

Coroner's findings in Hobart clinic suicide a whitewash.

In April 2009, 42-year-old Alastair McLeod hanged himself and died. At the time, he was a patient in a private psychiatric clinic on Hobart's Eastern Shore, in the Australian Island state of Tasmania. It was subsequently discovered that the chief executive officer of this small 27-bedded facility, had ignored recommendations to remove hanging points. But the continuing presence of hanging points was not the only factor sealing Alastair McLeod's fate that April morning in 2009. Nursing staff, incredibly, decided not to even attempt CPR (cardiopulmonary resuscitation) when they discovered his limp body hanging in the shower bay, effectively denying him any chance of survival. However, most of the staff, including some in management positions, had spoken openly and frequently before the legal team had convinced them to keep their mouths firmly shut. (That included the fact that Mr McLeod confided in staff that he had spent many hours throughout the previous night on the Tasman Bridge resisting an impulse to throw himself into the cold depths of the Derwent River.) As the clinic hierarchy were congratulating each other for ensuring the cat remained securely in the bag, it was in fact sitting on a Melbourne-bound jet, with a Scotch and Soda in one hand, and a sackful of documents in the other.

These documents were fated to resurface, and so they did, but not until January 2012, one year after the coroner, Christopher Webster, published his findings. In his final report, the coroner dismissed the significance of hanging points in the death *by hanging* of Mr McLeod. He did the same with the failure of the staff to initiate CPR, and he denied the documented suicidal indicators. The RCA (Root Cause Analysis) produced by the facility itself—a document which he had in his possession—tells a different story, and proves that the coroner had a greater awareness of the circumstances surrounding Mr McLeod's death than he is willing to divulge. In his findings, Mr Webster alludes to this document, but he never speaks of its content.

In his response to criticisms of the process, the chief magistrate, Michael Hill, supports the coroner's skewed arguments and supplements them with equally bizarre arguments of his own. This leads to the question: is it the best explanation that both the coroner involved and the chief magistrate are incompetent, and incapable of critical analysis, or is there another account for their apparent disregard of the truth and abandonment of reason? Ultimately, by neglecting their duty to seek the truth, they are compromising the safety of the community they purport to serve. The following documentation will allow readers to form their own opinion.

John B Cole.

October 2013.

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Coroner's report.

Regent
Victoria 3073

Wednesday, 06 March 2013

Mr Michael Hill
Chief Magistrate
23-25 Liverpool St.
Hobart 7000

Dear Mr Hill,

Record of Investigation into the Death of Alastair James Douglas McLeod
– 4th and 5th November 2010.¹

Regarding the above, I am aware that you were contacted last year by the ombudsman in relation to discrepancies in the coroner's report. Apparently, despite the clear issues, it was decided not to follow up the complaint because no name had been appended. I am not sure how that would change the situation, but I am happy to remind you of the problems my associates and I have found with this report.

As you were furnished with the documents left at the office of the health complaints commission in August of last year, you would have noted the obvious falsehoods, and a multitude of fallacies. Although one would expect the coroner to be able to winnow the truths from the untruths, it is remotely conceivable that he was duped; however, I would suspect the fallacies found in the report would be less easily explained.

Firstly, let us consider the following comment made by the coroner: '[o]n 14 April 2009 he [Mr McLeod] was admitted to the Hobart Clinic for injuries sustained in a motor accident.' This of course is blatantly untrue. The Hobart Clinic is a private *psychiatric* clinic, and nobody is admitted to such a facility for this reason. As per the Root Cause Analysis (RCA), he was referred by Dr Cheah of the Royal Hobart Hospital, who described his having 'passive wishes to die.' As part of the same entry Mr McLeod is quoted as saying that he 'doesn't care about himself' and, 'he is on a [self-destruction] path.' For the 23rd of April, 2009, it is said of Mr McLeod: 'he was

¹ http://www.magistratescourt.tas.gov.au/decisions/coronial_findings/m/mcleod,_alastair_james_douglas

feeling flat' and 'struggling with thoughts of self -sabotage.' An additional suicidal indicator was his expressed fear of being jailed for a driving offence – the absence of any reference to these remarks in the report raises very serious questions indeed. So, it was for his suicidal ideation that Mr McLeod was admitted to the Hobart Clinic, and not 'for injuries sustained in a motor accident.'

Secondly, let us examine the proposition that the distance between the reception area and Mr McLeod's room was 300 metres. Is it feasible that a man in his mid seventies with a heart condition was 'moving quickly from the Reception desk to Mr McLeod's room on at least three occasions'? This represents a distance of 1.5 kilometres if we accept that Mr Meier did not go back to the office after returning to Mr McLeod's room for the last time before the ambulance arrived. He may have walked this route hurriedly on three separate occasions, but this is not a distance of 300 metres, and I am amazed that this would not have been questioned. How could anyone accept that a man of Mr Meier's age and condition could possibly have covered such a distance in the suggested time frame? The true distance between the office and Mr McLeod's room, I am reliably informed, is approximately 82 metres. Did it not strike the coroner as strange, that a small 28 bedded unit would have a corridor extending for one third of a kilometre? The evidence for this is of course demonstrable. Where did that figure come from, and why? Of course, such a false premise cannot support the inferred conclusion. The entire argument is false.

The above are two examples of falsehoods to be found in the report; I accept however, that their origins are external – somebody has lied to the court (perjury). It seems extraordinary that a senior officer of the court would not be able to see through these inventions immediately however. More concerning are the amount of fallacies peppered throughout the report. Since you are already in possession of the annotated report I will only mention the most significant. The inclusion of Dr Konrad Blackburn's rightful assertion that 'any treatment administered by the first paramedic team after 20 minutes was extremely unlikely to result in resuscitation' only proves the point that had the nursing staff carried out CPR when they first discovered Mr McLeod, the whole saga might have ended quite differently; therefore these comments do nothing to absolve the Hobart Clinic of negligence. Furthermore, one has to question the reasons why evidence from the paramedics, that they were able to discern a pulse when they first examined Mr McLeod, was not recorded in the report. This was clearly stated at the coronial hearing, as reported by the ABC:

Paramedics managed to get a pulse but Mr McLeod died later.

One of four ambulance officers who attended, Matthew Cane, said it was best to start CPR within four to five minutes, giving paramedics time to arrive and use drugs and defibrillation.

But he said Mr McLeod was a young, fit male and even if half an hour had passed, he still would have tried to revive him. ²

If Mr McLeod had a pulse when the paramedics arrived, how much more likely would it have been that he might have been resuscitated had attempts been made twenty minutes earlier?

A further point of issue is the following statement:

I do not consider that the Hobart Clinic was remiss in failing to remove "hanging points" to deter or prevent suicides or that the existence of "hanging points" contributed to Mr McLeod's death ...

The Hobart Clinic was remiss in failing to remove hanging points. The management was advised to do so following an audit a couple of years previously, and any organisation of quality would have ensured their removal. The comment that hanging points did not contribute to Mr McLeod's death is beyond parallel in its absurdity. It appears Justice Shan Tennant, in her findings in the 'Deaths in Custody Inquest,' 2001, took a somewhat different view of the DJIR's poor response to earlier recommendations pertaining to hanging points:

The cells in E Division where two of the deaths occurred continued to the date the inquest commenced to have an abundance of suspension points. The cells within the prison hospital also retained some although steps had been taken to reduce those and work was underway at the time of the inquest. However that work had only been recommended in the first half of 1999 some 3 years after the death of an inmate in 1996.

