements for her.[102]

[94] Exhibit 1, Tab 15, p. 3.
[95] Exhibit 1, Tab 15, p. 3.
[96] T 110.
[97] T 110.
[98] T 111.
[99] Exhibit 1, Tab 27 [30].
[100] Exhibit 1, Tab 27 [31].
[101] T 28 – 29.
[102] Exhibit 1, Tab 25.

81. Nurse Parke did not recall reading the 5.12 am bedside note that Ms Reilly had attempted to leave the ED. Nurse Parke was asked what he thought he would have done if he had seen the 5.12 am note. Nurse Parke said he thought he would have queried the assessment lead who was doing the handover, to check if the psychiatric team knew and whether there was anything that needed to be followed up regarding it. He noted that at the time of the handover, Ms Reilly was quite settled in her bay, so he felt that even with the benefit of reading the note, he was unlikely to have initiated a Nurse Special for Ms Reilly.[103]

82. Nurse Parke did recall that on one or two occasions during the morning he had to redirect Ms Reilly back to her allocated bay. He indicated Ms Reilly was easily redirected and complied with his direction on each occasion. Nurse Parke recalled the nature of the interaction was that Ms Reilly approached him as he was situated right opposite her bay at his computer and on each occasion she asked, in effect, "what was happening?" and he would tell her whatever information was current in regard to her care and redirect her back to her bay. Nurse Parke did not make any entries in Ms Reilly's medical record to that effect as he was not the nurse tasked with looking after her and the information was not something that would further her plan or a decision being made about her care.[104]

83. Nurse Parke took his lunch break at sometime between 11.00 am and 11.30 am. He was relieved by Nurse Kaitlyn Lucy, who had started her shift at 11.00 am. Nurse Parke said he provided a brief verbal handover to her before taking his break. He believed the plan for Ms Reilly was still uncertain at that time, as to whether she would be discharged or admitted.[105]

84. Nurse Parke's account of events is that while accessing the staff amenities room to take his break, he found Ms Reilly in a corridor near the amenities room. He did not know how she entered the area as the door to the corridor was a swipe access door. He described her being there in those circumstances as a "little bit bizarre."[106] He believes it is possible she followed someone through the door without their knowledge, although the door had also been faulty previously and been able to be pushed open, so that was another possibility.[107] Nurse Parke asked her what she was doing there and Ms Reilly said she was "looking for the way out."[108]

85. In his original statement signed in October 2019 Nurse Parke said that he recognised Ms Reilly and knew that she was supposed to be in the ED assessment area. When Ms Reilly said she was looking for a way out he told her she couldn't leave and directed her back to the assessment area with the assistance of another nurse. Nurse Parke stated he then went on his break for approximately half an hour, and when he returned to the ED he was told Ms Reilly was missing.[109]

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[103] T 33 – 34.
[104] T 36 – 37; Exhibit 1, Tab 25.
[105] T 38 - 40.
[106] T 44.
[107] T 51.
[108] T 44.
[109] Exhibit 1, Tab 25.

86. Shortly before the inquest, Nurse Parke spoke to his counsel in preparation for the inquest and was asked if he could recall his particular conversation with Nurse Spinks after these events. This refreshed his memory and Nurse Parke said he then recalled some further details of the day. He conceded what he remembered meant that certain details in his original statement were incorrect and key information was missing.[110]

87. Nurse Parke advised in an additional statement signed on 20 February 2020, that when he found Ms Reilly in the corridor outside the tea room, he noted she had her bag with her, which confused him, and Ms Reilly told him that she was looking for the exit. This much is consistent with his original statement. He believed following the recent handover that Ms Reilly was awaiting either admission to a psychiatric ward or for a decision to discharge her home, and the fact she had her bag with her gave the impression "she was absolutely ready to go."[111] Nurse Parke states that he escorted Ms Reilly back to the nurses' station desk, opposite Bay 37. At this stage, his supplementary statement diverges from his earlier account, as he describes further actions that were not included in the first statement, most notably the fact that he directed Ms Reilly to the exit.[112]

88. Nurse Parke states in his second statement that he spoke to Nurse Kaitlyn Lucy, who was sitting behind the nurses' station desk. He believes about 5 minute had elapsed at this stage since Nurse Lucy had taken his place.[113] Ms Reilly was standing next to Nurse Parke and they were both facing Nurse Lucy. Nurse Parke asked Nurse Lucy if Ms Reilly was being discharged. He indicated in his evidence he asked this as Ms Reilly had her bag and was dressed and looked like she was ready to go. He recalls now that Nurse Lucy looked at her computer then looked up from the computer towards them both and said, "yes".[114] On that basis, Nurse Parke states that he directed Ms Reilly towards the exit and headed back off for his lunchbreak.[115] When he returned from his break at around midday, he was told Ms Reilly was missing and a search was underway. Nurse Parke said he was concerned and confused, given he had been told earlier she was discharged. He couldn't recall specifically telling anybody that he had pointed Ms Reilly to the exit, but he assumed he did.[116]

89. Nurse Parke said he was told by the Nurse Coordinator at about 5.00 pm that Ms Reilly had died and he was "obviously quite devastated."[117] He still had to complete the last two hours of his shift, and it was during this time or after that he had a coffee and spoke with Nurse Spinks so that they could have a debrief about events.

90. Nurse Parke said he thought he had made a note of his interaction with Ms Reilly to refresh his memory later on, but he has been unable to locate it, which he said was "very frustrating."[118] He did not make a note in any of

T 54.[110] Exhibit 1, Tab 25A.
[111] T 44.
[112] Exhibit 1, Tab 25A.
[113] T 45.
[114] T 48; Exhibit 1, Tab 25A [10].
[115] Exhibit 1, Tab 25A [13].
[116] T 52 – 53, 60.
[117] T 54.
[118] T 55.

