CITATION: *Inquest into the death of William Mark Bunting [2005] NTMC 006*

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FINDING OF:	Mr Greg Cavanagh SM
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REPRESENTATION:

Counsel:

Assisting:	Mr Michael Grant
Representing the Department of Health & Community Services:	Mr Kelvin Currie
Representing the family of the deceased:	Mr John McBride
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IN THE CORONER'S COURT
AT ALICE SPRINGS IN THE
NORTHERN TERRITORY
OF AUSTRALIA

No: A0079/2003

In the matter of an Inquest into the death of

WILLIAM MARK BUNTING ON 15 DECEMBER 2003 AT THE ALICE SPRINGS HOSPITAL IN THE NORTHERN TERRITORY OF AUSTRALIA

FINDINGS

(Delivered 7 February 2005)

Mr Cavanagh SM:

The nature and scope of the inquest

1. William Mark Bunting ("the deceased") tragically hung himself in the Alice Springs Hospital at some time in the early hours of 15 December 2003. At the time, the deceased was apparently a voluntary patient pursuant to the *Mental Health and Related Services Act*. As a result, he was a "person in care" within the meaning of s12 of the *Coroners Act*.

2. Section 34(1) of the Act details the matters that an investigating coroner is required to find during the course of an inquest into a death. The section provides:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
> (i) the identity of the deceased person;
> (ii) the time and place of death;
> (iii) the cause of death;

(iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*; and

(v) any relevant circumstances concerning the death; or

(b) a disaster shall, if possible, find –

(i) the cause and origin of the disaster; and

(ii) the circumstances in which the disaster occurred."

3. Section 34(2) of the Act operates to extend the Coroner's function as follows:

"(2) A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

4. The duties and discretions set out in subsections 34(1) and (2) are enlarged by s35 of the Act, which provides as follows:

"(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

"(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner."

5. The public Inquest in this matter was heard at the Alice Springs Courthouse between 27 September and 1 October 2004. Counsel assisting me over the course of the Inquest was Mr Michael Grant. At the commencement of the inquest, Mr Kelvin Currie sought leave to appear on behalf of the Department of Health and Community Services and Mr John McBride sought leave to appear on behalf of the family of the deceased. I granted that leave pursuant to s40(3) of the Act.

Formal findings

6. The mandatory findings pursuant to s34(1) of the Act are as follow.

(1) The identity of the deceased was William Mark Bunting.

(2) The deceased died at Alice Springs Hospital on 15 December 2003.

(3) The cause of death was self-inflicted hanging.

(4) The particulars required to register the death are:

(i) the deceased was male;

(ii) the deceased was of Caucasian ethnicity;

(iii) a post-mortem examination was carried out;

(iv) the pathologist viewed the body after death;

(v) the pathologist was Dr Terrence Sinton;

(vi) the father of the deceased was Francis Bunting;

(vii) the mother of the deceased was Anita Faye Bunting, nee Johnson

(viii) at the time of his admission to Alice Springs Hospital the deceased resided at Lot 3504, Ilparpa Road, Alice Springs; and

(ix) the deceased was a businessman and voiceover artist.

Relevant circumstances concerning the death

7. The deceased first presented to Mental Health Services at the Alice Springs Hospital on 22 October 2003 ("the first admission"). He was suffering from depression and alcoholism. He was admitted for treatment and underwent alcohol withdrawal during the course of the admission.

8. Following discharge on 10 November 2003, he travelled to Brisbane and was admitted to the Belmont Private Hospital on 12 November 2003 as part of the general treatment plan formulated during his time with Mental Health Services. He was discharged from Belmont for continuing alcohol consumption and attempts at overdose. During this time in Brisbane, the deceased also underwent a number of other ill-fated admissions or attempted admissions. The difficulties experienced by the deceased in this respect appear to have been largely attributable to his non-compliance with treatment regimes and conditions, and to his demanding personality.

