IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 1116

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: AMY HAUSERMAN

Delivered On:	26 July 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	20, 21, 24, 27, 28, 29 February 2012 1, 2 March 2012 3 May 2012
Findings of:	Peter White, Coroner
Representation:	Ms F. Ellis appeared on behalf of Peninsula Health Mr D. Wallis appeared on behalf of the Hauserman family Ms C Serpell appeared on behalf of Nurse Sheila Newman, during Nurse Newman's testimony.
Police Coronial Support Unit	Leading Senior Constable Amanda Maybury assisting the Coroner

I, PETER WHITE, Coroner having investigated the death of AMY HAUSERMAN

AND having held an inquest in relation to this death on 20, 21, 24, 27, 28, 29 February and 1, 2 March and 3 May 2012

at MELBOURNE

find that the identity of the deceased was AMY WYATT HAUSERMAN

born on 23 December 1981

and the death occurred on 16 March 2008

in the Intensive Care Unit, Frankston Hospital, 2 Hastings Road, Frankston 3199

from:

1 (a) HYPOXIC BRAIN INJURY INJURY IN THE SETTING OF IMMERSION

in the following circumstances:

Background

1. Amy Hauserman (Amy), was born on the 23 of December 1981. She was the much-loved daughter of Christine Hauserman and Colin Hauserman.

2. At the time of her death Colin, who was separated from Amy's mother, was her carer and they resided together in a home in Seaford.

3. Amy had previously been diagnosed with schizophrenia and anorexia nervosa and on past occasions had been treated for these conditions in a hospital setting.

4. It is also the case that from May 2005 until her last appointment on 12 March 2008, she had been treated in the community by her long time psychiatrist, Dr Le Bas.

Dr James Le Bas

5. His opinion was that while suffering from chronic schizophrenia over this period she had shown no overt signs of the condition and was well presented with good interpersonal relations, affective fluidity and an absence of declared delusions and hallucinations.

6. Dr Le Bas had prescribed the antipsychotic medication, Clozapine. His view was that over the time in question Amy battled with the idea of being sick and grieved about the impact that her sickness had on her life.

7. Dr Le Bas also referred to her eating disorder and offered the following:

> *(She) 'retained anorexic ways of thinking and exercising, though she had made significant progress in her eating through the assiduous attention of her father.*
>
> *Quite abruptly, Amy was unwell on the 12/3/08, with gross thought disorder, perplexity and interpretation of psychotic dreams such as having new insight through watching cartoons and her usual relapse sign of preoccupation with colours.*
>
> *In addition, she appeared to be losing weight. This arose because of poor adherence to her clozapine regime, taking roughly only 50mg since May 2007 covertly. This had been in spite of regular attendance with her GP, Dr Colman, filling her scripts and behaviours, which indicated to her father, that she was taking her tablets. I understand that she had been spitting the tablets down the toilet.*
>
> *... On the 14.03.08 Mr Hauserman was not able to contact me and due to the deterioration,... she was seen by the Acute Service who admitted her to the Frankston Ward 2 West, the in patient psychiatric unit, directly."*[1]

Psychiatric Nurse Cathryn Rancz

8. Nurse Rancz saw Amy on admission and completed the intake assessment in the presence of Colin Hauserman. As a result, Amy was admitted to the hospitals psychiatric unit as a voluntary patient. Nurse Rancz did not complete the short-term risk assessment with respect to self-harm or suicide.

Psychiatric Registrar Dr Suzanne Redston

9. Dr Redston saw Amy after she was admitted to Ward 2 West on 14 March, in the company of her father and brother. Initially Amy responded monosyllabically to questions put to her but became more engaged as the interview proceeded.

10. Amy was guarded, distractible and seen to be responding to psychotic phenomena during the interview. Following a mental state examination, it was considered that her affect, thought content, stream and form, together with the possibility of auditory hallucinations and the

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[1] See exhibit 22 page 27. *Dr Le Bas in his statement incorrectly refers to admission on the 14th. Admission in fact occurred on the 13th.

presence of a delusional system involving persecutory and grandiose themes, were indicative of an acute deterioration in her mental state and that her judgement was impaired.

11. Dr Redston also considered (and recorded) that she was experiencing a relapse of schizophrenia, secondary to non-compliance, and that there was a risk of relapse in respect of her eating disorder.

