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MEDICO-LEGAL SOCIETY OF NSW INC.

SCIENTIFIC MEETING

WEDNESDAY, 11 NOVEMBER 2015 AT 6.15 P.M.

THE TOPIC: ARE CATASTROPHES IN MENTAL HEALTH FORESEEBLE?

SPEAKERS: DR MATTHEW LARGE
DR PEGGY DWYER

Transcript prepared by Karen Russell

DR MICHAEL DIAMOND: Thank you very much. In the style of a true drama, we're left with the question hanging and we have as our next speaker Dr Peggy Dwyer who has a history in her law career, being admitted as a legal practitioner in 1998 and going to the Bar in 2010.

She has a wide ranging practice involving criminal matters, jury trials, contested hearings, appeals, Children's Court matters and Parole Board hearings and also assisting the coroner.

There is also a significant interest in medical law and Dr Dwyer appears at disciplinary tribunals, medical tribunals and the Medical Council for both the prosecution and defence.

From 2005 to 2008 Dr Dwyer's career was as the managing criminal lawyer for the North Australian Aboriginal Justice Agency and she appeared in jury trials in the Northern Territory Supreme Court and in appeals in the Supreme Court and Court of Criminal Appeal.

In 2000 Dr Dwyer was awarded a doctorate from the University of Edinburgh. Her PhD focused on drug trafficking, specifically the registration of synthetic drugs of abuse and the pre-cursor chemicals used in their manufacture.

As an aside, Dr Dwyer has, as part of her career, served as an associate to Justice Michael Kirby in the High Court of Australia in the mid-nineties.

I welcome you to the Society to address us and I understand that you are looking at the issues of prediction of homicide, so we look forward to that, and after that we'll have questions from the floor.

DR PEGGY DWYER: Thank you very much for having me tonight. I should start with a disclaimer in relation to the publicised umbrella title of the talks to be given by Dr Large and myself. The publicised title was Are Catastrophes in Mental Health Foreseeable? I'm sure that all of us in this room can confidently foresee all sorts of catastrophes in mental health that will keep some of us employed for many years to come.

But what Dr Large and I are really addressing tonight involves hopefully averting catastrophic outcomes and it does touch on foreseeability.

We are both looking the relevance of risk assessments for people who are mentally ill or mentally disordered; that is assessing the risk that they will harm themselves or others. So I'm looking at homicide in one case and going on to look at suicide in others.

I'm focusing on beyond the in-patient setting but then will be directing some questions to Dr Large about that and other risk assessments.

One of the great things about the Medico-Legal Soc is the chance to chat amongst colleagues, both legal and medical, usually over a glass of champagne at the City Tats following a talk such of this and the genesis for this talk lies in a few glasses of champagne some months ago when I was privy to a debate involving psychiatrists who take very different views about the relevance and reliability of risk assessment.

Much of my work currently is as counsel assisting the coroner or counsel appearing for parties in the Coroner's Court involving cases where mental health issues are the focus, and the debate in the City Tats centred around the fact that different experts have such different opinions on critiquing the risk assessment done by others that it was possible to predict what those experts were going to say in one case or another; and so the idea for this talk was born, with the hope that we could get some sort of barney going at the end of this lecture.

My focus today, directed to both lawyers and doctors, is on practical examples of how that debate plays out in a court room.

On the one side you've got a group of very prominent and experienced psychiatrists, including Dr Large, who argue that the type of tools for risk assessment that are used do not assist us to reliably predict risk of suicide or self-harm.

Another group of psychiatrists, equally eminent and experienced, acknowledge that while risk assessments may be difficult and they're certainly not foolproof, the assessment tools are a useful guide for practitioners. That is, they're a useful guide as red flags for nurses or doctors conducting the assessments to look out for. They help to ensure that patients are provided with appropriate care and they can be used as a measure to

determine whether or not the patient was provided with appropriate care.

I plan to address you firstly on recent case examples from the Coroner's Court where the psychiatric profession has been divided about the significance of risk assessment in determining appropriate care, one homicide case and one suicide case, but the particular examples are not unique.

Second, on recent case law in the civil jurisdiction, and I'm going to finish with some questions for Dr Large in an effort to try and get that barney going and to direct the questions to Dr Large rather than myself.

The first case involves the tragic deaths of Chloe and Nicholas Waterlow. Antony Waterlow had been unwell for a about a decade before he stabbed to death his father and his sister.

Over a period of time Antony's father, sister and others had told his treating psychiatrist that they were frightened of Antony and that he had threatened to stab them. Antony never agreed to voluntary treatment and he was never detained involuntarily and he was never medicated.

I'm going to cut these facts very short so that I can get through a package of cases, so I mean no disrespect to his treating doctors if I rapidly summarise their care. Obviously it was much more detailed than I am about to summarise.

By late 2004 Antony's behaviour became more violent and more bizarre. He was arrested and charged with two counts of malicious damage in circumstances where he was acting erratically and he was intoxicated. He also claimed that neighbours were running cables above him, talking about him, blowing smoke into his room, filming him and the classic symptoms of psychoses.