9. The deceased returned to Alice Springs and was readmitted to the Mental Health Services at the Alice Springs Hospital as a voluntary patient on 5 December 2003 ("the second admission"). Whilst he was formally processed and assessed at the time of his admission and in the following days, no written record of a risk assessment or a nursing care plan for the second admission could be located during the course of the investigation following the death. It is common ground, however, that one was prepared at the time and this was borne out by the evidence of the relevant witnesses.

10. The deceased's primary treating psychiatrist during the course of both admissions was Dr Abusah. During the second admission, he was assisted in his care and treatment of the patient by Dr Noonan and Dr Van Dijk. The deceased's behavioural program during the course of the second admission was administered by Registered Nurse Blunt, with the assistance of other nursing staff. The deceased's Case Manager upon his discharge into the community following the second admission was to be Mr Castle.

11. In the week following the deceased's admission his condition remained relatively stable. His condition was such that he was released on weekend leave with his family on 13 December 2003. The deceased returned to the Ward on the Sunday night prior to his death and retired to bed in the normal course. It is plain from the various statements taken during the course of the police investigation, and particularly that provided by the wife of the deceased, that there was no noteworthy event or occurrence during the course of the leave. I pause here to note that the wife of the deceased is a trained psychologist.

12. The rounds on the night of 14 December and the early morning of 15 December 2003 were undertaken by Registered Nurse Williamson. The deceased was not sighted during the course of those rounds.

13. The body of the deceased was discovered hanging from the bathroom door by Registered Nurse Scheid at 0740 hours on 15 December 2003. Registered Nurse Scheid called for assistance. That call was answered by Registered Nurse Blunt, Patient Care Assistant Blunt and Registered Nurse Buckley. Registered Nurse Allan called for the resuscitation team. The restraint team was mistakenly sent. The resuscitation team arrived at 0745 hours and was led by Dr Jonathan St Clair. The deceased was pronounced dead at 0800 hours. The scene was secured by Registered Nurse Buckley until the arrival of Police.

Public health issues

14. A number of matters of concern in relation to public health were raised prior to and during the course of the Inquest. All health care professionals who played any significant role in the treatment of the deceased were called to give evidence during the course of the Inquest. During the course of the coronial investigation of the death by the

Northern Territory Police, an independent expert review of the medical and outpatient files and relevant statements was commissioned and undertaken by Dr Campbell, a Consultant Psychiatrist. Dr Campbell is a Psychiatrist with 30 years experience who has held appointments as Director of Clinical Services at the Rozelle Hospital, as a member of the New South Wales Mental Health Review Tribunal, and various advisory and teaching appointments. I received evidence from Dr Campbell during the course of the Inquest.

15. The Department of Health and Community Services also commissioned an Internal Review of the death of the deceased. The review was undertaken by Jill Pettigrew, a consultant psychiatrist for Top End Mental Health Services. Dr Pettigrew also gave evidence during the course of the inquest.

16. These reviews and the report prepared by investigating police raised the following issues for consideration during the course of the inquest:-

(1) The appropriateness of the deceased's discharge on 10 November 2003.

(2) Whether the deceased's general treatment and medication regime prior to his death was appropriate.

(3) Procedures in place to ensure the appropriate recording and dissemination of accounts of self-harm, suicidal ideation, attempts at suicide and other clinically significant observations.

(4) The appropriateness of the observation regime to which the deceased was subject during the course of the second admission and, in particular, following 11 December 2003.

(5) The nature of overnight observations and the appropriateness of sighting patients during the course of those observations, including furniture and observation port configurations.

(6) The adequacy and appropriateness of patient to nursing staff ratios within Mental Health Services at the Alice Springs Hospital.

(7) The circumstances in which the restraint team was mistakenly sent to the scene of the death.

(8) Whether the delay in the arrival of the resuscitation team compromised the attempt to resuscitate the deceased.

(9) Whether steps might be taken to minimise hanging points in patient rooms.

17. I will deal with each issue of concern in turn. I would preface those comments with the observation that there can be no suggestion on the evidence that the death was either preventable or contributed to by any deficiency in the deceased's treatment and care within the Mental Health Unit at the Alice Springs Hospital.