The evidence before me makes it abundantly clear that the DJIR, notwithstanding numerous coronial recommendations over a long period about the need to remove suspension points throughout the Risdon Prison Complex, made conscious decisions not to do so for budgetary reasons. Budgetary concerns took precedence over compliance with statutory obligations to provide care.³

She further comments in her recommendations:

I am conscious that many if not all of the recommendations I will make will have budgetary implications. However it is

² <http://www.abc.net.au/news/2010-11-04/psych-clinic-inquest-begins/2324108>

³ http://www.magistratescourt.tas.gov.au/__data/assets/pdf_file/0013/52600/Deaths_In_Custody_Findings.pdf.p.205

clear that the response to previous coronial findings affecting the Risdon Prison Complex has been dictated by budgetary considerations and the result has been 5 deaths, some if not all of which may have been avoided...⁴

Ms Tennent clearly understood the connection between hanging points and death by hanging. We cannot logically accept both views.

Other factors to consider are:

1. Discrepancies in the time of Mr McLeod's return to the Hobart Clinic on the 24th April 2009.
2. The suggestion that a Mini Mental Assessment was conducted – these can take easily fifteen minutes to complete, are commonly used to evaluate cognitive function in conditions such as dementia, and require the client to sit down with pencil and paper.
 - i. Why was no definition of terms sought?
 - ii. How long did it take?
 - iii. What was asked?
 - iv. How did Mr McLeod respond?
 - v. Was it recorded?
3. Why was the door to Mr McLeod's room not lifted off its hinges using the specially designed handles?
 - i. Was the staff not aware that this could be done?
 - ii. Why were they not aware?
 - iii. Why was this not mentioned?
4. Why did the staff waste valuable time by checking Mr McLeod's pulse whilst he was still suspended?
5. Why did the nurse in charge think it was more important to call the psychiatrist, the police, and the nurse coordinator, none of whom could have been of any assistance, and leave Mr Meier to deal with the situation alone?
6. Why was the 'cut down knife' not used?
 - i. Was the staff aware of the existence of the cut down knife?
 - ii. If not, why not?
7. Why was assistance not sought from non-nursing staff?
8. Why did the nurse in charge take the 'crash trolley' to Mr Meier and not remain with him to assist?
 - i. Was this because the decision not to attempt CPR had already been made?
9. Why was the third nurse on duty, at the time Mr McLeod returned to the Unit, not called to give her version of events?

⁴ *Ibid.* p.207

It seems that whilst some elements of this case have been misrepresented, others have been completely suppressed. The reason for this undermining of the law may only be known by a few, but having been advised of the parties and networks involved it is not difficult to understand the conclusions that are being drawn; however, the reason I am writing to you today is not based on speculation but on absolute certainty. Facts are facts, and they have been quite unashamedly ignored, and in many cases, manipulated. This represents an abuse of the legal system, and a betrayal of those who rely upon it to make the community a safer place for all. It casts a very large shadow over the competence and integrity of the judiciary, and I hope this can somehow be lifted. It is much more important to rectify this situation and restore the public's faith in our legal system by bringing to account those responsible for the initial gross negligence, and the subsequent deceit.

I respectfully request that you investigate this matter thoroughly, not only out of respect for Mr McLeod and his family, but for the entire community.

NB. I do not give permission for my name or other details to be used other than for the purpose of communication between you and me.

Yours sincerely

John B. Cole

Regent
Victoria 3073

Tuesday, 23 April 2013

Mr Wayne Johnson
Administrator of Courts
23-25 Liverpool St.
Hobart 7000

Dear Mr Johnson,

Record of Investigation into the Death of Alastair James Douglas McLeod –
4th and 5th November 2010.

As requested during our conversation on the 15th of April, I am forwarding to you a copy of the letter I sent to Mr Hill last month, and for which I have still not received a reply.

Please note, I am including evidence, directly from an internet source, that demonstrates clearly the dimensions of the Hobart Clinic and the surrounding grounds. This in fact means that my earlier estimate of 82 metres is well in excess of the true distance between the office and Mr McLeod's room, which makes the exaggerated distance of 300 metres even more incredible. This misinformation is not insignificant, and acts as a signpost for the other highly questionable statements in the coroner's report.

I understand that you may now be on vacation; nevertheless, I shall anticipate a response within the next few weeks.

Thank you for your assistance.

Sincerely

John B Cole.



MAGISTRATES COURT of TASMANIA

16 May 2013

Mr John Cole

Regent
VICTORIA 3073

Dear Mr Cole

Inquest into the death of Alastair James Douglas McLeod held 4th-5th November 2010

I refer to our telephone conversation of 15 April 2013 which was shortly before I went on annual leave.

I have now returned from leave and acknowledge receipt of your letter dated of 23 April 2013 which details your concerns about the above matter.

I have brought your concerns to the attention of the Chief Coroner, Mr Michael Hill. Mr Hill is in the process considering the various matters that you have raised and I expect that he will reply to you once he has had an opportunity to do so.

In the meantime, should you have any questions please contact me.

Yours faithfully,



Wayne Johnson
Administrator of Courts



12 June 2013

Magistrates' Chambers,
Hobart

Mr John Cole

Regent
VICTORIA 3073

Dear Mr Cole

Inquest into the death of Alastair James Douglas McLeod - 4-5 November 2010

I acknowledge receipt of your letter concerning the findings handed down by Coroner Webster at the conclusion of the inquest he held into the death of Mr Alastair James McLeod.

I write to advise that this matter has been further investigated.

As you are aware s58 of the Coroners Act 1995 empowers the Chief Magistrate to re-open an investigation either on his or her own initiative or on application of a person whom the Chief Magistrate considers has a sufficient interest in the findings of the investigation. To re-open any inquest the Chief Magistrate has to be satisfied either that:

1. There has been fraud;
2. The investigation was not sufficiently thorough;
3. There are mistakes in the findings;
4. New facts or evidence has come to light;
5. The findings were not supported by the evidence, or;
6. There is another compelling reason to reopen the investigation.

On the advice given to me you have not provided any information upon which it can be assessed whether you are a person 'of sufficient interest...' within the meaning of the legislation and it is clear that I would be entitled to reject your application on the basis that the precondition to having jurisdiction to re-open has not been met.

However, for the reasons set out below, I am prepared to order the inquest be re-opened but only on a strictly limited basis.

You criticise the findings because you say they include two mistakes.

...../2

The first is the Coroner's assertion that Mr McLeod was admitted to the Clinic 'for injuries sustained in a motor accident.' You point out that the Clinic is a psychiatric facility and it does not receive patients requiring treatment for physical injury.

The file shows that a short time before his admission Mr McLeod was involved in a motor vehicle accident and had suffered lacerations to his forehead and forearm, however, his attendance at the clinic was not for treatment of these injuries but rather for management of his poly drug abuse. It seems the Coroner has made an error in his findings by stating that Mr McLeod was admitted for motor vehicle accident injuries

The second error of fact you complain of is the Coroner's statement that Mr McLeod's room was 'approximately 300 metres distant' from the Clinic's reception area. You assert that the true distance is 82 metres and you have provided a plan which suggests that this is probably correct. Certainly the plan makes it clear that 300 metres may not be a correct measurement and the Coroner again it seems has made a factual error.

There were two nurses on duty at the time of Mr McLeod's death. It is common ground that neither of them carried out CPR. You are critical of this and by implication the Coroner's finding that neither nurse contributed to the death. However, this was an issue that was explored at the inquest proceedings and the Coroner was clearly satisfied that in the circumstances, the conduct of both nurses was explicable. The evidence was that they both examined Mr McLeod and were satisfied that he was deceased hence CPR would have been pointless. However, even if CPR had been undertaken the evidence was that it may not have been successful in saving Mr McLeod in any event. The conclusions reached by the Coroner were available to him on the evidence and different opinions are not a reason to re-examine the issue.

You are also critical of the Coroner's conclusion that the Clinic did not contribute to the death because of its apparent failure to act on an earlier audit and take steps to remove all hanging points. Again, this was a topic considered at the inquest and the Coroner has given his reasons for his finding. They are valid. Even if the hanging points had been removed it does not follow that the death of Mr McLeod would have been avoided.

Finally, you list in your letter nine different subjects which you say should have been explored at inquest. Whilst some may be legitimate questions, I am not persuaded that the failure to pursue them indicates that the inquest was not sufficiently thorough so to warrant re-opening

Therefore, it seems there are the two factual errors in the findings which I have mentioned.

