Continuing Professional Development Case Study: Coronal Inquest into the death of Adam Trent Ryan

In January 2013 the Queensland Office of the State Coroner handed down findings on the death of Adam Trent Ryan, who committed suicide by hanging at his home in Charleville on 12 July 2009. Mr Ryan was a former patient of the Charleville Base Hospital and the Charleville Community Mental Health Service. The principal purpose of the inquest was to examine the adequacy of the medical, nursing and mental health care provided to Mr Ryan in the lead up to his death.

The Coroner found that Mr Ryan died as a result of committing suicide and that there were no suspicious circumstances.

The inquest heard that Mr Ryan attended the hospital late on 6 July 2009 and spoke with the duty nurse. During this attendance Mr Ryan denied suicidal ideation and this factor was recorded in the nurse’s notes. The nurse was also told that Mr Ryan had attempted suicide in the past but failed to make any note of that suicide attempt in the hospital records. The Coroner criticised this failure to record information and stated that it reduced the chances of doctors being able properly treat Mr Ryan or at least fully appreciate the extent of his mental health concerns.

Mr Ryan was admitted to the Charleville Hospital for alcohol detoxification on 8 July 2009. Mr Ryan was discharged from the Charleville Hospital on the morning of 11 July 2009 only to be returned to the hospital apparently intoxicated on the afternoon of 11 July 2009. A short time later on the afternoon of 11 July 2009 Mr Ryan absconded from the hospital, leaving behind possessions and medication.

At 7:30am on 12 July 2009 Mr Ryan returned to the hospital and spoke to nurses at the nurses’ station. Mr Ryan appeared normal and sought the return of his property including a substantial amount of medication that he had been admitted with when he returned to the hospital the previous day. Mr Ryan was given this medication and his other possessions and he then left the hospital. The Coroner found that it was unfortunate that Mr Ryan was given back his medication in that way. The Coroner also found that it may have been better for this medication to have been entrusted to the mother of the deceased, if possible.

Mr Ryan was found deceased due to asphyxiation at 8:25am on 12 July 2009 at his home at Charleville.

Subsequent to Mr Ryan’s death several members of the nursing staff returned to the hospital to “write in the notes”. Four nurses rewrote their respective notes, in the hospital record, with respect to their recent interactions with Mr Ryan. The notes which were ultimately retained on the hospital file were these four nurses’ after the fact entries and were not marked “add it” or “in retrospect”. This was an error for which these nurses were criticized.

The earlier (original) notes were then destroyed by one of the nurses, because she didn’t think that there was any need for the first set of notes. The nurse who destroyed these notes knew that destroying notes was absolutely forbidden but did it anyway. The nurse was criticized for acting in this way.

Following Mr Ryan’s death Queensland Health conducted an Ethical Standards Unit investigation which concluded that the re-writing of the notes was ill-advised but not an attempt at concealment or falsification. It was found that there was no malice in what had been done. Disciplinary action was taken against the four nurses who had rewritten and/or destroyed notes and some re-training was imposed upon them.

The Coroner found that it was completely unprofessional for the four nurses to rewrite hospital notes and for the old notes to have been destroyed. Having said that, the Coroner found that there was no evidence during the course of the inquest which could support a finding that Mr Ryan’s death had been contributed to by the deficiencies made in his medical care specifically, his nursing care.

The Coroner also found that if there is any tension in relation to the nurses’ knowledge and practice with respect to document management then that is not a basis for criticising the nurses, but an opportunity for recommendations to be made in relation to document management training provided by Queensland health.

The Coroner noted that a number of measures have been put in place across Queensland Health including at the Charleville Base Hospital with a view to improving the prospects of a better outcome in a similar...
case. The Coroner found that there was much to be critical about from the point of view of the Charleville Mental Health service and the Charleville Hospital however most of these matters had been addressed by Queensland Health and the Charleville Hospital by the time of the inquest.

The Coroner made the following recommendations:

- That a requirement be made that the Community Mental Health Service advise any treating specialist consultants of the admission of a Community Mental Health Service patient as an in-patient of any hospital.
- That nursing staff be specifically instructed to record any reference to any active suicidal behavior by or depression of a patient from any credible source, in particular, police officers.
- That the handover of patients by one medical officer to another be recorded in writing, including a specific written record of daily medication dose limitations for such patients.
- That a protocol be established in order to ensure that the family member of a person admitted to hospital who then absconds is contacted by the hospital immediately and if necessary, the hospital enlists the assistance of the police service to do so.
- That a protocol be established that nursing staff not return prescription medication to patients in circumstances where the patient's circumstances have changed since the previous prescription by a medical officer and where the patient is unwilling to be reviewed by the medical officer. In other words, where there is any doubt at all about the efficacy of returning medication to a patient, such medication should not be returned without the patient being first reviewed by a doctor.

The Coroner referred the Department of Health to the above recommendations for them to be actively considered and implemented as necessary. The Coroner also made passing mention of two other recommendations which were encouraged, although apparently not formally imposed by the findings.

On the whole, the outcome of the inquest was a good one for the Queensland Nurses’ Union (“QNU”) and its members who were involved in the care of Mr Ryan. Counsel Assisting the Coroner had sought that criminal charges be recommended against certain QNU members however none were ultimately recommended by the Coroner. Indeed, no further sanction was imposed against any of the QNU members involved.

The findings are valuable to members of the nursing profession as a timely reminder of nurses' professional obligation to ensure the accuracy and integrity of your entries in hospital records.

Hall Payne Lawyers was proud to assist the QNU by representing its members in this inquest and looks forward to providing similar assistance to the QNU and its members in future inquests.

The complete findings are located at: