IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2019 000738

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner David Ryan
Deceased:	LKV[1]
Date of birth:	[redacted]
Date of death:	9 February 2019
Cause of death:	1(a) Neck compression in the circumstances of hanging
Place of death:	The Victoria Clinic, Room 2 North, 324 Malvern Road, Prahran, Victoria, 3181

[1] This Finding has been de-identified by order of Coroner David Ryan to replace the names of the deceased and their family members with pseudonyms of randomly generated three letter sequences to protect their identity and to redact identifying information

INTRODUCTION

1. On 9 February 2019, LKV was 73 years old when he passed away at a private psychiatric facility in Prahran where he had been receiving treatment as a voluntary patient. LKV is survived by his wife PLR and their two children. He is warmly remembered for his passionate and energetic personality and for his kind and generous nature.

2. LKV was a successful [redacted] who owned and operated a [redacted] business. In the months prior to his death, the business was undergoing financial stress which caused him significant anxiety and led to a decline in his mental health.[2]

3. LKV had diagnoses of non-insulin dependent diabetes mellitus, hypercholesterolaemia, hypertension, and a clinically benign enlarged prostate. His medical conditions were well-managed.

THE CORONIAL INVESTIGATION

4. LKV's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural, or violent or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

6. Under the Act, coroners also have the important function of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Section 7 of the Act requires the coroner to liaise with other investigative authorities and to not unnecessarily duplicate inquiries and investigations.

[2] Statement of PLR dated 26 September 2020.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of LKV's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. Further material was requested, including from the Victoria Clinic and Safer Care Victoria (**SCV**),[3] and an expert report was obtained by the Court. Material was also submitted on behalf of PLR, including a further expert report.

9. This finding draws on the totality of the coronial investigation into LKV's death including evidence contained in the coronial brief. While I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[4]

10. A mention hearing was held in the investigation on 23 May 2022. Notwithstanding the existence of some conflicting evidence, none of the interested parties sought that an inquest be conducted and I ultimately determined that an inquest was not required. I am also satisfied that all of the interested parties were provided with a reasonable opportunity to respond to the material before the Court, including the expert evidence.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

11. On 22 December 2019, LKV attended a General Practitioner, Dr Doron Gaddie who conducted a mental health assessment which "*showed he had extremely severe depression, anxiety and stress*". LKV reported to Dr Gaddie that "*some serious business issues in the previous three months had led to him drinking half a bottle of Scotch a day. He was considering suicide. He would either take an overdose of pills or cut his throat*". Dr Gaddie arranged for LKV to be admitted to the Victoria Clinic the following day.[5]

12. On 23 December 2018, LKV was admitted to the Victoria Clinic under the care of psychiatrist Dr Brian Ferry. On admission, he reported low mood, reduced concentration, and increased alcohol consumption over the previous three months, but denied any current thoughts of self-

[3] Victoria's peak authority for leading quality and safety in healthcare.
[4] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.
[5] Statement of Dr Doron Gaddie dated 24 September 2020.

harm, or any plan or intention to take his own life. Dr Ferry considered that LKV's symptoms were consistent with a major depressive episode and that his level of risk was "*moderate*".[6]

13. During his admission, nursing staff recorded that LKV was difficult to engage with and he also indicated to Dr Ferry that he was unhappy with his prescribed medications. After ceasing his medications, LKV was recommenced on antidepressant escitalopram 10mg, which was later increased to 20mg due to perceived improvements in his mental state throughout early January.[7]

14. By the time of his discharge on 22 January 2019, LKV had commenced a low dose of antidepressant mirtazapine and Dr Ferry observed his mood, concentration and self-care had greatly improved.[8]

15. Within days of his discharge, LKV's mental state once again deteriorated. On 29 January 2019, LKV was readmitted to the Victoria Clinic and reviewed by Dr Ferry. He reported low mood and energy, ruminations, and sleep disturbances. PLR also advised that her husband had raised several methods by which he could take his own life, and it was reported to Dr Ferry that "*he had put a plastic bag over his head*" which he "*later removed with no harm being done*". Despite these reports, LKV denied any current suicidal thoughts or any intention or plan. Dr Ferry subsequently increased his mirtazapine to 30mg.[9] His level of risk for suicide was marked as "low".