It is open to me therefore to re-open the investigation under s58(1)(c) of the Coroners Act and then for amended findings to be published. The Coroner would be directed to do this under s58 (4).

However, having considered the matter and the advice I have received I will be re-opening the investigation under s58(1)(c) to correct the two factual errors which have been identified. I am not prepared to reopen the investigation on any other basis on your application because;

- I cannot be satisfied that you are a person who has a sufficient interest in the findings as required by s58(2)(b); and,
- In any event I am not satisfied that you have identified any matters which satisfy me that the investigation should be reopened under any of the remaining provisions of s58.

I direct your attention to your right of appeal against my decision to the Supreme Court under s58(7).

Yours sincerely



Michael Hill
Chief Magistrate

Regent
Victoria 3073

Sunday, 21 July, 2013

Mr Michael Hill
Chief Magistrate
23-25 Liverpool Street
Hobart 7000

Dear Mr. Hill,

Record of Investigation into the death of Alastair James Douglas McLeod – 4th and 5th
November 2010.

I am currently in Hobart where I have discussed with all interested parties the contents of your letter dated 12th June 2013. The consensus is that you have not gone far enough in addressing the issues that I described in my previous letter. I shall endeavour in the following paragraphs to explain, as succinctly as I can, why we have come to this conclusion.

Firstly, although we understand that following a request for a judicial review the court may base its decision on what it refers to as a 'sufficient interest test,' I am not bound by the limitations of such legal discourse. From my perspective, and from the perspective of the wider community, we all have sufficient interest in ensuring that this and every other matter that comes before the court is dealt with in a manner that exhibits full moral integrity and meets the needs of the community. If it appears that the needs of private organisations are being put before the safety of the public, then members of the public must be made aware so that they can make informed decisions about, for example, where they choose to be treated for mental health problems. In any case, no lacuna in the law should be tolerated if it permits irregularities simply for the lack of a sufficiently, personally interested claimant.

Secondly, I cannot agree with you that you can only reopen this case based on the single criterion that: '[t]he investigation was not sufficiently thorough.' With perhaps the exception of fraud, all of the remaining criteria are satisfied. But regarding the elements on which you base your decision to reopen this case, let us be perfectly clear on the following point: these 'two factual errors' both form the basis of separate syllogistic arguments which lead to conclusions that could not otherwise have been made. It is therefore, in the first case, not simply a matter of replacing 300 metres with 82 metres (probably less). If you modify the antecedent substantially, as you do in relation to the distance between the Hobart Clinic reception area and Mr. McLeod's room, then it follows that you must also modify the consequent; about this there can be no disagreement.

In the second case you replace one false proposition with another. Whilst it is true that Mr. McLeod had an addiction, it was mainly for his suicidal thoughts that Dr. Cheah of the Royal Hobart Hospital referred him to the Hobart Clinic on this occasion; something to which you and the Coroner have made no reference. Dr. Cheah described his having 'passive wishes to die.' As I wrote in my previous letter to you, Mr. McLeod is also quoted as saying that he 'doesn't care about himself' and, 'he is on a [self-destruction] path.' On the 23rd of April, 2009, it is said of Mr McLeod: 'he was feeling flat' and 'struggling with thoughts of [self-sabotage].' These points are well described in the RCA (Root Cause Analysis), which was produced by the Hobart Clinic itself. These facts are of such significance to this case, yet neither you nor the Coroner makes the slightest allusion to them, even in your response to my letter. The absence of any such allusion is extremely noteworthy. Page | 2

Thirdly, with regard to the advice you have been given, you may be entitled to reject my application based on current legislation, but the public is always entitled to analyse and be critical of decisions made by the courts; particularly when those decisions are based on fallacious arguments. Furthermore, it is clear that advice given to you in no way touches on your remit to pursue the truth and protect the community; it simply recommends avoidance tactics. The 'sufficient interest' rule is useful in preventing the hindrance of the smooth running of government, but seems rather out of place in the less grand setting of the Hobart Magistrates Court.

The fourth major issue that I wish to discuss is in relation to the absence of CPR and your comment: '[y]ou are critical of this and by implication the Coroner's finding that neither nurse contributed to the death.' The implication is not that the nurses involved contributed to Mr McLeod's death, although some may find that point arguable, but that they did nothing to prevent it. It is very important, as you are aware, that such distinctions be made; there is no place for ambiguity in the legal arena. But in regard to your comments on the explicability of the nurse's conduct, all conduct is explicable whether appropriate or otherwise. Williams' decision to leave Mr Meier alone with a dying man carries with it an explanation, but it is indefensible by the standards of any logical thinking person. The fact that the Coroner was 'satisfied that in the circumstances, the conduct of both nurses was explicable,' is the problem; therefore, your argument is circular. It is like saying that God exists because the bible says so, and the bible is the word of God, therefore it must be true. The rationales given in your response have the flavour of ever expanding tautologies. This is also true of the contention that: '[t]he staffing level generally is 1 psychiatric nurse for every 7 patients.' The only reason this ratio exists is because the management of the Hobart Clinic made it so in its push to increase profit margins. There is no reason why anyone should believe it is therefore adequate.

Continuing the topic of CPR, or rather, the absence of CPR, you say: '[t]he evidence was that they [the nurses] both examined Mr McLeod and were satisfied that he was deceased hence CPR would have been pointless.' As psychiatric nurses, with no recent general experience or training, they were not in a position to pronounce death. Under certain circumstances, nurses may assess whether life is extinct (normally in a nursing home or hospice where patients are expected to die), but they are still required to check for a number of different signs. The nurses involved did not carry out these necessary observations, rendering

their assessment invalid, along with your argument. In any case, as Mr McLeod still had a pulse when the paramedics arrived some twenty minutes later, he clearly was not dead at that time and should not have been declared so – a fact that also negates your argument. (Although the paramedics made the Coroner aware of this fact during the hearing, he makes no reference to it in his findings – another significant omission). But what was Mrs Williams' motivation in placing the crash trolley outside of his room if only moments before she had determined that Mr McLeod was already deceased and could not possibly benefit from CPR? This is another false argument. Page | 3

A further argument that you offer is that: '...even if CPR had been undertaken the evidence was that it may not have been successful in saving Mr McLeod in any event.' Of course, it is always possible that CPR may not be successful, but there is also evidence that it often is. If everyone were to adopt this principle there would be no reason for ever trying to save anyone. Perhaps we should recommend the dismantling of the ambulance service? This is a preposterous argument, and it should be of considerable concern to the community that it is being suggested.

The fifth area of concern is the comment that hanging points did not contribute to Mr McLeod's death - they clearly did. The reasons for the Coroner's findings, in relation to hanging points, cannot be considered valid in any logical sense; that, I suggest, is why Justice Shan Tennant took a different view when she investigated the deaths in custody back in 2000. In addition to the comments made by Shan Tennant, you will read of similar findings in the articles I am forwarding with this letter: they relate to suicides which resulted from the continuing presence of hanging points. I think you will find your peers in these cases all took a much more rational approach than that which you and the Coroner have taken.

You also say that: '[e]ven if the hanging points had been removed it does not follow that the death of Mr McLeod would have been avoided.' It most certainly follows that he could not have hanged himself in his room had the hanging points been removed. A key problem faced by staff in a psychiatric facility is the impulsivity of the clients. People with depression or personality disorder comprise a high percentage of the client base in private psychiatric clinics and are among the most likely, on impulse, to make an attempt or pseudo attempt on their lives. This is why all risks must be minimised. It is the belief that the management of such facilities have ensured the building is free of major risks that induces people to seek the safety of an admission to what they, in this case wrongfully, assume is a *controlled environment*, either for themselves or for their family members.