The appropriateness of the deceased's discharge following the first admission

18. The evidence discloses that the deceased became quite disturbed when the issue of discharge was first raised with him on 30 October 2003. After that time it was determined that upon his discharge from the Alice Springs Hospital the deceased would travel to Brisbane for treatment

dedicated to addressing his condition, which was complicated by the combination of alcoholism, demanding personality traits and a depressive illness.

19. I consider that the discharge following the first admission was appropriately made and managed. I heard evidence from Dr Pettigrew to the effect that referral to the Brisbane facilities was appropriate in that such a facility might be best placed to implement a treatment plan to address the deceased's complex presentation. I also heard evidence from Dr Campbell to the effect that Mr Bunting's condition was, once stabilised, best treated in the community setting rather than in the context of a protracted or indefinite admission. Finally, I heard evidence from Dr Abusah to the effect that the deceased had reached a point by 10 November 2003 where he was comfortable with discharge on the basis of the Brisbane referral, suicidal ideation and intent were not overly active, and a relatively comprehensive discharge plan was in place.

The deceased's treatment and medication regime

20. I consider that the deceased's care, treatment and medication regime was satisfactory over the course of the two admissions. Indeed, during the course of the Inquest I heard on a number of occasions that the Mental Health Services facility in Alice Springs handled Mr Bunting's case more ably, appropriately and compassionately than the institutions in Brisbane to which he was admitted.

21. Dr Campbell's evidence in that respect was as follows: --

> "Now, sir, you go on to make the observation that the hospital staff correctly identified the clinical features of the deceased's condition, what were those features?---Well

> they focused firstly on the alcohol dependency syndrome and his withdrawal stage, they had the good documentation of the - his suicidal ruminations that had been with him since he was a teenager and they - it seems he tried to put a management program firstly towards a detoxification program, some counselling about alcohol and I also looked at the relationship issues and the problems that's built up as a result of his drinking.
>
> So doctor, you say that the clinical features of his presentation or his condition were appropriately identified?---Yep.
>
> And the treatment was within current guidelines?---Yep."

22. I would also conclude on the basis on the evidence received during the course of the Inquest that the composition of staff within the Mental Health Services at the Alice Springs hospital is appropriate and, in particular, that staff are appropriately trained and have suitable access to expertise for the purpose of dealing with patients suffering from alcohol and drug dependency in combination with a psychiatric disorder.

23. Having made that general observation as to the appropriateness of the deceased's treatment and medication regime, there are a number of specific comments that fall to be made in light of the evidence.

24. There was some suggestion in the evidence of Dr Campbell that the psychotherapy sessions that formed part of the deceased's treatment regime were ill-directed and of little utility. This view was based largely on Dr Campbell's assumption that nursing staff have little or no training in these matters and the deceased's recorded complaints that he was getting nothing from the sessions. I am not able to make any adverse findings on that basis. Registered Nurse Blunt had specific training in psychotherapy and Dr Campbell himself conceded that the sessions were of some benefit.

25. There was a further suggestion that the new generation antidepressants that were being administered to the deceased increased the risk of suicide by him. There are a number of observations to be made in that respect. There is nothing but the thinnest of circumstantial evidence that this may have been the effect in the deceased's case. On any objective reading of the clinical notes, it is somewhat attenuated to suggest that the deceased's expression of suicidal intent was reduced when Cipramil was withdrawn and increased with the introduction of Venlafaxine. Moreover, the research suggesting increased suicidality in this regard is new, controversial and, on its own terms, only has that potentiality with 10% of the patient population. I consider that this is a matter for the health industry to pursue and not one that is amenable to any comment or recommendation in the context of this Inquest.