Psychiatric Consultant Dr Lanka Cooray

12. Dr Cooray also saw Amy on the 14th and concluded that she had a deteriorated mental state, because of her reduced use of medication. She had been difficult to manage in the community. On examination, she appeared anxious although engaging at times with inappropriate smiles. She was vague in her answers and her mood was labile with anxiety.

13. Dr Cooray also observed that Amy did not appear to have suicidal thoughts or any depressive symptoms.

14. Dr Cooray prescribed Diazepam for her anxiety while not reintroducing clozapine, which Amy had previously stopped taking while at home. (Dr Newton testified that there would not have been a diminution of her symptoms over the weekend of the 15th/16th, even if she had been put back onto clozapine).

15. Dr Cooray directed that her 15-minute observation regime continue.

16. On the 15 and 16 March, Dr Cooray further reviewed Amy's medical records and the observation notes prepared over that time by the units nursing staff. She also spoke with relevant staff and was updated concerning Amy's intermittent ongoing abdominal pain and the investigations conducted by the surgical team.

17. Dr Cooray formed the opinion that there was no evidence of ongoing risk relating to her mental state and/or her potential to self-harm, although her insight into her condition remained poor.

18. On 17 March Dr Cooray was informed of Amy's death and later wrote an account based upon her memory at that time of her earlier interview with Amy on 14 March, which was also included in the clinical file, as a progress note.[2]

The events of March 15 2008

Psychiatric Nurse Sheila Newman

19. Nurse Newman testified that on the afternoon of 15 March, the day before Amy's death, that Nurse Marc Van Der Neut was walking through Unit 2 West doing visual observations and that he came to her in the nursing station and asked that she have a look at Amy in her bed as she was said to be,

> *'I can't remember his exact words but he was talking about unusual movements and that he was a little concerned about them.'*[3]

20. Her further testimony was that she went with him to see Amy at that time and observed that she had some unusual movements.

> *'To the best of my knowledge the movements were from the waist up and it was kind of like a shifting from side to side ...sort of like an Egyptian if you like...the lower body did not appear to me to be involved and it was just a bit of a shift and maybe a bit of a thing with the shoulders and then a gulp...(or swallow).*
>
> *It wasn't a normal swallow. It was like an involuntary swallow...I know I saw it more than once'*[4]

21. Nurse Newman's further testimony was that she felt this was unusual and that she told her colleague that she would discuss it with Dr Marcus Aitkin and have Amy looked at, and that she did not record her observations at this time. Her later evidence was that she did contact Dr Aitken about the matter shortly thereafter and that they both then saw Amy.

> *'Marcus nearly always looks at the medical notes before he goes so I suppose he did that.'*

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[2] See attachment 1 to her statement at exhibit 2(b), at pages 1-2.

[3] Transcript at page 590.

[4] Transcript page 591-93.

22. At the consultation (over approximately 5 minutes at an uncertain time on the afternoon of the 15th), Nurse Newman stated that Dr Aitkin asked Amy questions about her pain...questions about bowel problems, stomach problems etc. Her further recollection was that Amy had difficulty answering questions. There were delays and non-responses and poor communication with Dr Aitkin attempting to compensate for Amy's difficulty.

'And that gulping thing happened at least once...'

23. She stated that she again saw movement of the torso, shoulders etc similar to but not the same as that she had previously witnessed.[5] Dr Aitkin spoke to Amy about her abdominal pain, but not the torso movements. Her further testimony was that she asked Dr Aitkin about the movements, which he stated he hadn't seen, this conversation taking place later at the nurses station.

24. Nurse Newman further testified that she had informed Nurse Van Der Neut of these matters both before and after she saw Amy with Dr Aitkin, and that her colleague was,

'disappointed,'

when told that Dr Aitkin hadn't seen these movements.[6]

25. Her additional evidence was that Dr Aitkin told her that Amy was faecally loaded on the 15th, and that approximately 15 to 60 minutes later she saw Amy sitting in the corridor on the carpet with her back against the wall opposite the nurses station. [7] Nurse Newman's further testimony was that she had difficulty remembering dates and that she could not be sure that the events set out above occurred on the 15th rather than the 16th [8].

26. Nurse Newman, who was privately represented, gave a further account as to why she had given a less complete picture in her various statements, than that given in the evidence set out above, and how and why she had focused on the matters set out in the clinical notes when preparing those materials.