The sixth very important, albeit brief point, is that contrary to your assertion that: '[t]he conclusions reached by the Coroner were available to him on the evidence...', large portions of evidence have been utterly disregarded. Based on the way he chooses to describe the events of that morning, and omit vital evidence in his findings, he could not possibly come to any other conclusions in some of his arguments; the remainder make no sense at all.

Finally, I would like to bring your attention back to the point that neither of the staff members on duty, at the time Mr McLeod was found hanging, availed themselves of the use of the cut down knife. A cut down knife, as you will already be aware, has a curved blade

specifically designed for cutting through a ligature quickly and safely without causing further trauma in the process. The fact that neither of the staff sought to use the knife indicates that they responded in a way that can only be considered negligent, or that the management of the Hobart Clinic had not provided appropriate in-service training. In ignoring this, and the aforementioned issues, the Coroner consequently fails to make the necessary recommendations that would create a safer environment, and protect future vulnerable clients.

It is an interesting and telling fact that all the errors and fallacious arguments lead to favourable outcomes for the Hobart Clinic. Even though, during a period exceeding two years, not one single person sought to advise the Coroner of the two most glaring 'factual errors,' it is remotely feasible that that is what they were, not likely, but remotely feasible; however, it is undeniably the case that all other arguments are arrived at through purposeful design, and act as straw men arguments, diverting attention from the facts.

I believe this case would be more fairly judged in the public forum, and I will be passing it on to those who are best able to ensure that this happens.

Yours sincerely

John B Cole

cc.

Mr. Wayne Johnson.

Office of the Ombudsman, Hobart.

HANGING POINTS RISK ASSESSMENT AND RECOMMENDATIONS

In July 2006, the ACHS put out a discussion paper on the "Management of Potential Hanging Points".

In this discussion paper, a comprehensive list of potential hanging points were identified, along with the suggestion that "where possible/practicable these should be removed or replaced" (ACHS discussion paper, July 06).

Following on from this discussion paper, the ACHS are in the process of completing an update for the health industry with regards to identifying potential suicide risks. This will include the issue of hanging points. Surveyors have been advised to address the following points when reviewing an organisation's risk management processes with regards to suicide risk:

The organization has:

- A list of potential suicide risks identified;
- Risk assessments for these identified suicide risks;
- Treatment/control plans for identified suicide risks;
- Evidence to support ongoing attempts to reduce suicide risk;
- Systems to support ongoing management of these risks;
- Evidence the staff have undergone education in clinical risk assessment; and
- Supportive policies to provide direction and advice for staff on the management of at risk patients and suicide risk.

The Hobart Clinic undertook a hanging points risk assessment in the first half of 2007. Two staff members – one clinical, the other non-clinical, undertook the assessment. This risk assessment identified a number of hanging points, categorizing them into low, medium, or high risks.

Preliminary discussion then centred around what risks were able to be eliminated, which ones were to have controls implemented and what were acceptable risks.

The attached list shows all risks identified, internal and external, along with comments and recommended controls.

I recommend that this list be reviewed, initially by OH&S, and additional controls identified as appropriate. Following on from this, an action list can be formulated.

Alison Keleher
May 2007

Extract only. Since the shading on the original copy obliterated the print once it was photocopied, I have retyped this exactly as it is to be found in the original document.

NB. Redmond Wing is the wing in which Mr McLeod's room is to be found.

	[RISK LEVEL]					[PRIORITY]
Cupboard handles			✓		Change to recessed handles	High for first 3 rooms
Curtain rail	✓					
Metal hook behind door			✓		change to suction/stick on Plastic hooks	High
Metal hook behind bathroom door			✓		change to suction/stick on Plastic hooks	High
REDMOND WING	Low	Med	High	Comments		
Handrails (toilet/shower)					Risk assessment performed on all patients and reviewed at least daily	
					patients allocated a Redmond wing (room 4–15) bed to be low risk (Category 3 or 4)	
Shower screen			✓		Program of replacement	Medium
Handrails hallways	✓					
Telephone cord		✓				
Manhole			✓		secure	Medium
Light fitting	✓			(Low – would break)		
REDMOND GROUP ROOM						
Fire hydrant hose		≤		Area secured in pm	secure area after hours except when in use	

Somewhat inexplicably, the Director of Nursing who compiled this risk assessment rated certain risks highly, while only giving them a medium priority for action; however, she must be credited for bringing these risks to the notice of the management, even though they were subsequently ignored.

Root Cause Analysis, Incident number 512

Date	Time	What happened	Questions	Findings
14/4		<p>AMcL admitted to THC</p> <ul style="list-style-type: none"> Referred by Dr Cheah at the RHH. Noted "passive wishes to die" 	<p>What was the doctor's management plan?</p> <p>Was the Drug and Alcohol withdrawal policy followed?</p>	<ul style="list-style-type: none"> Regular diazepam Relapse prevention groups Alcohol withdrawal assessment scale Category 2 – 1 hrly obs <p>The Drug & Alcohol withdrawal policy was followed.</p>
?		<p>Nursing Assessment findings</p> <ul style="list-style-type: none"> Stressed over impending jail Feels like pushing the boundaries Doesn't care about himself Parental problems Aware he's on a self destruction path 	<p>What was the nursing management plan?</p>	<p>Interventions section on the management plan <u>not</u> completed.</p>
15/4		<p>Seen by Lauderdale GP</p> <ul style="list-style-type: none"> Laceration to scalp – staples insitu Laceration to R elbow – signs of infection – on keflex. <p>Complaining of a headache</p>	<p>Cause of lacerations?</p> <p>Did AMcL undergo a CAT scan post MVA?</p>	<p>MVA on 10/4 – drink driving offense.</p> <p>No.</p>
15/4		<p>Did not attend program.</p>	<p>Actions taken?</p> <p>When did AMcL start attending the group program and which groups were attended?</p>	<p>No documented actions taken, AMcL attended part of the group program on 16/4.</p>
16/4		<ul style="list-style-type: none"> Reported to be less agitated. Commences chlorprom prn Attended part of the addictive group session 	<p>Is there a possibility that adverse drug interactions affected Alastair's behaviour?</p>	<p>Advice from Pharmacist is that there is a slight possibility that AMcL suffered from serotonin syndrome. This is not a strong possibility however, due to the absence of neuromuscular, or other, symptoms of the syndrome and because AMcL had been taken these drugs with no ill effect for some time, as was evidence by his ADWS monitoring.</p>
17/4		<ul style="list-style-type: none"> Staples removed. 		<p>AMcL's condition had not</p>

		<ul style="list-style-type: none"> Recategorised category 3 	Basis for reclassification?	deteriorated. He was giving no indications of intending self-harm.
18/4		Talking to staff often and in depth		
19/4		Talking to staff often and in depth.		
20/4		<ul style="list-style-type: none"> Reported to have a restless night. Attended the group program Management plan reviewed Complained of a headache 	Were interventions planned?	No.
21/4		<ul style="list-style-type: none"> Attended group program Attended community meeting 		
22/4		<ul style="list-style-type: none"> AMcL requested a move to Redmond wing Attended Group sessions Complained of severe headache. Given leave to go shopping between 4 – 6 pm with his mother. Returned ruffled after an altercation with his mother Wrote a letter of complaint re staff numbers, stated that he felt there was insufficient staff to deal with an emergency. 	<p>Why?</p> <p>What was done about this?</p> <p>What action was taken?</p>	<p>AMcL felt uncomfortable about how he might be causing a disturbance to his elderly neighbour.</p> <p>No follow up action taken. Notes indicate that AMcL felt he had sorted the situation out himself.</p> <p>Complaint handed to CSM, who reviewed staffing levels and felt that patient numbers and patient's acuity levels were adequately covered by the number of staff available.</p>
23/4		<ul style="list-style-type: none"> Reported 'feeling flat'. Struggling with thoughts of self sabotage. Minor headache 	What was done about this?	Nil interventions recorded. Self-harm policy refers to physical harm only, this needs to be updated to address all types of self harm.
23/4	2345	<p>AMcL noted to be AWOL</p> <ul style="list-style-type: none"> Bed made up to look like it was occupied. Fly screen removed and hidden behind curtain. 	<p>What actions were taken?</p> <p>When was the last time AMcL was sighted?</p> <p>Does a policy/procedure exist for AWOL patients? Was the policy/procedure followed?</p>	<ul style="list-style-type: none"> THC searched. On-duty Psychiatrist called. <p>Attended Group program until tea time. DS saw AMcL at medication time, approximately 2200.</p> <p>The policy exists. The</p>