16. In the days that followed, LKV again expressed to Dr Ferry that he did not wish to take any medication for his mental health. He continued to experience low mood, anxiety and agitation, but continued to deny any thoughts of suicide or self-harm.

17. On 4 February 2019, LKV reported feeling embarrassed, ashamed, guilty, and continued to ruminate and experience suicidal thinking. He attended the ward program and was described to be consumed by his work stressors. He requested that Dr Ferry increase his mirtazapine dosage and he expressed a willingness to engage with a psychologist.[10] Notwithstanding a referral by Dr Ferry and LKV's willingness, he was not in fact seen by a psychologist prior to his death.

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6 Statement of Dr Brian Ferry dated 30 September 2020.
7 Statement of Dr Brian Ferry dated 30 September 2020.
8 Statement of Dr Brian Ferry dated 30 September 2020.
9 Statement of Dr Brian Ferry dated 30 September 2020; Statement of PLR dated 26 September 2021.
10 Statement of Dr Brian Ferry dated 30 September 2020; The Victoria Clinic Medical records, 4 February 2019, p 49.

18. On 7 February 2019, Dr Ferry noted further improvement in LKV's mental state and mood, however LKV's daughter, who visited later that day, observed a deterioration in her father's self-care and personal hygiene. LKV stated that he wanted to be discharged so that he could work.[11]

19. At a subsequent review on 8 February 2019, Dr Ferry observed further positive improvements in LKV, namely his willingness to commence antipsychotic medication, which he saw as a sign of being more engaged in his therapy. He considered that the "*therapeutic alliance*" with LKV had improved. However, it is noted that his medical records indicate that he was not engaging in the ward program. According to PLR, she found a removable strap from her husband's suitcase in his room which she discussed with Dr Ferry.[12]

20. Dr Ferry stated that he did not recall this discussion with PLR and that it is likely that if he had been advised of her discovery of the strap, that he would have referred to it in the medical records. Although LKV reported some thoughts of suicide, he denied any plan or intention to act on the thoughts, and Dr Ferry considered his risk of self-harm was low. However, to provide added protection, Dr Ferry changed LKV's leave arrangements to be escorted only.[13]

21. On 9 February 2019 at around 7.23am, a nurse sighted LKV in his bed and observed that he was breathing.[14] LKV would usually take his medications between 8.00am and 9.00am by attending at the "medication window". Nursing staff realised LKV had not yet taken his medications that morning and had intended to follow him up but were distracted by attending to other tasks.

22. At approximately 10.43am, they attended his room to check on him. As they entered the room, turned on the lights and opened the curtains, they observed LKV unresponsive on the floor beside the bathroom door. He was not found with a ligature around his neck, although a pair of tracksuit pants were observed hanging from the bathroom door.[15]

23. Nursing staff commenced cardiopulmonary resuscitation (**CPR**) and contacted emergency services, who arrived a short time later. Responders were unable to revive LKV and he was pronounced deceased at 11.00am.[16]

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[11] Statement of Dr Brian Ferry dated 30 September 2020; Statement of QEP dated 1 October 2020.
[12] Statement of PLR dated 26 September 2020.
[13] Statements of Dr Brian Ferry dated 30 September 2020 and 11 October 2021.
[14] Statement of Stephanie Wilkes dated 9 February 2019; Statement of Allison Carr dated 16 August 2021.
[15] Statement of Stephanie Bennett dated 9 February 2019; Statement of Allison Carr dated 16 August 2021.
[16] Statement of Sanjeeta Sharma dated 9 February 2019; Statement of Findlay Burns-Fabb dated 26 September 2020.