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[5] Transcript page 607-8

[6] Transcript page 611.

[7] Transcript page 611 and exhibit 11(a).

[8] Transcript page 620.

27. She was then taken to the file notes prepared by Frankston Hospital's solicitor, which referred to a divergence of views on the issue of Amy's presentation on the 15/16 March between Nurse Van Der Neut and Dr Aitken on the one hand, and herself.

28. In regard to this apparent inconsistency she testified as to how her various reports came into existence, which evidence was allowed as rebutting any suggestion of recent invention, concerning in particular, her abovementioned evidence of observing both Amy's gulping and her unusual upper bodily movement.[9]

Dr Marcus Aitkin

29. Dr Aitkin was at the relevant time employed as the liaison psychiatric registrar at the Frankston Hospital and was the on call registrar on the evening of the 15 March, a Saturday. He stated that he saw Amy, in connection with her abdominal pain, at 5.46 pm, but was unable to recall who called upon him to see her.

30. Following his review, he confirmed the fact of her on going abdominal problem, and ordered that her treatment continue.[10] He was unaware of and did not observe the mannerisms in Amy's presentation alleged by Sheila Newman.

31. Dr Aitkin further testified that he had no recollection of being requested to see Amy by Nurse Van Der Neut.[11]

32. Dr Aitkin was questioned about the treatment and risk management plans. His testimony was that these should be undertaken at the time of admission, and reviewed thereafter by the consultant psychiatrist.

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[9] Initially, it was suggested by Counsel representing the family, that there might have been some impropriety in the manner in which unspecified members of Peninsular Health's legal team, had taken statements from Nurse Newman.

Following, what was a careful examination of the matter, Counsel for the family did not seek to support that position and on the evidence before me (and in the absence of any assertion to the contrary), I accepted Counsel's submission concerning that matter.

[10] See clinical notes at exhibit 4(a). See also his evidence from transcript page 251-2 where he states that on examination he could not see or locate an abdominal mass.

[11] See exhibit13 and 13(a), the statements of Nurse Van Der Neut and testimony at page 228-29 and at 239, concerning the allegation that Dr Aitkin initially indicated a reluctance to see Amy, when he was requested to do so by the nurse, about which matter I make no finding.

33. Dr Aitkin further offered that he was not aware of previous incidents of a patient taking a bath within the psychiatric unit, and was not aware whether risk assessments about this matter were normally undertaken. He felt however that,

> *'It would be good to do a risk assessment before a patient took a bath in that situation'.*[12]

The events of 16 March 2008

Psychiatric Nurse Mary Hendry

34. Nurse Hendry a long time psychiatric nurse on Ward 2 West, first met Amy when she had been an inpatient in the ward back in 2004.

35. On 15 March she was on duty and had been the *'medication nurse'*. She administered a microlax enema to Amy, without success.[13]

36. On 16 March Nurse Hendry commenced a double shift at 7am. At about 4.15pm she checked on Amy who was again complaining of stomach cramp, this at the specific request of Nurse Gwynne. Amy's allocated nurse, Sheila Newman, was not available at this time.

37. Nurse Hendry knew that Amy was not *'actively suicidal'* and understood that her admission had occurred in a context of,

> *'.. vulnerability and neglect. Amy was alert, engaging appropriately, and spontaneous. She did not appear to be suffering from hallucinations at the time and her distress was in relation to her abdominal pain. There was no change between how I had observed Amy on the ward in preceding days and how she appeared to me on that day.*
>
> *I went down to her room. She seemed so distressed about the pain, I offered her a bath. She was bent over with pain and holding on to her abdomen I knew none of the other interventions had worked. She accepted this offer immediately and we went off to the bathroom in such a hurry that I had to grab the towels on the way. I unlocked the room and she began undressing as we got inside. I turned the tap on and left the decision about how full the bath was to Amy. I drew the curtains, shut the door and left the room,*

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[12] Transcript page 249

[13] See statement at Exhibit 7 page 1.

telling her I would check on her soon and I asked if she was okay. By this, I meant was she okay to get undressed and get in and out of the bath on her own. She told me she was okay.