			Is the policy/procedure adequate?	policy was not followed exactly, but the policy is out of date and, therefore, inadequate and needs to be reviewed.
24/4	0030	Dr Pargiter called. <ul style="list-style-type: none"> • Call police if not returned by 0140. • Do not call parents. 	Why this time? Why?	Hotels closed by then. It was felt that there was nothing to be gained, would only cause concern to the parents.
24/4	?	Reported by another patient that AMcL had \$50 on him, and that he had taken his meds.	What did he actually know?	Reported that AMcL had said he was going out to get some drugs and had asked if he wanted some too.
24/4	B/W 0736 and 0741	Appeared at nurse's office. <ul style="list-style-type: none"> • Stated he had been "wandering around". • Offered breakfast – which he refused. • Told to go to his room, would check on him shortly? 	Who did he speak to? What did they ask/say? Does a policy/procedure exist to cover patients returning from being AWOL? Does a policy/procedure exist to cover patients suspected of consuming alcohol/illicit drugs? Does a policy/procedure exist for nursing risk assessment and/or level of observation Were the policies/procedures followed? Are the policies/procedures adequate?	Spoke to CW. WM was in the background. Appeared tired, but otherwise okay. AMcL was reluctant to answer questions in depth, giving light-hearted, cheeky answers in response. CW said it was possible that AMcL might have been drinking or had taken some drugs, but undertook no investigations. No policy exists to cover a patient returning from being AWOL. The Clinical Risk Assessment Policy includes direction for increased observation and a revised risk assessment of patients who have absconded. The policy was not followed, is out-of-date and, therefore, inadequate.
24/4	0742	AMcL returned to his room.		
24/4	0750	WM commenced a check of the Redmond wing.	For what purpose? When did he reach AMcL's room?	Routine morning procedure. This was the last room checked in the wing and WM reached it at 0754, 13 minutes after AMcL had left the nurse's office.
24/4	0754	Door to R11 could not be opened	Why not?	Chair jammed against door.

24/4	0754	WM forced door and entered room. Found AMcL hanging from shower rail.		
		WM checked for signs of life	How?	Felt his chest for movement associated with breathing, and a radial pulse. He tried twice to lift AMcL up the release the ligature around his neck, but failed.
	0754	WM called for assistance from CW	How?	WM left R11 knowing that CW was in the courtyard. He did not try to use the nurse call system stating that CW would not have heard it.
	0756	WM & CW both proceed to R11	What did CW do?	Assessed the situation and determined that they needed the crash cart and some scissors to cut AMcL down.
	0758	Crash cart retrieved	By whom? Are there any staff in the facility? What are they doing?	CW CW encountered ST on her way to retrieve the crash cart, asked for her assistance.
	0800	ST arrives at THC and is asked to assist by CW	Where is WM? What is CW doing? What does ST do? Which other staff are present? What are they doing?	WM has remained in R11, however he leaves and returns with CW and the crash cart. CW leaves again to make phone calls. ST assists WM to cut AMcL down. Two cleaning ladies were present; their assistance is not requested at this stage.
		AMcL cut down	What first aid was administered? What assessment of the patient's condition was undertaken? What policies/procedures exist to guide staff in these situations?	Once cut down, AMcL is placed on the floor. ST checks for signs of life, checking for carotid pulse and movement of chest. CW, ST and WM all believe there are no signs of life. The only available policy relates to actions to be taken in the event of a patient's death. This policy infers that staff have the right to determine that life is extinct.
	0800	PF called	By whom?	CW

		SH called	By whom?	CW
		Ambulance called	By whom?	CW
		Police called?	By whom?	CW
		Ambulance arrives	What actions do they take?	Attempt resuscitation, some cardiac output is detected.
	0820	PF arrives		
	0830	AMcL moved to ambulance		
		AMcL pronounced DOA		
	0900	AMcL's parents notified.		Dr McLeod suggested that AMcL's intention was possibly not to actually commit suicide. He believed that AMcL feared he would have no accommodation to go to if THC expelled him for being AWOL. An attempt at suicide would see AMcL removed to the RHH, from where he would be able to return to THC once his period of expulsion was up.

Additional specific questions

Was information from various patient assessments shared and used by members of the treatment team on a timely basis?	All patient assessment information was contained within the medical record; however it is spread across several forms and does not provide the reader with a quick and easy glance to ascertain a patient's current status, or any trends in patient's thinking or state of mind. Reporting was shift by shift, and therefore timely.
Did existing documentation provide a clear picture of the work-up, the treatment plan and the patient's response to treatment?	The treatment plan was not completed, no nursing interventions were planned. Generally the form does not allow for comments on the patient's response to treatment.
Was communication between front line team members adequate?	Communication between the nursing staff appeared to be adequate. AMcL was talking freely with some members of staff and his comments and thoughts are well documented.
Did adequate communication across organisational boundaries occur?	SH has documented his consultations with AMcL in the medical record. Neither the nursing staff nor SH perceived AMcL as a serious suicide risk. Even upon his return from being AWOL, there is no indication in his manner, bearing, or body language that indicates a suicide is planned.
Was there sufficient staff on-hand for the	There were three staff assigned to care for 12

workload at the time?	patients. One staff member had taken 3 patients for ECT therapy, leaving 2 staff and 9 patients. In terms of staff to patient ratios, and considering patient acuity the staffing levels were sufficient. However, the appropriate number of staff required to successfully manage a medical emergency, needs to be considered.
Were the staff properly qualified and trained to perform their functions?	The staff have general nursing, psychiatric and ICU training and can therefore be considered to be properly qualified for the work they were undertaking.
Were all staff orientated to the job, facility and unit policies regarding life safety management?	Staff had been orientated to the facility, to their job. All policies are readily accessible for staff.
Were there written, up-to-date policies and procedures that addressed the work processes related to the incident?	Some policies had never been developed, and those that existed were inadequate to support staff in dealing with the situation.
Were these policies/procedure consistent with relevant state/federal legislation/guidelines?	The existing policies were not consistent with external guidelines.
Were the relevant policies/procedures actually used on a day-to-day basis?	The policies and procedures have not been reviewed for some time, and this lack of currency would deter staff from referencing them on a daily basis.
If the policies and procedures were not used, what got in the way of their usefulness?	It is possible that nursing practice differs greatly from policy, and whether this is a failure of policy implementation, or a failure of policy writing, needs further investigation.
If the policies and procedures were not used, what positive and negative incentives were absent?	No monitoring of adherence to policy, policies allowed to become out of date.

Big picture questions

Are policies and procedures communicated adequately?	With new management only recently commencing within the clinical services division, the process for communication on new and/or updated policies and procedures has yet to be determined.
Is the communication of potential risk factors free from obstacles?	No. Stronger guidelines are required on situations where verbal, rather than just written, communication of risk factors is required.
Does the overall culture of the facility encourage or welcome observations,	The recent changes in management have led to some reticence amongst staff to talk about

<p>suggestions or "early warning" from staff about risky situations and risk reduction?</p>	<p>issues, and a general loss of trust. New managers are still developing rapport. During the period of time where no permanent clinical management team was in place, team meeting schedules slipped and few formal meetings were held. All of these issues were being addressed prior to the incident occurring, however a stronger focus is required.</p>
<p>Is there a program to identify what is actually needed for training of staff?</p>	<p>Work is underway to survey staff on their current skills base. Performance development models are also being investigated.</p>
<p>Had a previous audit been done for a similar event, were the causes identified, and were effective interventions developed and implemented on a timely basis?</p>	<p>Previous audits have been undertaken in relation to security and assessment on hanging points. The actions resulting from these investigations cannot clearly be ascertained.</p>

Root Cause Analysis, Incident no. 512

Overview:

On Friday April 24, 2009 Alastair McLeod was found hanging from the top shower rail in the bathroom of room 11 on Remond wing. Prior to this, Alastair had absconded from The Hobart Clinic and had been absent for at least eight hours overnight. He had been sighted, and had engaged in conversation with the nursing staff on his return. The time from the end of this conversation to the time he was discovered hanging was twelve minutes duration.