Identity of the deceased

24. On 12 February 2019, LKV was visually identified by BMA, his son-in-law.

25. Identity is not in dispute and requires no further investigation.

Medical cause of death

26. Forensic Pathologist, Dr Victoria Francis from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 11 February 2022 and provided a written report of her findings dated 15 February 2019.

27. Toxicological analysis of post-mortem samples identified the presence of diazepam[17] (and its metabolite nordiazepam), citalopram[18] and mirtazapine.[19]

28. Dr Francis provided an opinion that the medical cause of death was 1(a) Neck compression in the circumstances of hanging.

29. I accept Dr Francis' opinion.

FAMILY CONCERNS

30. On 16 February 2019, LKV's family forwarded an email to the Court expressing their concerns in relation to the care he received while at the Victoria Clinic. Further concerns and submissions were raised on the family's behalf in correspondence from their solicitors.[20]

[17] Diazepam is a sedative/hypnotic drug.
[18] Citalopram is a selective serotonin reuptake inhibitor used to treat a number of mental health conditions including depression.
[19] Mirtazapine is used to treat depression.
[20] Correspondence from Maurice Blackburn to the Coroners Court of Victoria dated 9 August 2021, 15 March, 13 and 14 April 2022.

REVIEW OF CARE

Root Cause Analysis

31. The Victoria Clinic conducted a Root Cause Analysis (**RCA**) into the circumstances of LKV's death in consultation with SCV.[21] It should be noted that Dr Ferry has stated that, to the best of his knowledge, he was not involved in this process.[22] The following root causes were identified in the RCA:

    a) Patient factors: LKV's condition of deteriorating major depression, low mood, anxiety, agitation – for which he displayed a pattern of resistance to care; in the background of business and financial stressors.

    b) Environmental factors: The bathroom door inside LKV's room provided a ligature point as it did not swing on both directions, was not secured with a piano hinge, and was not cut down from the door frame or on an angle.

    c) Staff factors: The nurse was attending to other patient/activities at the time and allowed the patient to sleep in longer, which resulted in the period of visual observation of the patient exceeding the minimum observation interval for patients assessed as low risk.

32. The following recommendations were made as a result of the RCA:

    a) That a process be developed to conduct a risk assessment when a patient displays resistance to 1:1 therapy and/or treatment, and that this be documented in the clinical record and be advised to the health care team. The feedback from SCV on this recommendation was that they considered that a patient's reluctance to engage with the treating team was better seen as a clinical issue and not one to be addressed by means of policy and procedure. They also considered that "*the failure to engage in treatment by a depressed, anxious older man should probably, on reflection, have led to a higher risk rating than applied in this case*".

[21] Correspondence from Safer Care Victoria and the Chief Psychiatrist dated 18 June 2020.
[22] Statement of Dr Brian Ferry dated 27 June 2022.

b) That the bathroom doors in the facility be adjusted so that the doors are able to give way and swing in either direction under load, are secured by piano hinges, are cut down from the door frame, and cut at an angle. This recommendation was supported by SCV.

c) That the patient Risk Assessment and Visual Observations policy be reviewed to include "medication times" in the list of concerns where patients are to be observed, and [management] consider a reduction in the maximum allowable interval between observation. This recommendation was supported by SCV.

d) That the Visual Observation form be altered in a way that requires the nurse to confirm on observing the patient, that it has been established without any doubt that the patient is alive at the time. This recommendation was supported by SCV.

e) That a copy of the clinical handover sheet from each shift on each day be retained and be reproducible for a minimum of 12 months. This recommendation was supported by SCV.

f) That documentation be ideally completed contemporaneously or if in summary, toward the end of the shift. This recommendation was supported by SCV.

g) That when an "Items of Risk" check is undertaken, that the result be documented in the medical record, including whether any items were located: and if so what the items were, and what was done with them. The feedback from SCV on this recommendation was that they had difficulty understanding how it would be applied in practice given the multitude of items that can be used to self-harm (for example, pyjamas).