Ms Reilly's medical records about his involvement with Ms Reilly. Nurse Parke agreed at the inquest that, in hindsight, it would have been helpful to have a made an entry about it at the time, and certainly at least a retrospective note after he was advised of Ms Reilly's death. He suggested that he probably didn't do so at the time as he was busy with other matters in the ED, and he didn't make a retrospective note as he was so distressed and shocked at the news.[119]

91. Nurse Parke was not interviewed by anyone in relation to the clinical incident review that was conducted by Fiona Stanley Hospital after Ms Reilly's death. He said he would have expected to be contacted, although he also accepted that the fact he had not made an entry in the medical notes about his interaction with Ms Reilly made it less likely this would occur.[120] Nurse Parke signed his first statement, which I gather was prepared with the assistance of the hospital's legal team on 28 October 2019 (more than two years after the event). This was the first time he had any written record of his involvement in this incident.[121] His supplementary statement, as noted above, was signed on 20 February 2020, approximately 4 months later, after he had been proofed by counsel in preparation for the inquest. The extra details in his supplementary statement came when Nurse Parke was told Nurse Spinks' recalled he had said he had pointed Ms Reilly to the exit, and then he remembered that he had, in fact, done so.[122]

92. Nurse Parke's version of events in his supplementary statement is largely consistent with Nurse Spinks' recollection of the conversation she had with Nurse Parke on the day Ms Reilly went missing, and this seems to be the version that was provided by Nurse Spinks to the clinical incident investigation. As noted above, Nurse Parke was still on duty when he was notified of Ms Reilly's death. He was very upset and distressed at the news and spoke to Nurse Spinks for support over a cup of coffee.[123]

93. Nurse Spinks recalled that Nurse Parke told her that he had seen Ms Reilly in the corridor near the tea room and she had told him she was looking for a way out. As he was not her primary nurse, he asked another nurse sitting at the computer at the nurses' desk if Ms Reilly was being discharged and he was told that she was, so he told Nurse Spinks that he pointed Ms Reilly in the direction of the exit.[124]

94. Similarly to Nurse Parke, Nurse Lucy had not mentioned her conversation with Nurse Parke in the first statement she signed on 30 September 2019. That statement had been prepared with the assistance of Fiona Stanley Hospital's legal team. Nurse Lucy's initial statement gave an account that she had overheard that Ms Reilly would have to go to Bentley Hospital and later realised that Ms Reilly's bay was empty. She stated that she initially thought Ms Reilly was with a family member, but then made a call to the PLN office to ask if Ms Reilly was for discharge and received the information that she was being placed on forms.[125]

[119] T 55 – 57.
[120] T 57 - 58.
[121] T 58.
[122] T 58.
[123] Exhibit 1, Tab 27 [40] – [41].
[124] Exhibit 1, Tab 27 [41] – [43].
[125] Exhibit 1, Tab 23.

95. Nurse Lucy provided a supplementary statement on the morning of the inquest, dated 24 February 2020, that she had prepared with the assistance of her new counsel. Nurse Lucy also gave evidence at the inquest. This additional information shed a new light on what had occurred, and was consistent with Nurse Parke's second statement and Nurse Spinks' statement.

96. Nurse Lucy stated she had received a short handover from Nurse Parke so that she could fill the Assessment Lead role while he took his meal break. She was aware from the handover that Ms Reilly was in the ED as a psychiatric patient. Nurse Lucy said the curtains of her bay were closed during the handover as Nurse Spinks and Dr Wood were in speaking to Ms Reilly, but she overheard some of the conversation. In particular, she overheard that Ms Reilly was to go back to Bentley. From what she overheard, Nurse Lucy had incorrectly formed the belief that Ms Reilly was to be transferred to Bentley Hospital as a voluntary patient. Nurse Lucy also mistakenly believed that Ms Reilly's sister was with her and she assumed Ms Reilly's sister would take her to Bentley Hospital.[126]

97. When Nurse Parke guided Ms Reilly back to the Emergency Department after finding her in the staff access only corridor outside the tea room, Nurse Lucy agreed that he spoke to her. Nurse Lucy's evidence at the inquest was that although she had not seen Ms Reilly before that time and did not know what she looked like, she did understand that the patient in his company was Ms Reilly. When Nurse Parke asked her if Ms Reilly was to be discharged, Nurse Lucy did not look at the computer or any other records for Ms Reilly before telling Nurse Parke that Ms Reilly was for discharge based upon what she thought she had overheard. Nurse Lucy was frank that she did not access any of the medical information available and she also did not check with the mental health team before telling Nurse Parke this information.[127]

98. Nurse Lucy gave evidence that she had not been told that Ms Reilly was being placed on Mental Health Forms, which is why she assumed she would remain a voluntary patient. She gave evidence that she was not the blonde female nurse at the Assessment Lead station who Dr Wood spoke to about Ms Reilly being placed on forms.[128] Nurse Lucy said she would have expected that Dr Wood would tell her, as she was the lead of that area and responsible for the patients in it, and then she would have passed that information on to the Nursing Coordinator, who could then take steps to arrange a Nurse Special. However, she denied having a conversation with Dr Wood.[129]

99. The forms themselves were still being completed by Dr Wood and Nurse Spinks at the time Nurse Parke brought Ms Reilly back to the ED, so even if Nurse Lucy had tried to access that information it would not have been in the system. Nevertheless, Nurse Lucy accepted that the option of speaking to Nurse Spinks (which she later did) was always available to her and was what she should have done at the time.[130]

[126] T 62 - 63; Exhibit 1, Tab 23A.
[127] T 64; Exhibit 1, Tab 23A [17].
[128] T 64; Exhibit 1, Tab 23A [13], [15].
[129] T 71.
[130] T 65.