26. The deceased's medication regime during the course of the first and second admissions was generally satisfactory and within the accepted guidelines. There was some faint criticism by Dr Campbell of the introduction of Solian when the deceased was not manifesting any psychotic symptoms. Dr Campbell questioned the efficacy of that medication in the treatment of disthymia, but seemed to accept it would have done no harm. There was a degree of tinkering and fine-tuning with the medication regime, but the timing and nature of those measures was accepted as appropriate and unremarkable. It is clear from the analyses conducted on autopsy that the deceased was not taking the Solian, for reasons we will probably never know. Even so, the deceased was not displaying any gross fluctuation in mood. I note the Venlafaxine was still in the deceased's bloodstream at therapeutic levels or higher at the time of his death. There can be no suggestion that the planned withdrawal of the Venlafaxine and its substitution with Solian had any bearing on the deceased's suicide.

27. It is generally conceded that there was an underestimation of the degree of the deceased's suicidal intent. No one expected him to commit suicide on that night. He had apparently stabilized over the week leading up to the death. Registered Nurses Buckley and Rio could discern no intent or other difficulty on the night of the deceased's return from weekend leave. Staff had probably to a degree, become desensitised to the deceased's complaints, threats and expressions of intent by reason of their sustained nature. That said, it is not possible to identify any manner in which the deceased's treatment and medication regime could have been altered or tweaked so as to prevent the tragic result.

The adequacy of the deceased's observation regime

28. That underestimation of the deceased's intent leads necessarily to some consideration as to the adequacy of the deceased's observation regime. The Mental Health Unit policy in place at the time, and still in place today, required periodic observations where there was "some" risk of self-harm. At the time of his death the deceased was not on any special or periodic observation regime and had not been since a brief period on 8 December 2003. The word "some" as it appears in the policy is clearly open to interpretation.

29. The evidence was consistently to the effect that special or periodic observations were not necessary or appropriate in the circumstances. To some extent, that evidence, so far as it is given by the treating health professionals, is based upon their underestimation of the degree of the deceased's suicidal intent. The same cannot be said of Drs Campbell and Pettigrew who, with the benefit of hindsight, do not consider that

periodic observations were called for. Dr Campbell's evidence on this point was in the following terms:

> "Doctor, in those circumstances, would it have been better at that time to put the patient on some sort of periodic observation status as a matter of caution? Now in saying this, I don't want to yet go to your final conclusion with is that the result would have been the same in any event but can we just deal with that issue in isolation, would it have been better to put him on some form of special observation, or period observation?---My feeling is that those notes indicate that the problem had been there but had passed and that it was noted as more of a sign that there was some improvement because a lot of the other observations were that he was bright, active, settled, no significant management problem. Certainly, the doctors were well aware that there was a risk that in managing that they tried to put the responsibility back to him, tried to - and keep simply - keep family contacts going which was, I think, very important. So, and by far the conclusion was that even had that been tended to with observation it wasn't going to prevent a suicidal (inaudible)- - -
>
> Wasn't necessarily going to - yes I accept that, doctor, and I also accept that you're in the difficult position of conducting something in the nature of the psychiatric autopsy not having attended upon this patient?---Yeah.
>
> But given - leaving aside whether it would have made any difference, are you able to positive opinion for his Worship as to whether or not, in your view, special observations or some form of period observation would have appropriately introduced in that week leading up to his death?---My understanding was that he was - they were, in effect, under 30 minute observations in the hospital but they were encouraging him to go out and to have leave and of course you can't do the periodic observations once people are on leave.
>
> That's true, now what - - - ?---And I'm not - I'm assuming that the - they've responded to this statements about previous - the rope particularly as something that was in the past, not as a current issue, but that's all I could make of the notes now if it's reasonable that they think it's a current issue to increase observation and have much closer

> observation but if a clinician decides, you know, is of the opinion that well this is the past issue that the medication is working, the person is responding, then at some point you've got to decide that okay, the next stage is to give him time out from the hospital and at that point it becomes illogical to have very close obs in the hospital and no obs outside.
>
> All right, so, I take it that what you're saying is that if he'd been shown to have improved in mood and presentation in the days leading up to his leave on the Saturday, then it was appropriate not to have any particular periodic observation regime in place, is that what you're saying?---Yep.
>
> Yes, thank you?---And with - in this as it proves in this that a person can kill themselves with just a belt in the door and going to the toilet in three minutes, it's really the only thing that could have prevented that suicide at that time would have been 1 on 1 observation and following him into the toilets.
>
> All right, and are you able to positive view on whether or not that sort of observation regime was appropriate in these circumstances at the material time?---I think it was not possible to apply that in these circumstances particularly with someone who'd been apparently suicidal for 20 years."