33. The recommendations made as a result of the RCA were also referred to Healthscope's Mental Health Committee for consideration as their application was not limited to the Victoria Clinic but potentially required an organisation-wide policy change. Relevantly, in relation to the recommendation identified in sub-paragraph (c) above, the Committee considered that *"three hours is an adequate amount of time for a Moderate Risk patient during the day because the general location of the patient is known to staff at all times and a number of other interactions occur throughout the day"*.

34. In respect to the recommendation relating to bathroom doors at the facility, the Victoria Clinic has advised that it has been unable to fit a door that swings in either direction due to the current door frame configuration but that the doors to all private bathrooms have been replaced with cut down and angled doors fitted with piano hinges. Further, work was in progress to build new private rooms without bathroom doors so that each patient will have individual control of entry to their room and the sight line into the bathroom will be maintained. The work is due to be completed at the end of August 2022.[23]

Expert reports

Dr Brett Coulson

35. The Court obtained an expert report from Senior Consultant Psychiatrist, Dr Brett Coulson. Dr Coulson supported Dr Ferry's diagnosis of major depressive disorder and confirmed that the treatments were in line with the guidelines at the time of LKV's death.

36. On review of the medical records for the Victoria Clinic, Dr Coulson noted that subsequent to the admission documents completed on 23 December 2018, "*there is very sparse documentation of mental state examinations by any clinical members of the care team*".

37. Dr Coulson considered that "*risk assessment for suicide is a complex and multidimensional task*" which includes a "*complex matrix*" of static and dynamic risk factors that acknowledges the dynamic relationship between observation and assessment.

38. Dr Coulson stated that world-wide data shows that older males have the highest rates of suicide. In reviewing the Mental health Clinical Risk Assessment form completed on LKV's admission on 29 January 2019, Dr Coulson considered that it has recorded multiple factors that would indicate the possibility of "*significant risk*", but that these factors had been diminished by a focus on LKV's declaration or "*contract*" of not self-harming or acting on suicidal ideation. Dr Coulson considered that this contract has a low sensitivity in relation to older males and has been shown not to be a good predictor of suicide.

39. On reviewing the records, Dr Coulson considers that "*there were concerning signs of greater than low risk*". He considered that the disclosure of the actual suicide attempt with the plastic bag, the concerns raised by LKV's family, and "*a sense of worsening engagement with the clinical staff*" should have been considered as possible evidence of escalation of the risk.

[23] Statement of Allison Carr dated 16 August 2021.

40. In his report, Dr Coulson referred to the Department of Health guideline, *Nursing observation through engagement in psychiatric inpatient care* which states:

> "*Nursing observation occurs through direct contact with people, including sitting with them, understanding their non-verbal and verbal indicators or cues, asking them pertinent questions and developing an understanding of the most pressing issues in their everyday lives.*"

41. Upon reviewing LKV's observation charts, Dr Coulson noted that the timed observations were limited to *"visual obs*" and there does not seem to have been "*elements of engagement*" in the process. He noted that there is no recording of what LKV was doing or a sense of his "*affect/agitation/distress*".

42. Dr Coulson observed that the "*medical record clearly notes in the last 48 hours a decline in interaction with the staff and there was no sense that the risk was reassessed or the change in clinical picture was fully handed over from shift to shift so the significance of this lack of engagement on the risk assessment and his clinical picture could be reviewed*".