100. When asked why she did not do that at the time, Nurse Lucy suggested the pressures of the emergency department to free up beds encouraged quick decision-making and she had already jumped to the conclusion Ms Reilly was permitted to leave, so she tried to act quickly based upon what she thought she knew.[131]

101. Based on the information he was told by Nurse Lucy, Nurse Parke directed Ms Reilly to the nearest exit and Ms Reilly left Fiona Stanley Hospital shortly after.

102. Not long after Nurse Parke directed Ms Reilly to the exit, it occurred to Nurse Lucy that she should check with the mental health team that she was right about Ms Reilly's plan. She volunteered that she "should have done that beforehand."[132] When she called the PLN office to ask if Ms Reilly was for discharge, Nurse Lucy was told by either Nurse Spinks or Dr Wood that Ms Reilly was being placed on forms under the *Mental Health Act*.[133]

103. Nurse Spinks, who I consider to be the more reliable witness as her account has not varied over time, recalled that Nurse Lucy actually came to the Psychiatric Liaison Office, put her head through the door and said, "Ms Reilly has been discharged."[134] Nurse Spinks and Dr Wood responded, "well, not by the mental health team" and advised her that they had not discharged Ms Reilly and in fact, they "had actually put her under the *Mental Health Act*."[135] Nurse Spinks gave evidence she recalled Nurse Lucy's face when she was told Ms Reilly was to be put on forms, and it was apparent Nurse Lucy realised at that moment that she had made a significant error.[136]

104. Nurse Lucy advised Nurse Spinks and Dr Wood at that stage that Ms Reilly had left the ED, although it does not appear she explained that this had occurred, in effect, with her permission. She simply told them Ms Reilly was missing/had left.[137] Steps were quickly taken to try to locate Ms Reilly within the hospital, although we now know that she had already left Fiona Stanley Hospital by that time.

105. Nurse Spinks gave evidence she was immediately concerned for Ms Reilly's safety. Nurse Lucy said she understood that Nurse Spinks was going to review the CCTV footage with security to see if they could locate Ms Reilly, and if not she was going to notify the police and family.[138] Nurse Spinks, on the other hand, states that Nurse Lucy asked them to call the police and Dr Wood indicated that they were still completing the forms and asked Nurse Lucy to contact the police instead. Nurse Spinks was at the other end of the table when Dr Wood and Nurse Lucy had this conversation and she understood at the end of it that Nurse Lucy would notify police.[139]

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[131] T 68, 75.
[132] T 62.
[133] T 62.
[134] T 115.
[135] T 115.
[136] T 115.
[137] T 66.
[138] T 65;Exhibit 1, Tab 23.
[139] Exhibit 1, Tab 27 [33].

106. Dr Wood indicates in her statement that police and security were notified by the ED as per protocol,[140] as that was her understanding, but this was based on the assumption Nurse Lucy would act on her request. It was accepted by Nurse Spinks and Nurse Lucy that there was a miscommunication and no one notified the police immediately that Ms Reilly was missing. Nurse Spinks eventually realised the police had not been notified and she rang the police herself, at approximately 1.45 pm.[141]

107. Nurse Lucy notified the Associate Nurse Unit Manager and Shift Coordinator and made an entry in the ED records at 11.45 am. The entry records that Ms Reilly had absconded after being placed on forms, the PLN and Psychiatric Registrar were aware and security had been notified.[142]

108. Nurse Lucy agreed in her evidence that her use of the word absconded was not ideal, given what she knew about the circumstances in which Ms Reilly left the hospital. It implied that Ms Reilly had disappeared from her bay, rather than being shown out by the ED staff. Nurse Lucy said in her evidence that she was not sure why she used the word absconded and she agreed that in hindsight it would have been more appropriate to have put in a more detailed description of what had occurred between her, Nurse Parke and Ms Reilly.[143]

109. Nurse Lucy said in her evidence that she did prepare a detailed note of what had occurred when she returned home late that evening after her shift. Nurse Lucy said she made the note on her home computer, and believed she provided it to either the legal counsel for the hospital when preparing her first statement, or counsel for Fiona Stanley Hospital, but that was a long time after Ms Reilly's death. No copy of that note was provided to the court.[144]

110. I put to Nurse Lucy that, given there were up to four places where a note could have been made at the hospital, it would have been better to have made a record of what occurred in the hospital notes, or at least have brought a copy of the note she made at home in to the hospital on her next shift. Nurse Lucy agreed that would have been a better course of action. She was unable to provide a reason as to why she didn't do so at the time.[145]

111. I also asked Nurse Lucy why she did not refer to her conversation with Nurse Parke in her first statement, and she said that she talked about it with the people helping her to prepare the statement, "but it never got put in the statement."[146] Given she had raised it, Nurse Lucy said she assumed it was not included by other people as it was not relevant.[147]

112. Dr Wood and Nurse Spinks had remained in the Psychiatric Liaison office and one of them called Ms Reilly's sister to inform her of the Form 1A and to advise her that Ms Reilly had gone missing from the ED and her whereabouts were unknown. Ms Reilly's sister indicated that she believed Ms Reilly would have

[140] Exhibit 1, Tab 28 [40].
[141] T 117, 129.
[142] Exhibit 1, Tab 23.
[143] T 72.
[144] T 72.
[145] T 72, 76.
[146] T 73.
[147] T 73.

got in a taxi, which later proved to be correct. She also advised that Ms Reilly had $100 cash on her, so she would have been able to pay the taxi.[148] Nurse Spinks also telephoned Amana Living to let them know Ms Reilly was missing.