In the years that followed there were numerous instances like that that made it obvious to friends and family that he was psychotic. They included instances directed towards not just his sister and father, who were the targets of that aggression, but also a very caring flatmate who had been very patient because she loved him, but he had threatened her with a large kitchen knife and made threats towards neighbours.

All of that was communicated to the treating doctor over a period of time, but Antony appeared to be quite a beguiling patient and so he could present, in spite of what was being told to the treating psychiatrist by family and friends, as being able to pass off some of his erratic behaviour on intoxication.

In November 2006 there was a clear deterioration in Antony's behaviour. There were threats of violence to family and friends. He saw his psychiatrist on five occasions in November, three occasions in December. He was no longer able to live with his very caring flatmate.

On 4 January 2007 the psychiatrist was sufficiently concerned about it to seek a second opinion from two very experienced psychiatrists, one of whom said - I'm summarising - that the risk of him harming other people was so significant that he must be detained under provisions of the Mental Health Act, because this was effectively first episode psychoses, given that he had not been treated for the psychoses previously.

The other advised that he should not be detained unless there was an immediate threat to the patient. No doubt there was some debate about the meaning of the Mental Health Act and the provisions that suggest that require you cannot detain somebody in hospital if there is another treatment available.

So it was that on 4 January 2007 the treatment plan for Antony was that he be treated within the community, encouraged to take his medication but not forcibly detained.

Antony subsequently moved away, he had brief interactions with the psychiatric community but because he moved into another area, they were unfamiliar with his history. In 2009 then he went on to kill his sister and father.

Issues in the inquest focused on whether or not Antony should have been subject to compulsory treatment first by involuntary detention. That necessarily involved again a review of the Mental Health Act 2007.

Section 19 of that Act, like its predecessor in 1990, which I'll come to in discussing another case, provides of course that Antony could not have been detained if there was another appropriate means for dealing with him, and that's where the risk assessment came in.

The psychiatrist who had been treating him had determined that the risk could be managed in the community.

The expert evidence was divided. Three very senior consultant psychiatrists were called to give evidence - Dr Michael Guiffrida, Dr Christopher Ryan and Dr Anthony Samuels. The evidence of two of those psychiatrists was that clinical decisions made were not unreasonable in the circumstances but one of those experts came to a different decision and thought that the risk assessment commanded that Antony be involuntarily detained for a period of time so that he could be treated.

One thing that was particularly interesting in the debate that took place during the hot tub with experts was whether or not we should move away from this model of risk assessment in order to determine whether somebody should be involuntarily detained.

Dr Chris Ryan argued that we should move away from risk assessment. We should instead move to determining capacity so that where somebody lacked capacity, as Antony did, then treatment could be commenced without his consent and should have been in that case.

The coroner was reluctant to criticise the experienced and no doubt caring practitioners actually involved in Antony's care but he did make recommendations that were focused on ensuring somebody in Antony's position would get care, compulsory care, in the future.

He did not think that he was sufficiently qualified to resolve the debate about whether we should move towards a capacity type model.

I come to a different sort of inquest, into the death of Vanessa McDonald which was held in 2012. Ms McDonald was 37 when she died after being struck by a train in Sydney. She had no significant history of depression but she was suffering from severe postnatal depression following the birth of her child.

On 27 April 2010 she told her partner she had thoughts of self-harm. He took her to hospital. She was assessed as being of low risk of self-harm or suicide. She was released but re-admitted the following day when she followed all the Serepax that had been given to her to help her to sleep.

Once admitted she was subject to a comprehensive mental health assessment by a psychiatrist and admitted to the Missenden unit, determined to be at high risk of self-harm or suicide.

She was subject to two hourly observations. Over the course of the next two weeks the level of supervision was made more lax - I don't mean any criticism by that. She was then subject to daily supervision but not on an hourly basis.

On 13 and 14 May she was permitted to go on unsupervised leave. On 13 May when she came back she told the nurse about dark thoughts to end it all, to end her life and that she was feeling burdened. She'd earlier noted that one of the methods she'd thought about if she ended her life, was to put her head on the train tracks and that there were trains that ran by her house.

On 14 May she was allowed out on leave. Not all of those risk factors - Dr Large might disagree with me - were communicated to the nurse who came on duty and Ms McDonald took her own life.

Because there had been a failure to hand over a key piece of information about Ms McDonald's dark thoughts while she was out on leave on the 13th, the coroner found that a clear warning about her risk of suicide went unheeded and there was a failure to pay proper attention to that risk.

The Area Health District impressed the coroner by referring to a number of reforms that had been introduced that now focused more on risk. They included the NSW Health between the flags initiative for detecting and managing a medically deteriorating patient.

I wasn't involved in the civil claim that followed, but a very successful civil claim followed in Ms McDonald's case on behalf of her family.