At the time of his admission, Alastair was in the process of alcohol and drug withdrawal, and had recently been involved in a MVA, where he had sustained lacerations to his scalp and forearm. The scalp wound still had staples in-situ, and Alastair was taking keflex for a minor infection in the forearm wound. The MVA was the result of Alastair driving while under the influence. Alastair's concern that he would be sent to jail as a consequence of his actions, was a recurring theme between April 14 and 24.

At admission, Alastair was noted to have "passive wishes to die", he stated frequently that he believed himself to be on a path to self destruction, but did not seem able to stop himself. He participated in Group Therapy on an ad-hoc basis, not always staying for the duration of the program. He responded well to staff during 1:1 counselling sessions, opening up and talking about his current problems and his dreams for the future. His mood varied from being quite low, to being 'brighter'. Parental issues also continued to be a theme throughout his stay, and on April 22nd he was noted to have had an altercation with his mother, whom he believed to be generally supportive. There were no reported issues with other patients, although there was some comment that Alastair's habit of 'constantly bumming cigarettes' was annoying a few people.

Initially Alastair was assigned a category 2 status, but this was changed to category 3 on April 17. His treatment regime consisted of diazepam and chlorprom, monitoring through the drug and alcohol withdrawal scale, and attendance at the relapse prevention groups. A nursing assessment was undertaken; however no nursing interventions were documented.

On Thursday April 23, Alastair attended the Drug & Alcohol Group, but stayed only until tea time. He was noted to be absent at 2345. The Psychiatrist on-call was called, who asked staff to call the police if Alastair had not returned after hotel closing times. Alastair's parents were not notified of his absence.

Alastair returned voluntarily to THC at 0736 on the following morning. He entered via the laundry door, which was opened by another patient who heard him knocking. Video footage does not show Alastair entering the building; however it is believed that he entered the building through one of the doors and reported straight to the nurse's station.

The nursing staff questioned Alastair on his movements overnight. He answered their questions nonchalantly without giving direct details. He was offered breakfast, which he refused. He appeared to be tired, but otherwise relaxed. Given that some of the patients were upset with Alastair for breaching the security of the building by leaving through his bedroom window (as was thought at the time), the staff suggested that he go to his room rather than mingle with the others in the courtyard. He complied, appearing to walk unhurriedly, and quite relaxed to his room. Video footage shows him entering his room at 0742

At 0754 one staff member, having undertaken his routine wakeup call of patients on Redmond wing, entered R11. He found Alastair hanging from the top door frame on the shower bay. He attempted twice to lift Alastair up, to free the ligature, but could not achieve this on his own. He was unable to detect signs of life and noted that Alastair was blue, and that his eyes were bulging and tongue protruding. The staff member went to seek help and returned with another staff member within two minutes. They were still unable to free Alastair, so the second staff member went to the nurse's station to retrieve the emergency trolley and a pair of scissors. There she encountered the Day Program Co-ordinator arriving for work and asked for her assistance.

Two staff members attended to the task of freeing Alastair, while the third member of staff called the ambulance, the police, the patient's doctor, and the Clinical Services Manager. Alastair was cut down and again checked for

signs of life. Believing him to be deceased, no active resuscitation was undertaken. Paramedics were on the scene at 0812; they attempted resuscitation and achieved some cardiac output. Alastair was transported to the RHH, where he was pronounced DOA.

Issues:

In investigating the circumstances of Alastair's death a root cause analysis was undertaken. This process identified several contributing factors, which if not addressed may adversely impact upon a similar incident occurring in the future.

1. No planned nursing interventions had been recorded for Alastair, this includes following review of Alastair's management plan a week after admission. Alastair's state of mind, and general demeanour were noted at least daily, but the structure of the record, and individual form design, does not allow for a quick glance view of any patient's, progress.
2. Self harm policies and procedures cover physical harm only, they do not recognise other forms of self sabotage or self destruction and do not give guidance on managing these tendencies.
3. The policy on clinical assessment, which calls for a review of the patient's risk factors after incidents such as going AWOL, was not followed.
4. No policy exists to guide staff in the management of a patient returning from being AWOL.
5. Methods of emergency communication between nursing staff members are limited, relying on the staff carrying pagers and mobile phones. The pagers are only activated by pressing the nurse call bell system, and are therefore only effective in areas where there is access to the call buttons. There is no means of communicating the need for urgent assistance with other staff members (e.g. admin, services staff etc).
6. There is no clinical emergency policy to cover the appropriate response to an incident such as this. There is a policy on patient death, which infers that staff are able to determine that life is extinct.
7. The staff to patient ratio at the time of the incident was adequate in terms of both the number and acuity of inpatients. However, consideration must be given to recognising that back up staff (e.g. an emergency response team, or additional nursing staff) are not immediately available at THC.
8. The staff member co-ordinating the emergency response co-opted some assistance from the non-nursing staff who were either present at the time of the incident, or arrived shortly thereafter. This is an appropriate and necessary use of all available resource, however guidance is required on the type of tasks that can and should be given to non-nursing staff.
9. Many policies and procedures are overdue for review, and while a project had already commenced to address this issue, it must be noted that staff's faith in the adequacy of existing policies would be tempered by their knowledge that they are not always reflective of current practice.
10. The policy implementation process is currently in a state of flux, given the change in numerous staff positions over the past year; therefore, it is possible that policies and procedures that may have been developed over the last 8 – 10 months may not have been adequately implemented.
11. Two previous audits, one on hanging points and one on security issues, had been undertaken, with minimal response to the problems identified.

Recommendations:

1. Policies and procedures, to cover patients returning from being AWOL and the management of a medical emergency, need to be developed and implemented immediately. The policy on patient death should be rescinded immediately and a more appropriate policy developed. The policies on self harm and nursing assessment need to be updated.
2. The clinical emergency policy should detail roles for each person responding to the emergency. Non nursing tasks (e.g. fetching the emergency trolley, calling the ambulance, marshalling all other patients to a safe location) can, and should, be allocated to admin or services staff. The need for 'all hands on deck' in the case of an emergency should be discussed with existing staff, and be included in the orientation program for new staff.
3. The policy review project needs to be pursued, with all existing policies being subject to a rigorous review of their accuracy, appropriateness and adherence to legislation and recognised standards. The project also needs to address the process of policy implementation, version control and monitoring of compliance.
4. Daily methods of communication, about patients' progress and/or condition, amongst nursing staff, and also between nursing and clinical staff need to be reviewed. The need for verbal communication of critical information must be stressed.
5. The process for seeking emergency assistance needs to be reviewed and a more comprehensive system introduced that enables nursing staff to communicate internally and externally to the building. Methods of communication with other staff members who may be in the building and able to offer assistance should also be investigated. Nursing staff are to be required to carry pagers and personal duress alarms with them at all times.
6. Forms used to document the patient's progress need to be reviewed, with some consideration given to developing a quick glance overview that gives a timely portrayal of the patient's state of mind and their progress (the well-being thermometer from Perth Clinic being one possibility).
7. Staffing levels are to be reviewed in light of the clinical emergency policy, to ensure that the minimum nursing staff levels are always sufficient to enable an appropriate and adequate response to any emergency. Staff patient ratios must consider the acuity of the patients, not just the number of patients.
8. The hanging points and security audits are to be tabled at the WHSC and a list of recommendations to be drawn up for the Board's endorsement.