30. There are a number of compelling reasons that lead to the conclusion that the deceased's observation regime was appropriate in the circumstances. First, close observation would have had a deleterious impact on the therapeutic relationship between the deceased and his treating medical practitioners. Secondly, the deceased had stabilized to some degree. Thirdly, it was appropriate to trial the deceased on day leave and, in those circumstances, both inappropriate and futile to place the deceased on close observation whilst on ward. This was particularly so in circumstances where the deceased did not manifest any warning signs upon his return from leave.

31. For these reasons, I find that the general observation status upon which the deceased was placed was appropriate in the circumstances. I make that finding cognisant of the fact that on any reasonable view the deceased must be said to have been of at least “some" risk of self-harm at the time. Technically, there was a breach of the Mental Health Unit observation policy, but its application was not warranted for any practical purpose in this case.

32. I do make three ancillary comments in relation to the observation policy.

33. First, it was conceded by all parties during the course of the Inquest that night observations should be conducted on an hourly basis regardless of the patient’s status. That regime has now been implemented on ward within Mental Health Services in Alice Springs. I **recommend** an amendment to the policy to reflect that regime, if such an amendment has not already been made.

34. Secondly, I am of the view that the implementation of periodic observations would likely not have averted the death in question. I received evidence to the effect that the process can take as little as three minutes. There was nothing in the evidence or circumstances to suggest that the deceased should have been on constant observation such that he would have been prevented from preparing and executing the suicide. At most, periodic observations were called for. Had they been implemented, the deceased may have been disturbed in his preparations. We will never know, but that eventuality must be considered the less likely possibility.

35. Thirdly, there is the issue whether the patient’s belt should have been taken from him. The belt was the means by which the deceased committed suicide. Dr Campbell says “no”, notwithstanding the

deceased's advertence to his belt as a potential means of self-harm during an earlier admission. For the same reasons that I found that there was no warrant for special or periodic observations, there was similarly no warrant for removing the belt.

The recording and dissemination of accounts of suicidal ideation and other clinically significant observations.

36. There were a number of events leading up to the death of the deceased that, with the benefit of hindsight at least, were noteworthy. The question arises whether they were appropriately dealt with by staff within Mental Health Services and appropriately keyed into the deceased's clinical picture.

37. On 10 December 2003, the deceased admitted to a hanging attempt on 8 December 2003. That admission was made to Dr Noonan. She subsequently discussed the matter with Dr Van Dijk and Dr Abusah. Dr Noonan's recollection of the exchange was as follows:

> "Yes?---Yep, the next time I saw him was on Wednesday evening, probably about half-past 6, and I was leaving the ward and I was leaving by the back door because I had a meeting over at the motel - get out the back door, I remember it quite clearly and he came up to me, he seemed quite sort of cheerful and he said: 'How much longer are you saying here?' And I said: 'Five weeks and how are you getting on?' And he said he was feeling reasonably well but he had from that - I think it was the Monday or over the weekend contemplated suicide but he sort of said it in a rueful kind of way but he had this dream and it, you know, it's as if he couldn't even manage that, as if it snapped and sort of made a gesture with his hands but he - - -
>
> Did he actually indicate that he had attempted suicide with this dream or merely that he had contemplated suicide with this dream?---I think he indicated that he had snapped a

string with his hands because I said: 'Did you actually try' and he said 'no' but my impression was that after he told me and I think he (swears?) 9.50.35 you know, (wants to know so or not so or not?) , he was relieved and retrospect I think he was relieved to have been able to tell me because I understand that when he told people, at the hospital in Brisbane, you know, on two occasions he was immediately sort of discharged from the hospital and I think he was relieved that he was able to tell someone and I said, you know, well, you know, he said he was no longer feeling suicidal and he agreed that we would have to come up the next day for the ward meeting and he was happy to do that.

