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Coroner's Findings into Death of Mark Raymond Parsell
COR 2008/3291

Background

On 30 July 2008, Mark Raymond Parsell was at the Dandenong Hospital Emergency Department awaiting admission to the Psychiatric Ward. Before he could be admitted to the Psychiatric Ward, he left the Emergency Department and made his way on to a nearby railway line and committed suicide. As a result of his death, a coronial investigation was conducted into the Hospital's procedures.

Coronial findings

Coroner Audrey Jamieson found that Mr Parsell had a long history of absconding and suicidal tendencies. However, as the Hospital's Psychiatric Ward did not have enough beds, it was decided among Hospital staff that Mr Parsell would be temporarily placed in the Emergency Department.

The Coroner found that the hospital's plan, was riddled with numerous inadequacies including a lack of a Constant Patient Observer (CPO), no special nurse to manage patients of this nature, and the Emergency Department being, in general, not adequately quipped for patients with a history of mental illness of this nature. In theory, the plan decided upon was appropriate but in reality was impractical.

Parsell was caught in a bureaucratic grey area somewhere between being classified as an involuntary patient and a voluntary one. He was initially a voluntary patient. However, the plan was that should he attempt to escape, he would be declared an involuntary patient. In any event, he was successful in escaping the Emergency Department. The relevant department staff were not notified of his absence. And clinical notes did not indicate that a handover of the patient to the Emergency Department was conducted suggesting that Emergency Department staff were not necessarily aware of his history of absconding or propensity to attempt suicide.

His status as a voluntary patient meant that no one-on-one supervision was provided for Mr Parsell. The issue of a lack of supervision should have been considered in categorising him as a voluntary patient, in light of his history as a serial absconder and suicidal tendencies. It was clear Mr Parsell required supervision and his classification as a voluntary patient was inappropriate. The Coroner also concluded that his placement in the Emergency Department was also questionable. He required close supervision and arguably a categorisation of involuntary status.

Conclusions

The Coroner found the following factors culminated in the death of Mr Parsell:

- Mr Parsell's non-compliance with anti-psychotic medication;

- a deterioration in his mental health;
- an apparent lack of adequate clinical handover between the Psychiatric Ward and the Emergency Department;
- a lack of adequate and constant supervision of Mr Parsell despite his risk assessment; and
- a level of care provided to him that was inadequate in light of his risk of suicidality, self-harm, non-compliance with medication and absconding.

Our observations

This case draws attention to the interdepartmental gaps which often exist within health service organisations. Mr Parsell's death was in large part a result of an asymmetry in information by hospital staff about his history of absconding and suicidal tendencies, and a lack of comprehension of the functions and resources of each department to meet his needs. It is also a case in which the hospital guidelines and procedures, in particular guidelines surrounding the categorisation of voluntary and involuntary patients, were too inflexible to meet Mr Parsell's unique condition.

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