113. A search of the Fiona Stanley Hospital grounds by security staff was conducted but they were unable to locate Ms Reilly.[149] This is not surprising, as other evidence indicates that Ms Reilly had already left the hospital premises in the taxi by the time hospital security were notified of her absence.

114. Nurse Spinks then went to the security office located within the ED and reviewed the CCTV footage with security officers, which showed Ms Reilly getting into a taxi across the road from the ED, although the name of the taxi company was not visible. Nurse Spinks contacted two taxi companies and asked them to check their systems to try to locate the drop off point. At some stage Nurse Spinks received a call back from one of the taxi companies to advise that Ms Reilly had been dropped off in Carlisle.[150]

115. Nurse Lucy made another entry in the notes at 11.50 am, indicating that the Psychiatric Registrar had logged a job with the helpdesk and was attempting to call the family, while the PLN had looked at security cameras and had not seen Ms Reilly leave. Security were to do a quick search then police were to be called if Ms Reilly was not found.[151] Nurse Lucy clarified that she was expecting the mental health team would notify the police and her note was not intended to indicate that it was a task for her to complete.[152]

116. Ms Reilly's sister attended the ED at approximately 12.30 pm after being brought to the hospital by Ms Reilly's brother. Ms Reilly' sister spoke to Nurse Spinks and she was advised to go home in case Ms Reilly went there.[153]

117. Nurse Spinks spoke to the on-call Consultant Psychiatrist, Dr Stephen Fenner, who suggested that she tell police that Ms Reilly was to be taken straight to Bentley Hospital when she was found.[154]

[148] T 117 - 118; Exhibit 1, Tab 28 [42].
[149] Exhibit 1, Tab 2, p. 3.
[150] Exhibit 1, Tab 27.
[151] Exhibit 1, Tab 23.
[152] T 66 – 67.
[153] Exhibit 1, Tab 21 and Tab 27.
[154] Exhibit 1, Tab 23; Exhibit 2, Tab 13.

118. Police records indicate that the police were not notified until they received a telephone call from Nurse Spinks at about 1.45 pm, after she realised the police had not been contacted.[155]

119. Police officers were assigned the CAD task at 2.43 pm and attended Fiona Stanley Hospital at 3.00 pm. They reviewed the CCTV footage that showed Ms Reilly leaving the hospital in a taxi a few hours earlier. They began to make enquiries with the taxi company but were advised that Ms Reilly had been found deceased on the railway tracks in Carlisle before their enquiries could continue much further.[156]

120. I indicated at the inquest that I was satisfied from the evidence that it was unlikely the police would have been able to find Ms Reilly and prevent her death, even if they had been notified shortly after her departure from the hospital was identified.

EVENTS LEADING UP TO HER DEATH

121. Footage from CCTV cameras shows Ms Reilly departed Fiona Stanley Hospital at around 11.36 am in a taxi. The taxi dropped Ms Reilly on Rutland Avenue in Lathlain at 11.59 am.[157] Ms Reilly crossed the road to Victoria Park Train Station and boarded a south bound train. At 12.19 pm Ms Reilly disembarked at Carlisle Train Station. She then left the platform and walked to a nearby carpark. Ms Reilly waited in the carpark for a few minutes before she entered the verge area near the railway line and stood behind a pole.

122. A man leaving the nearby Carlisle Hotel, Mr Gray, observed Ms Reilly standing behind the fence line of the railway, near the tracks. He crossed the road and spoke to her, asking if she was okay. Ms Reilly told Mr Gray that she was okay and she was waiting to meet a friend. Mr Gray tried to engage with her and encourage her to come to the correct side of the fence, without success. While still speaking to Ms Reilly, Mr Gray's telephone rang, so he answered it and told the caller he would ring them back. After ending the call he turned back to Ms Reilly and saw she was walking on to the train line. She stepped onto the tracks and faced the train with her arms in the air. Mr Gray saw the train was slowing as it approached her, but it did not stop in time and struck Ms Reilly, who then went under the undercarriage of the train. Mr Gray telephoned emergency services to get help.[158]

123. The train driver had been slowing the train to approach the station when he saw Ms Reilly come out towards the tracks. He immediately applied the full brake and emergency brake as he was unsure what she was doing. He saw Ms Reilly step onto the tracks in front of the train and she was struck by the train while it was still moving forward at approximately 30 – 40 km/hr. The train came to a stop approximately 30 metres from the platform and the driver notified the control centre, who contacted emergency services.[159]

[155] Exhibit 1, Tab 20, Incident Report.
[156] Exhibit 1, Tab 13.
[157] Exhibit 1, Tab 2, p. 3.
[158] Exhibit 1, Tab 10.
[159] Exhibit 1, Tab 9.

124. Paramedics and police attended the scene. Ms Reilly had suffered non-survivable injuries from the impact and she was declared deceased at the scene at 12.54 pm.[160]

CAUSE AND MANNER OF DEATH

125. Forensic Pathologist Dr Vicki Kueppers performed an external examination of Ms Reilly. The examination showed multiple severe injuries to Ms Reilly's body. Toxicology analysis showed prescription medications at levels within the therapeutic range. Dr Kueppers determined that she did not need to do an internal examination in order to form an opinion as to the cause of death. Dr Kueppers formed the opinion that the cause of death was multiple injuries. I accept and adopt the opinion of Dr Kueppers as to the cause of death.

126. As to the manner of death, there is clear evidence that Ms Reilly had been experiencing thoughts for a considerable period of time, and had admitted to thoughts of wanting to end her life when she was assessed by Dr Wood earlier that morning. When informed that she was being transferred to Bentley Hospital, against her wishes, she chose to escape from the hospital. Very quickly after, she directed a taxi to take to a train line, where she stepped onto the tracks in front of an oncoming train. All of that evidence strongly supports a finding of an intention to take her life. There is no evidence to suggest that Ms Reilly was psychotic and incapable of forming that intention. Accordingly, I find that the manner of death was by way of suicide.