Doctor, could you just please elaborate on the suggestion that he'd previously been discharged twice for admitting this sort of ideation?---Well I understand that in Brisbane he had taken an overdose and they had discharged him from one of the hospitals for that and that he threatened suicide at another hospital, he'd been in Brisbane, apparently in the interim between his first and second admission to Alice Springs, basically for sort of alcoholic withdrawal or treatment for alcoholism and that it happened there and I suppose, although on his first admission to Alice Springs, I think he'd been able to sort of freely ventilate about suicidal ideation but in Brisbane, you know, they had taken a very tough line with him about not allowing him to stay at hospital because of that. So that was my impression that he was relieved, I then sought out Dr Van Dijk who was his Registrar and I said you know - - -

On that afternoon, Doctor?---That evening.

That evening, yes?---Yeah, and Dr Van Dijk said, you know, that he'd been talking to him and the impression was that he was sort of better than on admission and it's agreed, you know, also that we would talk about it with Dr Abusah on the third day, at the next ward round and then later that evening, I came back into the hospital for something else and I saw Mr Bunting with someone who I think was probably, who I later found was his wife and he looked reasonably cheerful and composed. Then on the Thursday this was brought up in the board meeting that about this suicide idea/attempt, I don't remember whether it was clarified but I do remember, I think, someone saying that they had found a string and on that Thursday which was

> actually the last time I saw him, we again discussed this compulsive suicidal thought and he said you know, it's been a kind of a relief for it, and idea for him for many years if things got too bad that that was something he could do and it was put to him, I think that day, rather than the Monday that you know, what about his children and he said yes that was the thing that actually stopped him, what about, you know, trying to sublimate his, you know, he's gifted musically and that he has been planning to play some music with one of the other patients there who liked music, you know, trying to sort of work with these sort of compulsive death thoughts in another way and he said yes, he has tried all that, but he would give it a go and I did understand, I think, that he was going to take on some cognitive behaviour therapy when he left hospital, perhaps a look at that."

38. The description of the episode was somewhat equivocal and, at its highest, appears to have been comprised by Mr Bunting considering the use of a string to hang himself, but breaking the string when testing it with his hands before he could put his plan into effect. Whatever actually took place, it is clear that the matter was documented and discussed during the course of the deceased's case conference on the Thursday. All relevant treating healthcare professionals were aware of the matter.

39. On the evening prior to his death the deceased returned to the ward following weekend leave with his family. Upon his return, the deceased engaged in conversation with Registered Nurse Rio. During the course of the discussion he expressed some mild concern about his discharge, but was otherwise apparently contented and composed. Nurse Rio's evidence in relation to the conversation was as follows:

> "All right, tell his Worship the circumstances and content of that discussion please? ---When Mark had that onto the (inaudible) then we directly go to his room, he then (inaudible) too much towards the lounge, I had spoken to Mark on how everything went and he was very vague

about what he had said although what Mark said indicated to me with his sort of hands, he was sort of waving of hands left and right when indicating it was sort of, I guess was fairly (inaudible) sort of - it was sort of okay.

When you're talking about how it went, you're talking his weekend leave with his family?---Yep yeah.

Thank you, yes?---Yep and then he went out to the courtyard and I spoke to him again and I was probably with him a good 20 minutes, he's not the (inaudible) on about how everything went but just spoke of - just friends at no time did he indicate or he ventilated out that he was going to commit suicide. Actually, on when he returned back to the unit, he appeared quite reactive, quite (inaudible) and the conversation but it was nothing - there was nothing to indicate that this gentleman was going to harm himself.

All right, did he appear to you to be showing any signs of intoxication?---Not at all.

Were you able to smell any liquor on his breath?---I was (inaudible) up to see Mark and we were having conversations with him that I would have definitely have smelt alcohol on him at the time.

….