43. In relation to access to a psychologist, Dr Coulson appeared to suggest that it may not necessarily have been useful in LKV's circumstances. He stated:

> "*However, at the more severe end of the depression spectrum, in the acute unwell stage psychological interventions would more likely need to be in the supportive therapy and behavioural therapy range than other more intensive psychological therapies, which would have had a role more in the maintenance and prevention of relapse phase of the illness*."[24]

<u>Dr Jacqueline Rakov</u>

44. The solicitors for LKV's family provided an expert report to the Court from Consultant Forensic Psychiatrist Dr Jacqueline Rakov dated 12 April 2022. She stated that a large portion of her work is medicolegal report writing and expert evidence provision in both criminal and civil matters.

[24] Expert Opinion of Dr Brett Coulson dated 6 December 2021.

45. Dr Rakov was provided with a number of relevant documents to assist her in the preparation of her report, including the RCA and the medical records from the Victoria Clinic but she does not refer to having been provided a copy of the report of Dr Coulson.

46. Dr Rakov considered that it was clear that LKV's condition was deteriorating during his second admission. She considered that his medication regime was appropriate.

47. Dr Rakov considered that, subsequent to the admission documentation completed at this second admission on 29 January 2019, the documented mental state examinations in his records displayed "a paucity of content". She stated:

> "*The only means of hoping to assess risk with any semblance of accuracy, and in turn guide appropriate clinical management, is by taking an accurate and relevant assessment in the current context circumstances, monitoring any longitudinal change, and engaging meaningfully with the patient.*"

48. In the event that Dr Ferry was advised by PLR that she had located the luggage strap in his room, Dr Rakov considered that it would have been inappropriate to assess his level of risk as low.

49. Dr Rakov considered that LKV appeared to become increasingly withdrawn over the course of his second admission, supporting a worsening of his depressive state. He appeared to be spending more time sleeping and, in his room. Dr Rakov expressed the view that LKV's withdrawal and lack of engagement should have been seen as supporting a worsening of his depressive state. She stated that it is not uncommon for patients to convey reluctance to engage in a psychiatric hospital, and that it takes establishing therapeutic rapport and patience to provide an environment conducive to open dialogue and disclosure.

50. Although I have found Dr Rakov's report useful, it appears to have been prepared for the purpose of a civil proceeding with a focus on standard of care through a negligence lens rather than for a coronial investigation, the purpose of which is to establish the facts, not to cast blame or determine criminal or civil liability.

<u>Dr Ferry's response to the expert reports</u>

51. Dr Ferry disputed a number of the conclusions in the expert reports. Relevantly, Dr Ferry disputed that there was a decline in LKV's engagement with staff in the last 48 hours of his life. Dr Ferry expressed the view that LKV's level of engagement was consistent throughout

his second admission and that his mental state examinations in that period "*show a gradually improving trend*". Dr Ferry also expressed a particular view about the limitations of the risk assessment process (which will be dealt with below) and confirmed that his "*assessment of LKV's risk level and the factors informing that occurred at every interaction I had with him*".[25]

CONTENTIOUS ISSUES

Psychological referral

52. A submission was made on behalf of PLR that the delay in providing her husband with psychological therapy was inappropriate. Dr Ferry referred LKV for psychological referral on 4 February 2019 and submitted a further copy of the referral on 8 February 2019 "*as a gentle reminder to the psychology team*" when he became aware that LKV had not yet seen a psychologist.[26] The Victoria Clinic has advised that at the time of LKV's death, it was usual practice to arrange a one-to-one psychological consultation within five to seven business days of a referral being made.[27]

53. I consider that earlier psychological intervention may have been beneficial for LKV's mental health and a more responsive approach to Dr Ferry's referral on 4 February 2019 would have been appropriate. However, given the challenges associated with LKV's engagement with therapy and the evidence of Dr Coulson that intensive psychological therapy is less effective at the more severe end of the depression spectrum, I am not satisfied that earlier access to a psychologist would have prevented his death.