COMMENTS ON TREATMENT, SUPERVISION AND CARE

127. The evidence clearly raises a concern about the lack of supervision of Ms Reilly at Fiona Stanley Hospital, which enabled her to leave the hospital unobserved, as well as the delay in reporting her escape to the police.

Clinical Incident Investigation

128. An investigation was conducted by the South Metropolitan Health Service into Ms Reilly's death. The intent of the investigation was to independently review what occurred and look for any opportunity to improve hospital systems from the lessons learned from the incident.[161] The investigation was supposed to be completed within 28 days of the incident but it was completed later than anticipated, in mid-September 2017. Ms Sharon Delahunty, the Nurse Director of Mental Health for Fiona Stanley Fremantle Hospitals Group, had been asked to chair the investigation at a late stage, 47 days after the incident, which no doubt put unwanted pressure on her to get the job done expeditiously.

129. Ms Delahunty had not had any involvement in Ms Reilly's care, but was on duty on the day she went missing and had come in to the hospital and spoken

[160] Exhibit 1, Tab 2, p.2 and Tab 3.
[161] T 151.

to the staff involved to check on their wellbeing. Ms Delahunty agreed to chair the review as the more appropriate staff were involved in other investigations and were unavailable to take charge of this matter.[162]

130. It became apparent after hearing evidence at the inquest that the investigation had not been provided with all of the facts pertaining to how Ms Reilly left the hospital. Ms Delahunty had been assured that all relevant staff had been spoken to about the event, and she had personally spoken to Nurse Smith, Nurse Spinks and Dr Wardrop. However, Ms Delahunty accepted at the inquest that three key staff members, namely Nurse Parke, Nurse Lucy and Dr Wood, had not been spoken to as part of the investigation. Ms Delahunty was unaware why this was the case, as it was her understanding that all relevant Emergency Department staff had been spoken to by their line manager. However, she did suggest Dr Wood, in particular, may have been overlooked as she left the country around the time the investigation began.[163]

131. Based upon what information was available at the time, the investigation found:[164]

- on initial assessment a 1:1 Nurse Special was considered, but it was not deemed necessary at that point;
- Ms Reilly remained in the main ED assessment area as the Emergency Short Stay Unit was full at the time, so she was allocated a bay in a highly visual area in front of the nurses station;
- at 11.30 am Ms Reilly's usual nurse was on a break. Ms Reilly was walking around and encountered a different nurse, who spoke to her. Ms Reilly said she was looking for the exit. The nurse asked another nurse if the patient could leave, and it seems they have mistaken her for another patient and advised Ms Reilly could leave the department. The first nurse then directed her to the exit;
- CCTV showed Ms Reilly attempted to leave the ED via the main door but could not get out, so she lifted the rails of the ambulance entry door and pushed it open. The door has a pin pad for entry, but only has an open door button to exit;
- At 11.45 am an ED nurse noticed Ms Reilly was not in her assessment bay and it became apparent she had absconded. The ED nurse alleged that she asked the Psychiatric Registrar to call police, whereas the Psychiatric Registrar maintained that she requested the ED nurse to contact police and list Ms Reilly as a missing person;
- At the same time, a nurse documented in the Adult Triage Notes that a search was to be conducted and police were to be called if the patient was not found. This nurse thought the PLN was going to call police.
- in the end, the police were not contacted for some time after Ms Reilly absconded.

[162] T 149, 152; Exhibit 1, Tab 30.
[163] T 154 – 162.
[164] Exhibit 1, Tab 21.

132. As a result of the clinical investigation, the following issues were identified:

- Access points from the ED required review;
- There was no documentation in the DMR (BOSSnet) progress notes by ED staff after 5.36 am;
- Management of mental health patients in the ED was documented in the DMR, PSOLIS, end of bed notes and Emergency Department Information System (EDIS), which may have led to gaps in knowledge of the patient's condition/status. ED staff did not have access to PSOLIS;
- A 1:1 special was considered for Ms Reilly but was not deemed necessary, and it was pointed out that it is not routine to put a special on patients who present with a suicide attempt unless or until a patient is made involuntary, refuses to stay or does not guarantee their own safety;
- Care leading up to the patient absconding was in accordance with the Fiona Stanley Hospital policies. However, the policy states that if a patient is referred to the PLN, the PLN then manages the process and this includes the assessment of risk and informing the police, if necessary. The written paperwork was conflicting as to who was believed to be contacting police on the day;
- The panel could not conclusively determine whether the outcome would have changed if the police had been contacted earlier. However, if the police were contacted earlier the chance of the patient being found *may* have prevented her death.

133. The conclusion at the end of the clinical investigation was that the care and management of Ms Reilly before she left the ED, was appropriate, but there were system errors, which may have prevented the patient leaving the ED and the police being able to find her before her death.[165]

134. The following recommendations were made with the intention that they might minimise the opportunity of this type of incident recurring:[166]

- Reiterate 'Fiona Stanley Hospital Managing Patients with Mental Health and Psychiatric Conditions in Fiona Stanley Hospital Emergency Department' policy and flow chart to staff;
- All patients considered at risk, or under the *Mental Health Act*, are to be notified to the 'Nurse Area Lead' position to confirm information has been added to EDIS immediately. This change to be reflected in an update to the policy; and
- All referred mental health patients are not to leave the department without the allocated nurse checking EDIS or with the Mental Health Emergency Department Liaison Service.[167]

[165] Exhibit 1, Tab 21.
[166] Exhibit 1, Tab 21.
[167] Exhibit 1, Tab 21.