How would you describe his mood during the course of that conversation apart from being reactive, was his mood up or down?---The mood is that - the mood appeared - his mood appeared okay, like when I talked about his (inaudible) was down from side to side indicating that his - I've only figured out that his leave with family (inaudible) like I said, that's been accomplished - conversation that I had with Mark that he never really (inaudible) a big conversation (inaudible) we've gone that far that particular day.

You said that he didn't express any suicidal ideation or any plans for self-harm, had he previously expressed those sorts of matters to you?---He'd referred - talked about his friends he never talked to me anything about harming himself, he would always talk about his friends or previous friends in the past when they would accidentally hang themselves."

40. On the basis on that account, I find that there was no cause for concern on the deceased's return from weekend leave that properly warranted some response or other action from staff within the Unit.

The adequacy and appropriateness of patient to nursing staff ratios within Mental Health Services at the Alice Springs Hospital

41. The most vexed question considered during the course of the Inquest was the adequacy and appropriateness of patient to nursing staff ratios within Mental Health Services at the Alice Springs Hospital. I have previously received evidence during the course of inquests in relation to similar deaths in Darwin to the effect that the appropriate staffing ratios are one healthcare professional for every three patients on ward, with an additional allocation of one staff member for each patient on special observations.

42. During the course of this Inquest I received evidence from Ms Vicki Stanton, the Manager of Central Australian Mental Health Services. Her evidence was to the effect that there were no standard ratios applied in the Alice Springs situation, and that the staff allocation at any given time would depend on the nature of the ward, the number of patient care hours per day required by each client, the levels of acuity presenting in the ward, and various other factors. I accept that to be so, whilst at the same time acknowledging that I have some difficulty with the inconsistency of approach between Darwin and Alice Springs.

43. On the night in question staffing ratios were at "last resort" levels within the parameters laid down in the manual and protocols for the Unit. There was one registered nurse and two patient care assistants on shift. Ms Stanton gave evidence that the staffing levels at the time were

adequate. Dr Pettigrew and several of the other witnesses expressed the view that the staffing levels were inadequate. Different descriptions were adopted by different witnesses. There is little value for these purposes in exploring the semantic nuances and differences between terms such as "optimum", "adequate" and "sufficient". What can be said is that Ms Stanton's view receives strong support from Dr Campbell. His evidence was in the following terms:

> "Thank you doctor, now I want to take you to the specific circumstances that presented on this night, there were seven patients on the ward, one of whom was under - in the high dependency unit under some form of special observation. There was one registered nurse on duty, together with two patient care assistants with little or no training and experience in psychiatric care. Do you consider that that staff allocation on the night was adequate, so that's one registered nurse, two patient care attendants and you had seven inmates - seven patients, on ward, one of whom was under - in the high dependency unit under some form of special observation?---The real issue there is the lack of training of the two patient care assistants or the lack of experience. Most in Sydney, a 30-bed ward, with a 15-bed acute care unit would have two trained nursing staff and perhaps an enrolled nurse so there wouldn't be much more numbers and very many more patients in metropolitan Sydney and that overall there's four staff or three staff at the whole hospital, so those (inaudible) numbers anywhere and probably in Alice Springs they were better patient/staff ratios but the weakness in that is that the - if there is one, is that the patient care assistants had not had a lot of training and would need a lot of supervision from a registered nurse.
>
> Doctor, you talk about inadequate staffing down in Sydney and the staffing ratio has been better here, is there any - I'll put it to you this way, it's been suggested during the course of this inquest that in previous inquests that have been held in the Territory, that the appropriate patient/staff ratio or the optimum patient/staff ratio, is one registered nurse for every three patients on general observation, and one registered nurse for every patient on special observation. Is that a patient/staff ratio or a formula that is known to you at