The luggage strap

54. In her statement to the Court, PLR recalled telling Dr Ferry on 8 February 2019 that she located a removable strap from her husband's suitcase "*tucked between his bed and nightstand*".[28] Dr Ferry has stated that he recalled having a discussion with LKV on 8 February 2019 about methods of suicide he had considered, at which time PLR was present. However, he stated that he has no independent recollection of being advised about the strap by PLR and that if it had been disclosed to him, it would have required LKV's risk category to be entirely re-evaluated.[29] I also note that Dr Ferry made no reference to being advised of

[25] Statement of Dr Brian Ferry dated 27 June 2022.
[26] Statement of Dr Brian Ferry dated 11 October 2021.
[27] Correspondence from minter Ellison dated 19 May 2022.
[28] Statement of PLR dated 26 September 2020.
[29] Statement of Dr Brian Ferry dated 11 October 2021.

the luggage strap in the notes of the consultation on 8 February 2019 which are contained in the medical records.[30]

55. PLR made her statement to the Court on 26 September 2020 which she has stated was drawn from notes made by her immediately following her husband's death. However, the version of her discussion with Dr Ferry on 8 February 2019 contained in her statement is not consistent with the email to the Court on 16 February 2019 from her daughter, QEP, and son-in-law, BMA, which conveyed the family's concerns at that stage regarding LKV's medical care and management which included the following:

    2. *The day prior to his suicide in a session with the psychiatrist and PLR (LKV's wife) LKV admitted that he had thoughts of suicide, including expressing two ways he may go about this.*
    3. *In the days before (not exactly sure when) PLR found the straps to his suitcase on the floor beside his bed and took them home.*

56. Accurately recalling the precise sequence of events even soon after a traumatic event can be difficult and challenging. In resolving this factual dispute, I am also conscious that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters, taking into account the consequences of such findings or comments. In the circumstances, I am not comfortably satisfied that the information about the discovery of the luggage strap was conveyed to Dr Ferry on 8 February 2019.

Observations

57. During his second admission, LKV's level of risk was assessed as "low". Accordingly, LKV was required to be observed at shift handovers, meals and hourly overnight.[31] LKV was observed to be sleeping at 7.23am on 9 February 2019. There is no evidence he attended for breakfast. Staff noticed at around 9.00am that he had not presented for his morning medications and had intended to follow him up at the end of the medication round but were distracted by attending to other tasks. He was subsequently located unresponsive at around 10.43am. The Victoria Clinic has conceded that the failure to visually observe LKV during this period was not consistent with relevant Healthscope Corporate Policy and Procedure.

[30] The Victoria Clinic Medical records, p 55.
[31] The Victoria Clinic Medical records, Healthscope Visual Observations Chart.

58. It is possible that LKV's death may have been prevented if staff had checked on him soon after 9.00am when they noticed that he had not attended for his medication. However, the evidence does not enable me to determine exactly when LKV sought to take his life and it is also possible that earlier observation soon after 9.00am would not have prevented his death.

59. It is also noted that Risk Assessment and Observation Levels – Patient Policy (Policy 9.07) does not require or record any engagement with patients and only requires verification of their location.

Risk assessment

60. During his second admission, LKV's assessment of risk was consistently identified as "low". I consider that LKV's presentation during his second admission (an older man who had recently expressed suicidal thinking, spent most of his time in his room and with minimal engagement with staff) would have justified a higher level of risk assessment than low. This is consistent with the findings of the RCA and the expert evidence. I emphasise that I express this view with the benefit of hindsight and note Dr Ferry's own views on the limitations of the risk assessment process which he expressed as follows:

> "*From a purely clinical point of view, it is obviously difficult to reconcile a patient who is assessed as low risk as one who subsequently suicides; this being inherently unlikely if the risk assessment is working as it should. I can appreciate that the simplest explanation to rationalise this is to argue that human error was at play and that the treating team's risk assessment was incorrect, given the eventual outcome. This rationalisation exercise then becomes a case of reviewing the evidence with a view to identifying failings, which could have justified a moderate or higher risk assessment. The other option is that the risk assessment system itself is not flawless, and is rather a predictive tool with limitations.*"[32]

[32] Statement of Dr Brian Ferry dated 27 June 2022.