Record of Investigation Into Death

Coroners Act

Coroners Regulations

Regulations 14

I, Christopher P Webster, Coroner, having investigated the death of
Alastair James Douglas McLeod

WITH AN INQUEST HELD AT HOBART

in Tasmania on 4 and 5 November 2010

FIND THAT:

(a) Alastair James Douglas McLeod ("Mr McLeod") died on 24 April 2009 at the Hobart Clinic at Chipmans Road, Rokeby in Tasmania.

(b) Mr McLeod was born in London, United Kingdom on 8 March 1967. He was unemployed at the time of his death.

(c) Mr McLeod died as the result of asphyxia due to deliberately hanging himself in his room at the Hobart Clinic, at Rokeby.

(d) No other person contributed to the cause of Mr McLeod's death.

BACKGROUND INFORMATION:-

The Inquest

A formal Inquest was held into the circumstances surrounding the death of Alastair James Douglas McLeod on 4 and 5 November 2009.

Sergeant Gerard Kirkham, attached to the Coroners Office, acted as Counsel assisting the Coroner.

Various interested parties were represented at the Inquest, namely:

(a) Nurses Cheryle Williams and Sheryl Tatham, represented by Mr R Phillips and Mr G Dolliver (of Phillips Taglieri);

(b) The Hobart Clinic, represented by Mr D Barclay and Mr B Cassidy (of Page Seager);

(c) Nurse Walter Meier, represented by Mr Tom Cox (Barrister) and Mr M Barnier (of Hunt & Hunt);

(d) Dr S Hooper, represented by Mr C Cunningham (of Simmons Wolfhagen).

The totality of the Coroner's file was tendered into evidence. This file included, amongst other items, Mr McLeod's medical records from the Royal Hobart Hospital; pathologists report; clinical notes from the Hobart Clinic; photographs, video of movements at the Hobart Clinic on 24 April 2009, and affidavits of all witnesses.

The following witnesses appeared at the Inquest and were cross-examined on their affidavits, namely:

(a) *Matthew Cane and Andrew Summers* - Intensive Care Paramedics who were the attending ambulance officers on 24 April 2009 at the Hobart Clinic.

(b) *Amanda Quealy* - Chief Executive Officer of the Hobart Clinic.

(c) *Constable George Stirling* - the Police Officer who first attended the Hobart Clinic on 24 April 2009, following the death of Mr McLeod.

(d) *Dr Stewart Hooper* - the Clinical Director of the Hobart Clinic.

(e) *Peter Fraser* - the Clinical Services Manager at the Hobart Clinic.

(f) *Cheryle Williams* - Nurse at the Hobart Clinic.

(g) *Sheryl Tatham* - Nurse at the Hobart Clinic.

(h) *Walter Meier* - Nurse at the Hobart Clinic.

In addition to the Coroner's file the following documents were tendered by various parties during the Inquest, namely:

(a) Policy & Procedure Manuals of the Hobart Clinic;

(b) Report of the organisational-wide survey for the ACHS Evaluation and Quality Improvement Program - Hobart Clinic;

(c) Agreement between the Hobart Clinic and Patients relating to use of drugs and alcohol in the Clinic;

(d) Final Report - Root Cause Analysis Incident Report;

(e) DVD security analysis;

(f) Opinion of Dr Konrad? Blackman - Review of Events Pertaining to Alastair McLeod.

Circumstances Surrounding the Death -

The Hobart Clinic is a privately funded psychiatric hospital for private patients. It is a hospital for patients who have a motivation to get well, and funding to attend. It is not for the critically unwell or for persons with actual suicidal intentions. These patients are not accepted and a triage system exists to ensure that such patients are sent to other mental institutions who have the facilities to ensure safe care for such patients.

As the patients are private the Hobart Clinic has no power, apart from a contract between the patient and the hospital, to keep patients in the Hobart Clinic. The ultimate power of the Hobart Clinic over patients is to exclude the patient from attending the Hobart Clinic, or if medical grounds exist, to transfer that patient to another hospital or mental institution.

Mr McLeod had a history of admissions over the years to the Hobart Clinic, and had had some 7 admissions to the Clinic for poly substance abuse and on one occasion for depression.

On 14 April 2009 he was admitted to the Hobart Clinic for injuries sustained in a motor accident.

At the time of admission he was not regarded as a serious risk of suicide. He was assigned Category 2 status, which was reduced to Category 3 (the lowest indicator of suicide), on 17 April 2009.

On the evening of 23 April 2009 at approximately 11.45pm Mr McLeod was found by staff at the Clinic to be absent without leave. At 7.30am the next day, 24 April, Mr McLeod returned, of his own volition, to the Hobart Clinic.

Mr McLeod upon his return spoke to nurses and Nurse Meier at the nurses station. At that time a mini mental assessment was undertaken by Nurse Williams. Neither Nurse Williams nor Nurse Meier detected anything unusual in Mr McLeod's manner which caused any alarm. Mr McLeod went to his room. That room being the furthest room away from the Reception area (i.e. approximately 300 metres distant).

Nurse Meier attended Mr McLeod's room 12 minutes later. The door was barred and Nurse Meier had to force his way into the room using considerable force. Upon entering the room at 7.54am Nurse Meier found Mr McLeod hanging on the shower frame by a belt.

Nurse Meier made an attempt to get Mr McLeod down but was unable to do so. He checked for signs of life but there are no signs. He then left the room to seek Nurse Williams assistance. Both nurses then returned to Mr McLeod's room where Nurse Williams also checked unsuccessfully for signs of life. They still could not release Mr McLeod.

Nurse Williams then returned to the nurses station to make emergency calls and other necessary telephone calls. While Nurse Williams was making these calls, Nurse Meier was able to lift Mr McLeod and cut the belt.

At about the time that Nurse Meier released Mr McLeod, Nurse Tatham, who had been directed by Nurse Williams to assist Nurse Meier, arrived at Mr McLeod's room.

Nurse Meier described what happened initially when he located the body as follows:

"I tried to lift him - standing there and tried to lift him to undo the belt, but I couldn't, I mean he was over 100 kilos, so I thought, oh you know, try again and then I tried again but it was hopeless, and then I went to see Cheryle Williams"

He described what happened when he was left by Nurse Williams when she went to make the telephone calls as follows:

"And then by that time Cheryle - Cheryle Williams had left and Sheryl Tatham came (approximately 8.01am) and she also took the carotid pulse and shook her head ... we all felt that he was dead and we couldn't do anything anymore the way he was and we couldn't move him and we could not move him from exactly the position where he was, we could not even attempt CPR - and not apply - or apply the defibrillator. So we just - as I said I was exhausted and Sheryl Tatham came as I said and took the pulse and then Cheryle Williams came back (approximately 8.06am) and said the ambulance is coming so we actually left - left the trolley in that position ... [and then made the room tidy for the ambulance ... and then we went to check on the other patients and by that time the ambulance had arrived]"

The ambulance crew entered Mr McLeod's room 20 minutes, after Mr Meier had first entered his room, and unsuccessfully began resuscitation measures.

Mr McLeod's treatment was continued by ambulance officers and while being transported by the ambulance to the Royal Hobart Hospital Mr McLeod was declared dead.

Causes of Death

The cause of Mr McLeod's death was asphyxia, as a result of hanging himself by his belt from the shower frame in his room at the Hobart Clinic.

The primary reason that a formal Inquest has been held into the death of Mr McLeod was to ascertain whether there was any person that contributed to his death, and if so, whether measures could be introduced or improved so as to prevent a similar death.

The actions of the Hobart Clinic and the individual nurses will be considered.

(a) The Hobart Clinic

There was no evidence that the staffing levels generally at the time of Mr McLeod's death were inadequate.

The staffing level generally is 1 psychiatric nurse for every 7 patients. At the time of the death there were 2 nurses for 10 inpatients. This level of staffing exceeded the recommended levels.