I was happy to leave Amy in the bathroom on her own as she was keen to have a bath, she was wide awake and she was physically able to get herself in and out of the bath and undress herself...My other colleagues were conducting visual observations (every 15 minutes), so after setting up the bath for Amy, I went back to my previous tasks and did not really participate in her care any further.'[14]

38. At around 4.50pm Nurse Hendry states that she opened the door slightly and spoke with Amy who said she was OK. She did not see her, as the curtains remained closed around the bath.

39. In further testimony, Nurse Hendry stated that the bathroom was kept locked so that patients could not use the bath without the permission and co-operation of a staff member. She did not think there was any risk associated with Amy having a bath and that she was not aware of any hospital or Ward 2 policy or protocol associated with patients having a bath.

40. Nurse Hendry was further questioned about the oral medication given to Amy, which along with the Microlax enema, was intended to help relieve her constipation.[15] She could not recall if she became aware whether a dose of one of these oral medications, Buscopan, had been administered at 4.00pm but later found that it had not.

41. Her further evidence was that a call bell in the bathroom could not be utilized unless the patient got out of the bath, i.e. the bell could not be reached from the bath. Additionally, she testified that the bath had been used rarely during her employment at the hospital and that it had been withdrawn from use altogether immediately following Amy's death.

42. She felt that the 15-minute observations were reasonable given her overall presentation.

43. Significantly, Nurse Hendry did not believe that she should stay with Amy during the bath, this having regard to privacy concerns.

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[14] Ibid at page 2.

[15] Transcript page 346.

44. It was for this reason then that the bath was set up with the door partly open but with the curtain in place, shielding Amy as she sat in the bath behind it.[16]

45. Nurse Hendry also informed that there was a requirement for a risk assessment to be undertaken each day for each inpatient within the ward.

Nurse Alana Wilson

46. Nurse Wilson a Division 2 nurse reviewed Amy's file on the afternoon of 16 March, as Amy was one of her allocated patients. She found the surgical team reference to the fact that Amy was constipated. She was aware that at this time Amy remained on 15 minute observations.[17]

47. Nurse Wilson further stated that at some stage during the afternoon she believes she had a discussion with a nursing colleague about Amy and her ongoing abdominal pain. That discussion turned around whether Amy should be offered a warm bath to help relieve her abdominal discomfort.

48. At approximately 5.00pm, Nurse Wilson became aware of an accident in the bathroom at Unit 2 and witnessed Amy being taken from the water by Nurses Sheila Newman and Denise Gwynne. At this time, Amy was cyanosed and dripping wet. Nurse Wilson then assisted and observed the attempts at resuscitation by Nurses Bartle, Jenkins and Newman and the further efforts at resuscitation made following the arrival of the Code Blue team soon after. (Amy was then pulled into the hallway to give those attending her more room).

49. Nurse Wilson took notes at the scene and acted as a scribe for the Code Blue team.

Psychiatric Nurse Jennifer Pugh

50. Nurse Pugh first saw Amy on 15 of March and was aware of her deteriorating mental state presentation and her abdomen discomfort.

51. At 6.30pm on the 15th, she recorded that,

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[16] Transcript page 351-52.

[17] It was not in dispute that prior to the commencement of her bath, Amy's deteriorating mental state coupled with her unresolved abdominal pain plus a treatment plan which included Diazepam but did not include a return to medication specifically directed to her psychosis, that it was appropriate to maintain her on 15 minute observations. It is also relevant however that the evidence was that she remained on 15 minute observations because she was a recently arrived, patient and that such an observation regime, was always adopted in respect of such patients.

'Amy has spent the majority of the shift in bed. Isolated, little interaction with co-clients. Vital signs stable. No further complaints of abdominal pain. Fluid intake noted. Affect remains blurred.'

52. On 16 March, Nurse Pugh again carried out observations on Amy. She saw her between 3.30pm and 4.15 pm when Amy told her that she was not very well, and that she continued to suffer from abdominal pain.

53. At 4.30pm she spoke to Amy in the bathroom. She saw her outline behind a gauze curtain (put in that position to protect the patient's privacy), and believed that at that time she was standing in the bath. Amy told Nurse Pugh that she was OK and was told in reply that (Nurse Pugh) was finishing her shift and that Nurse Denise Gwynne would be taking over.

54. A short while later Nurse Gwynne was asked by Nurse Pugh to take over the observations in respect of Amy and, according to Nurse Pugh, she acknowledged this request.