> all or one that's applied generally in psychiatric inpatient facilities?---No, if it were we couldn't staff it in Sydney, there's not enough staff to do that.
>
> What sort of ratios to you apply in Sydney?---As I was saying the ratio - it basically comes down to nurses per unit rather than nurses per patient in Sydney and we would have two nurses in the non-acute area and two nurses in the acute area (inaudible) - - -
>
> Why isn't it (inaudible) to have two nurses - sorry doctor?---Because they would not work in a situation where they could be just on their own in a potentially violent or dangerous situation.
>
> What about issues in relation to consultation, checking medication - - - ?---All of that - all about - yes, now, those are fairly adequate figures but and I think it's causing problems everywhere, what I'm really just commenting that because the unit in Alice Springs is fuller there's - you can only produce the staff to a certain level but with small numbers, actually you wind up with a better ratio.
>
> Well could I - is the effect of your evidence this, one registered nurse and two appropriately trained and qualified patient care assistants or enrolled nurses would have been adequate but one registered nurse and two untrained, unqualified patient care assistants was not?---I'd say yes it was less than adequate, I'm not sure it would have made any difference to the outcome in this particular case."

44. On the basis of Dr Campbell's evidence, it would certainly appear that staffing ratios in the Northern Territory are significantly higher than those appertaining in Sydney. Having said that, it is also clear that there are compelling reasons why two registered nurses are required on each shift. On the night in question there was one registered nurse and two patient care attendants on duty. I accept Ms Stanton's evidence that this was a relatively irregular occurrence. That said, there would not appear to have been any immediate reason why one of the four registered nurses who were rostered on the afternoon shift could not have been

moved to the night shift. It would be unfortunate if the roster was so inflexible that such a reallocation could not be achieved. That the situation arose in the first place is reflective of poor rostering.

45. I hasten to add that staffing levels on the night in question were entirely unrelated to the death of the deceased in that there can be no suggestion that staffing levels contributed to that death. There are two matters that arise from the examination of staffing levels during the course of the Inquest that call for some recommendation.

46. The first is that it is plain that there are great difficulties recruiting adequate numbers of nursing staff to Alice Springs. I **recommend** to the Attorney-General that some high-level government consideration be given to initiatives to address this difficult and longstanding problem.

47. The second matter of concern relates to the quality and qualifications of patient care assistants and patient service assistants employed within the unit given the duties they are required to undertake on occasion. The occupants of these positions are referred to the Hospital under some form of recruiting contract with a private agency. That these positions have no formal duty statements or selection criteria is a lamentable consequence of the drive to outsourcing in government operations. It would appear that the agency performs some very loose form of "culling" arrangement prior to referring occupants for these positions. The agency would not appear to require any relevant qualification or experience, nor are candidates screened to assess whether they are suitable to undertake that type of occupation having regard to their aptitude and personal characteristics.

48. The potential difficulties are manifest. The Inquest heard compelling evidence from one of the nurses employed on the ward going to her

concern, dissatisfaction and fear stemming from the engagement of inappropriate people to undertake these roles. Accordingly, I **recommend** that duty statements and selection criteria be formulated for these positions, that the agency recruit in accordance with those duties and criteria, that candidates be possessed of a minimum level of qualification and/or experience, and that there be a closer involvement by the Department of Health and Community Services in the selection of staff to the these positions, rather than abrogating that function entirely to the agency.

Ancillary matters

49. That leaves two minor issues that can be dealt with in relatively short order.

50. As stated, evidence received during the course of the Inquest indicated that the deceased was not positively sighted during the course of ward rounds on the night on which he took his own life. This was due in part to the fact that the deceased's bed was situated such that it only its foot was visible from the observation port in the door of the deceased's room. I am aware from Ms Stanton's report, received into evidence during the course of the Inquest, that this situation has been rectified. The report also indicates that an audit is to be conducted to determine whether steps might be taken to minimise hanging points in patient rooms. Indications were also given during the course of the Inquest that the relevant manuals would be amended to mandate sighting each patient during ward rounds at night.

51. The circumstances in which the restraint team was mistakenly sent to the scene of the death are not entirely clear. It would appear that the hospital receptionist misunderstood the call and pressed the wrong

button. By way of response, a mechanism has been put in place within the Unit to allow for the direct call of the resuscitation team.

Dated this 7th day of February 2005

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GREG CAVANAGH

Territory Coroner