61. While an assessment of a higher level of risk may have increased the frequency of LKV's observations, I am unable to be satisfied that it would have prevented his death in the circumstances. LKV was not observed between 7.23am and 10.43am on 9 February 2019, which the Victoria Clinic has conceded was not consistent with relevant Healthscope Corporate Policy and Procedure. As a result, even with a higher risk rating,[33] LKV may well have still had the opportunity and means to take his life.

Ligature point

62. The available evidence suggests that the means by which LKV took his own life was by using his tracksuit pants as a ligature that were looped over the bathroom door in his private room. The Victoria Clinic has conceded that the relevant door lacked anti-ligature features and has undertaken works to address this issue, including the construction of new private rooms without bathroom doors.

63. The presence of the ligature point on the bathroom door to his room provided LKV with a mechanism to take his life. It is unlikely that he would have had the opportunity to take his life in the way that he did on 9 February 2019 without that mechanism.

FINDINGS AND CONCLUSION

64. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was LKR;

    b) the death occurred on 9 February 2019 at The Victoria Clinic, Room 2 North, 324 Malvern Road, Prahran, Victoria, from neck compression in the circumstances of hanging; and

    c) the death occurred in the circumstances described above.

65. Having considered all of the circumstances, I am satisfied that LKV intentionally took his own life. His death was tragic and understandably distressing for LKV's family who was clearly concerned about the decline in his mental health and had taken positive steps to ensure he received appropriate care and treatment.

[33] A "moderate" risk (the level above low) requires the frequency of visual observations to be every 3 hours at a minimum and hourly overnight.

66. While the investigation revealed the existence of several missed opportunities in relation to the risk assessment process and the frequency of patient observations, I am unable to conclude that they would have prevented LKV's death in the circumstances. However, I find that it is unlikely LKV would have had the opportunity to take his life in the way that he did on 9 February 2019 without the availability of the ligature point on the bathroom door to his room.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

67. Predicting when a person may seek to take their own life is a challenging and complex process. This case highlights the potential limitations on the risk assessment process as it applies to patients who struggle to engage with clinical staff. Risk assessment is a shared responsibility that is informed by multiple sources, including clinical staff and family.

68. The Department of Health guideline, *Nursing observation through engagement in psychiatric inpatient care* (**the Guideline**) refers to the "*reciprocity*" between nursing observation and assessment. The observation of a patient who is struggling with engagement should inform the risk assessment of that patient.

69. It is noted that since LKV's death and in accordance with recommendation of the RCA, the Victoria Clinic Risk Assessment and Observation Levels – Patient (Policy 9.07) has been amended to require a clinical risk assessment to be completed where a patient declines or displays resistance to attend 1:1 therapy, group program and/or treatment, and for that assessment to be noted in the medical records and communicated to the treating team.

70. The reciprocity between observation and assessment in the context of the relationship between engagement and risk assessment is likely to be more effective where a mental health facility's visual observation policy requires engagement (or attempted engagement) with patients at the time of observation (at least in daytime) and the outcome is then recorded on their observation chart. This is consistent with the Guideline which emphasises the importance of observation being grounded in therapeutic engagement and states that in the formal observation process, nurses should document the physical sighting of a patient as well as information from their interactions with the patient.

RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendation:

(i) The Victoria Clinic and the Healthscope National Mental Health Committee review the Risk Assessment and Observation Levels – Patient (Policy 9.07) in relation to the visual observation requirements to ensure it reflects contemporary practice, including expected engagement with a patient.

I convey my sincere condolences to LKV's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

PLR, Senior Next of Kin

Constable Luke De Bruyn, Coroner's Investigator

Healthscope Operations Pty Ltd

Dr Brian Ferry

Signature:

Coroner David Ryan

Date : 25 July 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an investigation. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.