135. My difficulty with the clinical investigation is that I believe there are inherent flaws in an investigation that does not speak to the actual people involved in the incident. I accept that the investigation seeks to avoid apportioning blame and to encourage full and frank accounts from all involved, but the specific individuals involved in events need to be spoken to in order to obtain those accounts, with the reassurance that the focus is on systems failures rather than disciplining individuals.

136. Nurse Lucy gave evidence she was informed by Nurse Spinks of Ms Reilly's death on the same evening it occurred. She was not spoken to by anyone in hospital management about her role in the events until she was spoken to by legal counsel for Fiona Stanley Hospital in preparation for this inquest.[168] Nurse Parke could not recall being spoken to, and certainly his account at the inquest did not make its way into the clinical investigation report.

137. The clinical incident investigation found that Nurse Lucy had mistaken Ms Reilly for another patient when she told Nurse Parke that Ms Reilly could leave, whereas this was not Nurse Lucy's evidence at the time of the inquest. Nurse Lucy gave evidence she did know the patient was Ms Reilly at the time she spoke to Nurse Parke, but had reached a false assumption about the plan for Ms Reilly based on what she had overheard. This could have been clarified if someone in the investigation had spoken directly to Nurse Lucy.

138. Dr Wood was also not spoken to as part of the investigation although she was informed of the death and had a one-to-one debrief with her head of service in the days after Ms Reilly's death.[169] For the clinical investigation it appears her BOSSnet note was relied upon, which did not include her conversation with the nurse. As a result, the clinical investigation report concluded that the "ED nursing staff were not informed that the patient had been made involuntary,"[170] but Ms Delahunty accepted that based on Dr Wood's evidence at the inquest, this was not accurate. However, given so much time has elapsed, it was not possible to identify the nurse whom Dr Wood informed of the change in Ms Reilly's status.

139. Dr Wood gave evidence that she had expected that once this nurse was informed that Ms Reilly was being placed on forms, that a nursing special would be allocated. She believed this would occur while Dr Wood and Nurse Spinks completed the necessary paperwork. Similarly, Nurse Spinks gave evidence she expected Ms Reilly would be supervised due to her status as a patient on forms, and she was creating the Behavioural Observation Form for that purpose, but she was unable to provide it to the ED nursing staff before Ms Reilly left the ED.[171] I note that Dr Budrikis also gave evidence that at Royal Perth Hospital the usual procedure is for a person placed on forms to be allocated a one-to-one Nurse Special.[172]

140. Ms Delahunty gave evidence that this was not the specialling policy at Fiona Stanley Hospital at the time and if a nursing special was requested, there

[168] T 67.
[169] T 93.
[170] Exhibit 1, Tab 21, Clinical Incident Investigation Report p. 6 of 17.
[171] T 185 - 186.
[172] T 144.

needed to be a conversation between the medical staff and nursing staff about what level of observation was required.[173] Ms Delahunty agreed that the evidence indicated there was a misunderstanding about what was going to occur and it indicated that there was a need to change the scope of the specialling policy, which is just nursing, to help other clinicians understand that process better.[174]

141. Ms Delahunty noted that communication was a factor in what went wrong on this day, which is a common finding in clinical incident investigations. From her investigation the communication was particularly around whether Ms Reilly could go, as well as around notifying the police. I would add to that, based on the above, miscommunication over the issue of Ms Reilly being placed on forms and requiring closer supervision by nursing staff.

142. The panel considered how to improve communication between the nursing and mental health teams, which led to the implementation of the 'review' box in EDIS. This is a simple process where the patient's main screen on EDIS has a box ticked when the patient is not to leave the department without review by the mental health team. Any staff member looking at the patient's information will then be alerted by a column indicating that review is required.[175]

143. I accept that this measure put in place after the investigation is helpful, even after noting the additional evidence heard at the inquest. In particular, the change allowing a note "Review" to be put next to the patient's information on EDIS to prompt a discussion with the psychiatric team before the patient can be allowed to leave, is helpful and might prevent a similar situation. While Nurse Lucy did not, in fact, check any information on the day, knowing this type of information would be easily available might have encouraged Nurse Lucy to check on EDIS before giving an answer to Nurse Parke.

144. Since these events Nurse Lucy indicated she has changed her practices and is now much more proactive in chasing up plans for mental health patients. Nurse Lucy also spoke positively about the new system implement in the Fiona Stanley Hospital ED where there is a notation 'review' made on the patient's notes in EDIS next to the patient's name if they are being reviewed by the mental health team.[176]

145. As to the issue of whether a nursing special was required, the South Metropolitan Health Service accepted after the inquest that the evidence of Dr Wood and Nurse Spinks was clear that it was their intention that a Nurse Special be allocated to Ms Reilly, and in those circumstances more needed to be done when Dr Wood had the conversation with the nurse to advise that Ms Reilly was being placed on a Form 1A and, by implication, that a Special was required in this case. Given Dr Wood and Nurse Spinks' belief that a Special was appropriate from that time, the South Metropolitan Health Service concedes that the supervision of Ms Reilly from that time was inadequate, as no steps were taken to assess what needed to occur in respect to her

[173] T 173.
[174] T 174.
[175] T 180.
[176] T 68.

supervision from that time. As a result, she was able to make her way into the corridor near the staff tea room unnoticed despite the fact there was an expectation by the psychiatric staff that she would be more closely supervised.[177]

146. Following the conclusion of the inquest, I am advised the South Metropolitan Health Service had determined that it will progress an amendment to the relevant 'Nurse Specialling' policy to attempt to address this issue, which appears to be an appropriate step and will hopefully clarify the position for all staff within the ED.[178]

147. I am also advised that the South Metropolitan Health Service "accepts that in future investigations, steps should be taken to ensure that all staff involved in an incident are spoken to by the relevant Panel member or the relevant Panel member is relayed the information obtained from relevant staff involved to ensure that the information forming the basis of the review is as comprehensive and as accurate as possible."[179] I am satisfied with this response and don't need to address it further in this finding.