The nurses had been nurses for many years. Nurse Williams was a nurse for 30 years and a psychiatric nurse for 11 years. Nurse Meier had been a psychiatric nurse for at least 19 years.

Adequate equipment was provided for the assistance of the nurses. There was a "crash trolley" containing all necessary equipment to enable the nurses to attempt to resuscitate Mr McLeod, and the nurses were trained and capable of using such equipment. There cannot be said to be any failure by the Hobart Clinic in failing to equip the Clinic with adequate staffing and equipment.

The question of not removing "hanging points" at the Hobart Clinic was raised. I do not consider that the Hobart Clinic was remiss in failing to remove "hanging points" to deter or prevent suicides or that the existence of "hanging points" contributed to Mr McLeod's death for the following reasons:

(i) Mr McLeod was a voluntary patient. If he had wished he could have left the Hobart Clinic at any time, which is in fact what he did the preceding night. If a "hanging point" was not available inside the Hobart Clinic he could have hanged himself elsewhere or committed suicide by other means.

(ii) The Hobart Clinic is an institution for persons at "low risk of suicide" and is a voluntary institution. It is unlikely that the conversion of the Hobart Clinic into a completely suicide proof institution is likely to create an atmosphere that would attract fee paying clients or that the cost would be justified by the actual risk of suicide. In any event the Hobart Clinic appears to have passed Quality Assurance checks by the relevant body.

I am satisfied that there was an appropriate risk assessment procedure in place for patients returning to the Hobart Clinic and that in fact such an assessment was undertaken by Nurses Williams and Meir on the morning of 24 April 2009. Nurse Meier went to check on Mr McLeod within 15 minutes of the readmission to the Hobart Clinic in any event, which was in essence the procedure that would have been followed even if Mr McLeod's category of risk had been increased on his re-admittance.

There is the question of whether failure to notify family of the absence of Mr McLeod on the night of 23 April 2009 contributed to his death. I do not consider that it did or that it was necessary for Mr McLeod's family to be notified of his absence.

The absence was relatively short and occurred late at night. It is unlikely that Mr McLeod's family could have done anything about his absence, but even if they had it is probable that he either would have been taken back to the Hobart Clinic or counselled to return to the Clinic. Whether he could have been located prior to consuming the illicit drugs and alcohol, which may or may not have affected his state of mind making him commit suicide, is purely problematical.

His death did not occur outside the Hobart Clinic. The Clinic had no authority to notify the police of his absence from the Clinic.

Since the death of Mr McLeod the Hobart Clinic has comprehensively reviewed their policies and appear to have adequate policies in place. There is no need to make recommendations in respect to the practice and procedure of the Hobart Clinic.

(b) The Nurses

Nurse Sheryl Tatham

Nurse Tatham was qualified as a nurse. She was employed in other areas by the Hobart Clinic.

Nurse Tatham arrived at work at 8.00am and was directed to assist Nurse Meier by Nurse Williams, who was at that stage making appropriate telephone calls.

Nurse Tatham's knowledge of the events when she arrived at Mr McLeod's room were sketchy at best. When she arrived at Mr McLeod's room and felt his pulse, and was satisfied he was dead, it was appropriate for Nurse Tatham not to take her directions from Nurse Meier as she did not know the preceding history and she was not employed as a nurse.

Nurse Tatham's behaviour was appropriate in all the circumstances and in no way contributed to the death of Mr McLeod.

Nurse Cheryle Williams

Nurse Williams conducted a mini assessment of Mr McLeod on his arrival back at the Hobart Clinic. There was nothing apparently unusual with Mr McLeod.

Within 15 minutes of Mr McLeod being re-admitted Nurse Meier was at Mr McLeod's room so that it could not be said that either Nurse Williams nor Nurse Meier were not keeping Mr McLeod under observation upon his return to the Hobart Clinic.

Nurse Williams appears to have done all that she could to assist Nurse Meier with Mr McLeod on the day.

She attended Mr McLeod's room with Nurse Meier as soon as requested. She took Mr McLeod's pulse. She assisted Nurse Meier in trying to lower Mr McLeod from the shower bay, and she brought the trolley to Nurse Meier. She then went to the nurses station to make appropriate telephone calls.

No criticism can be made of Nurse Williams' actions.

Nurse Walter Meier

The two questions concerning the actions of Nurse Meier are whether his (or the other nurses) failure to perform CPR on Mr McLeod contributed to the death of Mr McLeod, and whether he should be criticised for his failure to perform CPR.

The evidence presented at the Inquest was to the effect that even if CPR had been administered by Nurse Meier (or others) in a timely manner (i.e. as soon as he was lowered to the ground), the chances of a successful resuscitation were remote.

The evidence of both ambulance attendants was that the chances of resuscitation in the circumstances of Mr McLeod were small. Paramedic Cane state that the window of opportunity for a successful resuscitation expires after 4 to 15 minutes, and that after that time Mr McLeod's prospects were not improved by CPR, using compression or oxygen.

The report of Doctor Konrad Blackburn, Staff Specialist, Emergency Medicine Royal Hobart Hospital indicated that the prospects of a better outcome for Mr McLeod were extremely remote. His evidence was that after 20 minutes Mr McLeod had no prospects of a successful resuscitation.

Statistics referred to by Doctor Blackburn showed survival from cardiac arrest in any case is low: "A recent review pooling data from 79 studies (14 x 740 patients) showed that 23.8% survived to be admitted to a hospital. Only 7.6% survive to be discharged from that hospital".

In light of this evidence I am unable to conclude that Nurse Meier's failure to administer CPR contributed to the death of Mr McLeod. The lack of a chance of success is however not in itself sufficient reason for anyone, particularly a trained nurse, not to administer CPR in circumstances such as those surrounding Mr McLeod. If such an approach were universally adopted a significant number of persons (though statistically small) would needlessly die. CPR should be administered where possible and practical.

In the case of Nurse Meier I accept that the failure to administer CPR was due to factors beyond his control and he should not be criticised for failing to administer CPR for the following reasons:

- Nurse Meier was physically exhausted as a result of the cumulative effects of moving quickly from the Reception desk to Mr McLeod's room on at least three occasions; attempting on at least three occasions to lift Mr McLeod who weighed approximately 100kg (i.e. a heavy weight), and supporting Mr McLeod's weight with one arm while he cut him down.
- The room in which Mr McLeod was lying after being lowered to the floor did not allow Nurse Meier to effectively administer CPR, and Mr McLeod's body could not be easily moved. This version is supported by the evidence of the two paramedics, who while both young and fit, had difficulty in moving Mr McLeod's body.

(c) Ambulance Staff

After the adjournment of the hearing of the Inquest I received a letter which raised questions about the lack of training of the members of the first ambulance crew to arrive at the Hobart Clinic on 24 April 2009.

A copy of that letter was sent to all Counsel participating in the Inquest for their comment.

I do not propose to enlarge the Inquiry of the Coroner to include the possible lack of training of the staff in one of the attending ambulances.

Paramedics Cane and Summers gave evidence of their treatment of Mr McLeod. I am satisfied that their treatment was both appropriate and given in a timely manner. Any delay that occurred in the administration of treatment between the time the team involving Cane and Summers commenced giving treatment, and when the first team could have given treatment was very limited.

The paramedics did not arrive until approximately 20 minutes after the discovery of the body and any treatment administered by the first paramedic team after 20 minutes was extremely unlikely to result in resuscitation for the reasons stated by Doctor Konrad Blackburn.

I consider the matters raised in the letter to be too remote from the question of cause of death to investigate further. A line must be drawn at some point beyond which factors which come to light will be considered as too remote from the death.

Before I conclude this matter, I wish to convey my sincere condolences to the family of the deceased.

This matter is now concluded.

DATED: 11 January 2011, at Hobart in the State of Tasmania

**Christopher P Webster
CORONER**

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