55. **Psychiatric Nurse Denise Gwynne**

56. On the 16th of March Nurse Gwynne a permanent staffer at Ward 2 West, was rostered for a 12-hour shift commencing at 7am. She was not rostered as Amy's duty nurse but saw her on several occasions during the day.

57. At approximately 4.35pm, she recalled receiving an indication from Nurse Pugh to take over the observations as they fell due in respect of Amy. With this in mind she collected Amy's folder from the bench and walked along the hallway toward the bathroom where she was aware that Amy was taking a bath.

'The bathroom door was ajar. I could not see Amy. I have a distinct recollection of standing in front of the sliding door to the bathroom and seeing the drawn shower curtain through the gap and calling Amy's name.

Amy responded very clearly, saying,

"Yes I am OK".

At about 5 pm I walked back to the corridor to check again...When I got to the bathroom door I knocked and there was no response. I said Amy and again there was no response. Because she didn't answer I opened the door and pulled the curtain and saw that she was lying face down in the bath. I pushed the buzzer on the left of the door. I was the first one to attend to the patient. She was definitely lying down with her head fully submerged. It was a fairly deep bath...I immediately screamed for help. I scooped Amy and turned her over on to her back and sat her up. Her feet were to the door. I noticed a greenish substance floating in the bath. Her lips were blue but her other extremities were not. I pulled out the plug and was still screaming for help. I grabbed Amy and sat her up; She gasped and I said to her "Amy". I yelled for help again.

A patient came in and I said get help and call a Code Blue. Val Roman a PSA came in next and I sent him off as well.

Other staff arrived. Sheila Newman came around the left side to the position of Amy's head. I was on the right hand side. Other staff were there and we lifted Amy out. Sheila started mouth to mouth resuscitation after we placed Amy on the floor.'[18]

58. Nurse Gwynne further testified that she was not aware of Amy's medical history or the reasons why she had been admitted, as Amy had not been one of her allocated patients.

59. Nurse Gwynne was not aware that Amy had been prescribed Moxalon. She also testified about the symptoms associated with withdrawal from anti-psychotics, of which she was aware.

> *'They can become lethargic, confused, agitated, some of our antipsychotic medication can cause stiffness, nausea, vomiting, headache, so yeah.'*

60. Her further testimony was that the sudden withdrawal of anti-psychotics can lead to spasms, but that she was unsure how withdrawal from clozapine specifically, may impact a patient's condition or symptom presentation.[19]

61. According to Nurse Gwynne she was not a party to discussions which led to Amy being given a bath and only learnt of the matter (from Jenny Pugh), when she took over responsibility for her observations from 4.30pm.

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[18] See Exhibit 9 at page 2.

[19] Transcript page 532-34.

62. Under further questioning from Counsel for Amy's family Nurse Gwynne agreed that she was familiar with a nursing observation protocol, which required that patient observations in the ward were to be only visual.[20] In addition, that she did not actually sight Amy during her first observation from the door of the bathroom.

63. She understood that one of the reasons for such a requirement was that a visual observation of skin colour may be important.

64. Her further view was, however, that Amy's dignity and right to privacy were important and that she would have entered the room to visually observe in the event that Amy had not responded to her verbal inquiry.[21]

65. She agreed that the protocol required that,

> *'The observation nurse will observe that persons under purview are breathing and have good skin colour, i.e. not gray or cyanosed and are without physical injuries'*

And that,

> *'Any restriction on the liberty of a person or any interference with their rights, privacy, dignity or self respect will be kept to the minimum necessary in the circumstance'.*

66. She further agreed with Counsels proposition that these protocols contemplated ongoing dignity and privacy for the patient in a setting that also recognised a need for (ongoing) visual observations.[22]

67. Nurse Gwynne testified that she heard the Code Blue signal within one minute, at 5.08pm. Her further evidence was that she had commenced walking up the corridor to undertake her second observation of Amy at 5.00pm, first walking past and observing two other patients for whom she was also responsible.

68. Her further evidence was that Amy had been placed on 15 minute observations because of her physical rather than her mental health, and that advice had been provided at handover.

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[20] The protocol may be found at exhibit 7(b)

[21] Transcript page 536-7.

[22] Transcript page 537-9.