148. I note that discussion with the individuals involved might also aid in preventing some of the confusion that arose in this inquest as to what was said by the witnesses to the hospital's legal team, and why key evidence was not provided until shortly prior to the inquest. I do not propose to go into that issue any further, as one of the people involved was not given an opportunity to give evidence at the inquest on the issue, and evidence provided to me since the inquest suggests there is a conflict in the accounts of witnesses as to what information was provided, so it would be unfair to all involved to reach a conclusion as to who is the more reliable witness.

149. It was also submitted on behalf of Nurse Lucy, through the Australian Nursing Federation, that it was unclear whether the nurses were advised from the outset that they were entitled to obtain their own legal advice and representation in relation to the coronial process. I am advised that this is the usual practice of the South Metropolitan Health Service's legal team, and I agree that it is a proper practice to adopt, as in this case it was certainly of great assistance to the Court to have separate representation for Nurse Lucy. While it is, of course, practical in many cases for the State Solicitor's Office to represent the health service and the individual staff incorporated within that, this is an example of a case where the interests of the two had potential to diverge, and in such cases it is always helpful for individuals to have their own legal advice.

Comments on Ms Reilly's supervision

150. There was evidence the Fiona Stanley Hospital Emergency Department is a very busy and chaotic working environment, with on average 300 to 320 patients walking through the ED every 24 hour period, peaking up to 365 on certain days. This often leads to delays in assessing patients and there are not

[177] Submissions of the South Metropolitan Health Service filed 19 March 2020, [49] – [50], [54].
[178] Submissions of the South Metropolitan Health Service filed 19 March 2020, [64] – [68].
[179] Submissions of the South Metropolitan Health Service filed 19 March 2020, [12].

enough physical beds within the main department for patients, which means staff are constantly looking for flow options throughout the hospital, for both mental health and non-mental health patients. The particular problem with mental health patients is that there is often not another bed available elsewhere to send them on, although that did not apply in Ms Reilly's case as a bed was found at the Bentley Hospital Older Adult Mental Health Service.[180] Nevertheless, it is relevant to note that there is a strong feeling that the South Metro Health Service is not "resourced to be able to provide the care that we would like to and that we should provide."[181]

151. Ms Delahunty also described the Fiona Stanley Hospital ED as a "very traumatising environment to work in."[182] There is a lot of pressure to meet targets, in particular the four hour rule, so the primary focus is on trying to improve flow as "flow is key to access to care."[183]

152. Put in this context, Nurse Lucy's willingness to believe Ms Reilly was ready for discharge makes a bit more sense, although she accepted that even when faced with these pressures, she should have stopped and made more enquiry. However, it does appear that if she had simply looked Ms Reilly up on EDIS, there would have been nothing to tell her that Ms Reilly was being placed on forms. It was the enquiry with Nurse Spinks, which she made after Ms Reilly left, that gave her the relevant information.

153. It seems clear that if Nurse Lucy had made enquiry with Nurse Spinks, as she did after Ms Reilly left, she would have been told that Ms Reilly was being placed on forms for psychiatric review, and if she passed that information on, Nurse Parke would not have directed her to the exit and she would have been re-directed back to her bed to await transport to Bentley Hospital. She had complied with such direction before, so there is nothing to suggest she wouldn't have done so again. Even if she had resisted, it would have prompted discussion about perhaps taking further steps to detain her. Therefore, it would have been preferable if Nurse Lucy had made proper enquiry before giving an answer to Nurse Parke. I make that comment while acknowledging that people make mistakes, especially when under pressure, and there is no evidence to suggest Nurse Lucy did so for any reason other than she was trying to resolve matters quickly and keep patients moving based on what she mistakenly thought was the correct position, having briefly stepped into a relieving role.

154. Nurse Lucy's response was also on the background of the fact an unknown nurse had taken no steps to act on the information provided by Dr Wood, and the apparent misunderstanding that a nursing special would be automatically initiated, which might have prevented Ms Reilly leaving her bed in the first place and also should have been communicated to Nurse Lucy in the Assessment Lead role.

155. Nurse Lucy has frankly acknowledged her error and at the time she took immediate steps to try to rectify the situation. She also indicated that since

[180] T 191.
[181] T 193.
[182] T 193.
[183] T 193.

these events she has "always been proactive in immediately chasing up the plans for all mental health patients after they have been reviewed."[184] She also now always makes sure from the start of a shift that she is "certain whether a patient is allowed to leave or not."[185]

156. It was apparent from hearing from all of the witnesses that the nursing and medical staff who dealt with Ms Reilly on the day were all deeply saddened by her death, and I see little to be gained in focussing at any greater length on the behaviour of the individuals involved. There was, overall, a failure by Fiona Stanley Hospital staff to supervise Ms Reilly for a very brief window of time, which unfortunately gave her the opportunity to leave at a time when she had experienced a significant change in her thinking and her suicidal ideation had become acute. Once she left the hospital, there was very little that could have been done to prevent her death as she very quickly made her way to the train station and took steps to take her life in a very immediate and decisive way.

Comments on Ms Reilly's care

157. Putting to one side the issue of supervision, I am satisfied that Ms Reilly's general medical, and specifically psychiatric, care was of an appropriate standard.