I'm about to go on to talk about two cases involving case law outside the coronial jurisdiction. But what we don't see in the case law is a significant number of cases that are settled following the coronial jurisdiction, which of course causes some concern to the psychiatrists and doctors or may cause some concern to the psychiatrists and doctors giving evidence in the coronial proceedings. There may be perceived to be a tension between the coronial jurisdiction, which encourages open disclosure

and a civil jurisdiction where it may be difficult to do that if you know the civil jurisdiction follows.

The High Court grappled with risk assessment in Hunter and New England Local Health District v McKenna. That case involved Phillip Pettigrove who suffered from paranoid schizophrenia for more than 20 years and had treatment in the community in Victoria. He had at least one episode in 2001 which required him to be admitted to a psychiatric unit, but he had no history of committing threatening violence against others and a limited history of attempting self-harm.

In 2003 he travelled to New South Wales and met up with an old friend. He then became mentally unwell in such a way that it was obvious to the friend and he was admitted to Taree Hospital.

He was admitted overnight but release the next day so he could go with his friend back to Victoria to receive treatment in the community. In the course of the journey back to Victoria, Mr Pettigrove strangled and killed Mr Rose. He said in his interview with police that he had acted on impulse out of a desire for revenge because he was suffering from a psychosis that he had been attacked by Mr Rose in a previous life.

The mother and sisters of Mr Rose sued the Health District claiming that it had breached a duty of care towards them as the relatives of Mr Rose in failing to detain him and allowing him to be released in Mr Rose's car.

In brief, the plaintiff's lost at first instance in front of a single judge of the District Court, won on appeal to the Supreme Court and lost again when the matter went to the High Court.

The relatives argued that Mr Pettigrove should not have been allowed to leave the hospital, or at least not in the company of Mr Rose, because there was an obvious risk that he would do physical injury to Mr Rose and they alleged that the doctor and the hospital did not act with reasonable care and skill in deciding that Mr Pettigrove could leave the hospital and travel to Victoria with Mr Rose.

In the High Court the parties were asked to address only in relation to whether or not the Area Health District

owed a duty of care to relatives, because if not, other questions fell away.

The High Court held there was no common law duty owed to the relatives of Mr Rose because the provisions of the Mental Health Act identifying the matters to which doctors and hospitals are required to have regard in exercising or not exercising their powers, were inconsistent with the duty to the relatives, and that comes back to the provisions already discussed, that doctors cannot detain patients in hospital if they consider that there are any other reasonable alternatives available.

That was inconsistent with a consideration of matters related to relatives of those who might go on to be harmed.

The High Court appears to have been conscious of a flood gates argument or an argument in relation to the scope of claims that might follow. They said that if a person is mentally ill, the risk that they would act irrationally is often not insignificant, far-fetched or fanciful, so therefore it will be foreseeable in some cases, perhaps many, the reasonable person, as in the reasonable doctor who is responsible for the risk assessment, might behave by continuing to detain the patient for as long as he or she remains mentally ill, avoiding the possibility that risk to others may eventuate and that's not what the Mental Health Act requires. It focuses on the minimum interference with the liberty of the person.

The final case is Smith v Pennington, which is relatively hot off the press, having been decided on 28 August 2015. The Local Health District was successful in defending a claim that it was negligent in allowing an involuntary health patient four hours of leave, during which time he went on to harm himself.

The plaintiff argued that he should not have been granted leave from the mental health unit and had he remained in the facility, he would not have attempted to harm himself - something that Dr Large may well disagree with.

But in the end, the Court found that the decision to grant leave could not be criticised, it was not unreasonable because in the plaintiff's case it was a well-recognised and appropriate therapeutic measure to assist the patient's recovery.

I come now, knowing that I need to leave time for questions, to questions specifically directed at Dr Large, knowing that he does not think that there is much value in risk assessments, at least in the in-patient setting.

In spite of infallibility of risk assessment, it certainly appears from the cases I've outlined in the coronial jurisdiction and in the civil jurisdiction, that it will be relevant to courts who are reviewing the standard of care.

The risk assessment tools that are used in hospitals and then scrutinised in courts, do set out a number of risk factors that are to be taken into account by doctors and nurses conducting risk assessments.

Courts scrutinise those, at least in the coronial jurisdiction, to determine (a) if those risk assessment tools are completed and (b) if the risk is low risk, what's the justification for that?

The criterion in the Mental Health Act 2007 appears to me to invite a risk assessment to determine if involuntary detention can be justified.

Dr Large talks about a universal standard of care. The questions I have for him are: Accepting that it's not always possible for the medical profession to accurately assess the risk that patients will suicide, self-harm or cause harm to others, are risk assessment tools still helpful and appropriate, at least outside the in-patient setting? If not, in developing a universal standard of care, what measures are appropriate?

Is it ever reasonable for courts to judge a patient's standard of care by reviewing the risk assessment that has been done?

If we can't rely on risk assessment, how do we measure the standard of care, because lawyers are always going to want to be able to have a way in which they can do that in order to hold those who operate in our hospitals under such stressful and difficult conditions, to account? Thank you.