69. According to the witness, baths were uncommon in the unit. Nurse Gwynne did not know why a bath had been authorised and again was not aware of her relevant medical history all of which were matters for *'the clinicians'*. The depth of the bath was suitable and she did not know that Amy herself had favoured a bath.

70. Again, in response to a suggestion put by Counsel for Amy's family, Nurse Gwynne was not aware of a propensity for people to faint or otherwise lose consciousness, while bathing in warm to hot water.[23]

71. In answer to further questions from Counsel for Peninsula Health, Nurse Gwynne stated that she had been orally informed that Amy was on 15 minute observations for physical rather than mental health reasons.

Nurse Sheila Newman continuing

72. On the 16 March Nurse Newman's shift commenced at 1.00pm. She stated that she had selected Amy as a duty patient because of the interest created by Amy's unusual movements, her difficulty speaking and her physical illness, concerned with abdominal pain, as observed during the review undertaken by Dr Aitken.

73. However on this day she testified that she had no actual contact with Amy, until Nurse Gwynne was heard screaming out, this after she discovered Amy face down in the bath.

74. Thereafter Nurse Newman testified as to her involvement in giving mouth-to-mouth resuscitation and observed Amy's abdomen move up and down as she did so. She later saw green bile released from Amy's mouth and in that connection, heard a gurgling sound.

75. Her tongue was retracted and very small and blue.

76. She provided a history to the Code Blue team after their arrival.

<u>Opinion evidence concerning the decision to bath, observations carried out during the bathing period and the attempted resuscitation.</u>

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[23] Transcript page 547-548.

Dr Lester Walton[24]

77. Dr Walton reviewed the treatment provided to Amy, following her admission.

78. He noted that Amy was suffering from acute psychosis over the weekend, however, he considered that the failure to restart the Clozapine medication at this time, (a decision made by Dr Cooray), was reasonable in the circumstances, at least until she had conferred with the treating psychiatrist, Dr La Bas.

79. Dr Walton further considered that the fact that Amy was displaying psychotic symptoms over this period, did not of itself require her to be recommenced on clozapine or other anti-psychotic and that, in all the circumstances, Dr Cooray's decision to prescribe Diazepam only, was appropriate to counter the anxiety she experienced as a result of her psychotic symptoms.

80. His further conclusion was that there was no strong connection between these symptoms and her death, and that Amy's untreated psychosis did not put her at increased risk in the bathroom.

Dr Richard Newton

81. Dr Newton was (prior to Dr La Bas), a consultant psychiatrist in private practise who saw Amy from May 2002 until 2005. Thereafter he became the Clinical Director of Psychiatry at Peninsular Health. He was not involved in her treatment following her admission to Frankston Hospital in March 2008, but knew that she had been admitted and recalled that he saw her on the ward and greeted her at that time.

82. Subsequent to her death, Dr Newton had dealings with her family and chaired the Root Cause Analysis (RCA) team, which inquired into her death.

83. The RCA concluded that, the bath was offered in the context of the nurse believing that her pain continued and that she had not responded to the medications previously given. The RCA further considered that there was no formal risk assessment but further noted that there were no formal guidelines, which required staff to undertake such an assessment. The RCA also

[24] Dr Walton is a consultant psychiatrist called by Peninsula Health to give expert evidence concerning the medical management of Amy Hauserman, during her stay at Frankston Hospital.

reported that there was no agreed practice as to continuous direct observation of patients during bathing.[25]

84. The RCA also concluded that the lack of a formal risk assessment on the day of death did not increase the risk to Amy, as no one thought her mental or physical state had altered materially on the day of death or on preceding days. (I note here that this observation appears to disregard the opinion of Dr Cooray as to the nature of the deterioration in Amy's mental state).

85. The RCA also concluded that the absence of agreed contemporary practice that patients in psychiatric wards be under continuous supervision while bathing, may have led to the patient's death.[26]

86. As a response to the matters raised, the RCA recommended the ceasing of the practice allowing patients access to baths and the removal of the bath from the acute psychiatric unit altogether.

87. It was also recommended that other psychiatric patients only be permitted to access a bath facility when they could be continuously observed and that a clinical practice guideline, incorporate such a directive. A further response was to call for the guideline to require that a risk assessment be undertaken before offering a bath to all patients and that such an assessment should address,

> '*medical risk, cognitive impairment, risk of fall and risk of suicide, all to be documented immediately before a bath.*'[27]

88. Dr Newton also opined that there was an expectation that mental state assessments and risk assessments as undertaken by Dr Cooray, should always be documented at the time undertaken, which we know did not occur in this case.