158. Dr Budrikis identified in his report that Ms Reilly was a person with a long history of mental distress and contact with mental health services of one kind or another, and she was "very much the type of person who experienced attempts by authority figures such as psychiatrists to assertively help her as attempts at controlling her, and excessively so."[186] Dr Budrikis considered that Ms Reilly's crisis was compounded by what she perceived as excessive social control over her movements and decisions.[187] She had always coped better when she was able to live independently and place limits on her contact with others, including her own family, and those barriers were being broken down as she moved into care.

159. Dr Budrikis described Ms Reilly's suicidal ideation as falling within the French sociologist Emile Durkheim's phenomenon of "fatalistic suicide," being essentially a response to what an individual perceives to be unbearable suffering or crisis.[188] Unfortunately, in trying to treat Ms Reilly, the interventions put in place by the treating team were seen by Ms Reilly as an attempt to 'control' her, which exacerbated her unhappiness.[189]

160. Ms Reilly was placed in a difficult, but sadly not uncommon, situation where she wished to remain independent but was no longer safe to remain living at home alone. Ms Reilly had initially agreed to go into the transitional placement, but had quickly found that she was unhappy in that environment and there was no option to return to her former life. Her sadness and unhappiness with her new living arrangements is not uncommon for elderly

[184] Exhibit 1, Tab 23A [18].
[185] Exhibit 1, Tab 23A [18].
[186] Exhibit 1, Tab 15, p. 3.
[187] Exhibit 1, Tab 15, p. 3.
[188] Exhibit 1, Tab 15, p. 3.
[189] T 141.

people making the transition from independence to nursing homes, but given her longstanding personality disorder and frontal lobe impairment, Ms Reilly appears to have struggled more than most to make the adjustment.[190]

161. Ms Reilly's suicide attempt at Amana Living could probably be seen more as a 'cry for help' than a definite suicide attempt, as she had failed to take her life in a similar act at Bentley Hospital. Her actions achieved her aim of taking her out of the Amana Living facility, but once at Fiona Stanley Hospital she came to realise that her only other option was Bentley Hospital, where she also did not want to be.

162. Ms Reilly had been assessed as low in personal care needs but high in mental health care needs, and while Ms Reilly and her family wanted her to be placed in a non-secure facility near her sister, while Ms Reilly was still at Amana Living her sister had been told by a social worker that Ms Reilly would require a secure facility given her documented risks.[191] It's unclear whether Ms Reilly was aware that only a secure facility was now being contemplated for her, but it is fair to assume that if she was eventually placed in one, she would likely have found the increased regulation even more difficult, and probably intolerable. Dr Budrikis agreed with my suggestion that there was a strong possibility she would have eventually been unhappy there as well.

163. When told by Dr Wood that she was going to be sent to Bentley Hospital against her will, it appears Ms Reilly's self-harming behaviour escalated rapidly and she made the decision to take lethal action in a way that she had not previously done. Ms Reilly did not communicate her intention to the Fiona Stanley Hospital staff, and I draw the inference that she did not do so as she did not want anyone to prevent her leaving and taking the drastic action she eventually undertook.

164. There is evidence in the brief that Ms Reilly had tried to abscond from the ward at Bentley Hospital in a similar way, many months before, by waiting for an opportunity to leave the locked area and opening the front exit and walking away from the hospital. On that occasion staff were alerted quickly to her attempt to leave and ran after her and persuaded her to return to the ward.[192] Unfortunately, on this occasion, due to confusion, the Fiona Stanley Hospital staff were unable to do the same in time.

165. Dr Budrikis made the frank concession in his report that he was "completely unclear as to what could have been done differently in her case to produce a different outcome."[193] I accept his expert opinion, and from my assessment of the evidence, it seems very unlikely there was any short term or long term option available to Ms Reilly that she was going to be able to tolerate. Therefore, while her acute urge to commit suicide while at Fiona Stanley Hospital Emergency Department may have subsided if she had been kept secure, it seems fair to conclude that would have remained at high risk of behaving impulsively on another day. The more steps that were put into place to reduce her opportunity to do so, would have been designed to make her

[190] *Elder Suicide: Durkheim's Vision*, S Manson, 2019, Chapter 1, 1.
[191] Exhibit 1, Tab 29.
[192] Exhibit 2, Tab 5, Bentley Client Management Plan, p. 6 of 6.
[193] Exhibit 1, Tab 15, p. 3.

more unhappy and suicidal. It seems Ms Reilly realised this that day at the Emergency Department and despair set in, prompting her to take the drastic action that she did, without communicating her intention to anyone.[194]

CONCLUSION

166. Ms Reilly had a long history of mental health problems and medical issues. In early 2017 she experienced a significant relapse of her mental health conditions that led to a prolonged stay at the Bentley Hospital. Although the intention of the admission was to improve her mental health, it is apparent that she found the environment non-therapeutic and she became increasingly suicidal. Despite efforts to control her suicidal symptoms, she remained impulsive and continued to be at chronic risk of suicide.

167. It became apparent that Ms Reilly could no longer manage on her own in the community and she required permanent nursing home placement. She was transferred to transitional care on 2 June 2017, where her suicidal ideation increased and she made an attempt that led her to be taken to Fiona Stanley Hospital ED. She made it very clear that she was very unhappy at the thought of returning to either the transitional care facility or Bentley Hospital, but there was no other options available, so she was told she would be sent to Bentley Hospital for psychiatric assessment. Shortly after being told of this plan, Ms Reilly unexpectedly absconded from Fiona Stanley Hospital and took decisive steps to end her life.

168. The South Metropolitan Health Service has initiated changes as a result of this event, and following the evidence heard at the inquest, to try to put in place changes to ensure that lessons can be learned from Ms Reilly's death. I am satisfied those changes are appropriate and I do not make any recommendations for further changes to be implemented.

S H Linton
Coroner
26 May 2020

[194] T 142.