Professor Wendy Cross

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[25] See RCA at exhibit 16(a), page 6 where the practise in regard to bathing at a cross section of Victoria's major hospitals was set out.

[26] Ibid page 7.

[27] Ibid page 8.

89. Professor Cross is the Head of the School of Nursing at Monash University and was called by the Court to give expert evidence concerning the medical management provided in this case.

90. Her opinion, was that all patients in psychiatric inpatient units who, like Amy, require frequent observations, should only be permitted to take or use a bath if protocols are in place which mandate a written risk assessment and, if such patients are supervised, in accord with such assessment.

91. Speaking from the doorway through the curtain, as occurred in this case, was seen to be inappropriate and all observations be they required to be constant or every 15 minutes (or longer), must be carried out by way of direct visual observation with oral contact.

92. Her further opinion was that when weighing a patient's dignity and privacy against safety, that safety must be paramount.

93. The fact that Amy had been unwell for several days was a factor which when coupled with the frequent observation level already in place, should have alerted staff to the dangers of leaving her alone in a bath.

94. All of these matters should have been considered and put to Amy who might then have been given the choice of a bath, with the requirement that she be constantly supervised, or that she not have a bath at all.

Cause of Death

Dr Mathew Lynch[28]

95. Dr Lynch performed an autopsy on Amy and concluded that the cause of death was,

1(a) Hypoxic brain injury in the setting of immersion

His opinion set out that,

> '*While Amy's death occurred in the setting of immersion it is not entirely clear as to how she became submerged in the bath*'.

[28] Dr Lynch is a Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine.

96. Dr Lynch raised a simple faint and cardiac arrhythmia as two possible explanations, for a (possible) collapse, which may have precipitated her death.

97. In cross-examination, Dr Lynch was questioned extensively about his conclusion as to the cause of death. He was able to confirm both that his external examination did not reveal any evidence of a discernable relevant injury reflecting that she may have fallen forward into the bath having slipped or fainted, or having collapsed while suffering from cardiac arrhythmia. Equally, Dr Lynch confirmed that there was no evidence suggesting that she had (or had not) lost consciousness for any of the abovementioned reasons, while lying in a prone position and then fallen forward with her face submerged in the bath, the position in which she was found.

98. In conclusion, Dr Lynch testified that had Amy not been found in the bath the cause of death would have been undetermined and would have been the same as described in his report, with the exception of emersion. In other words, while he was satisfied that Amy had died of a hypoxic brain injury associated with cerebral oedema, he was unable to say whether that injury had resulted from cardiac arrhythmia, from drowning or from any other cause.[29]

Findings

99. At the time of death, Amy was suffering from a psychosis in respect of which she had earlier covertly withdrawn herself from medication.

100. This had caused or substantially contributed to an acute deterioration in her mental state.

101. Following her admission to Frankston Hospital psychiatric unit on the afternoon of March 13, she was put on 15-minute observations, which was a standard level for observation in respect of recently admitted patients. It is relevant to record that this observation regime, did not give nursing staff any particular clue, or allow any particular inferences to be drawn, concerning her needs, or risk presentation.

102. It is also the case that at the relevant time Amy was extremely frail and was suffering from severe constipation for which she had been prescribed both oral and enema medication, which course had not achieved any notable success.

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[29] Transcript page 798-802.

(I note here that Psychiatrist, Dr Cooray's additional opinion, which went to the greater probability that Amy suffered an arrhythmia, rather than vasovagal, or a drop in blood pressure caused by physical pain, was not evidence upon which I considered I could reasonably attach significant weight).

103. As a result, she was constantly uncomfortable, and became increasingly tormented by what I find were ongoing bouts of moderate to severe abdominal pain.

104. I further find that Amy's ability to deal with her abdominal pain became more impaired, as her mental state became increasingly unsettled.

105. I am also satisfied that Nurse Sheila Newman did call upon Dr Aitkin to examine Amy in the circumstances described in her evidence above, but that while with Amy in the ward that she did not specifically bring her concerns about her earlier (and present, though by this time different), observations to his attention.

106. It is also the case that these particular aspects of Amy's presentation were not evident to Dr Aitkin at the time of his examination and were not therefore observations incorporated into his decision to maintain the existing treatment plan.[30]

107. While it is easy to be wise after the event, I am further satisfied that the existing protocols did in fact suggest the need for a full risk evaluation in contemplation of a bath, though unfortunately did not specifically direct that such an evaluation should occur in connection with such a plan. The evidence establishes rather that the staff as a group, through what I hold was a failure in the management of Hospital training updates on this subject, were not sufficiently familiar with the relevant protocol.

108. In these circumstances and in the absence of a consultative approach, such an assessment did not occur before Amy was offered a bath and I find that, as a result, the risks associated with her presentation were not given any particular consideration and were not well understood, before the decision to offer a bath was reached.

109. I further find the potential risks associated with her bathing included a deterioration in her level of consciousness, accidental slipping while getting in or out of the bath, (or while in the

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[30] See transcript at page 610-11. I note here that Dr Aitkin, was engaged in questioning Amy and in recording notes at this time.

Amy's father's own observations of her atypical 'rocking' and 'drowsiness' on the 14th /15th, were relevant in this consideration. See transcript from page 24. In this regard I note the absence of clinical notes suggesting drowsiness or other, but prefer in this instance Mr Hauserman's evidence, this given his own greater understanding and familiarity with his daughters normal behaviours.

Although the possibility of the onset of a condition connected to the withdrawal of antipsychotic medication was raised in evidence, I find that the evidence does not establish whether this (apparently involuntary) behaviour occurred for reasons connected with Amy's deteriorating mental state, medication withdrawal, physical discomfort, or for what if any other reason.

bath), with each such risk either caused or contributed to by her severe faecal loading, her earlier intake of a course of diazepam and her noted drowsiness,[31] plus her poor mental and physical state.

110. Other factors contributing to her risk presentation were the possibility of a physical deterioration of unknown dimension, which range of possibility included fainting, cardiac arrhythmia and anti-psychotic medication withdrawal.[32]

111. In other words, the risk presentation at the relevant time was multi-faceted and present across several levels.

112. I am sympathetic to the intention of the nursing staff involved in this matter. However in all of the circumstances, I further find that the decision to allow Amy to undertake a bath (without a meaningful risk evaluation and/or without seeking her consultant's advice), and then to additionally allow her to get in and out of, and remain in the bath, all without constant supervision was made in error and cannot be supported.

113. As to the mechanism that led to death, I have reviewed the expert evidence provided, together with Counsel's submissions. The result is that I find that I am satisfied from all of the evidence that Amy died from hypoxia having inadvertently got into what was a very threatening situation, from which she was unable either to protect herself, (or be rescued). It remains uncertain as to whether she was conscious, semi-conscious or unconscious at this time.

114. I accept then the finding of Dr Lynch that the cause of death was,

1(a) Hypoxic brain injury in a setting of emersion

115. In so holding I also confirm that it remains uncertain as to how she got herself into a face down position within the bath, and whether she fell into an unconscious state or otherwise, and accidentally slipped or fell into the bath as she tried to step out of the bath, or even as she tried to get back in.[33]

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[31] See evidence of her father from transcript page 21.

[32] While arrhythmia may have been a possibility, it was not one, which I consider nursing staff had any particular reason to anticipate.

[33] I am satisfied from all of the evidence including that of Nurses Hendry, Pugh and Gwynne above, that it may be properly inferred that Amy had lifted herself into a standing position in the bath at the time of Nurse Pugh's last

116. I further consider that such an obviously dangerous situation whatever its cause, stood a very high chance of a successful outcome by rescue, and resuscitation if such was required, this only had a nurse been present within the bathroom and therefore able to respond in a timely manner.

117. Instead, in the case of this already vulnerable and physically frail patient, who was in a poor and deteriorating mental state, I find that the absence of such supervision was a primary feature leading to her death, in that it caused or contributed to an inability to successfully intervene and to give effect to her rescue.

118. It is important to record here my further finding that there is no evidence before the court from which I might properly infer that at the time of her death Amy was attempting self-harm or suicide. Rather the testimony of Dr Cooray and Dr Walton,[34] together with that of her father and the further evidence as to her changing general demeanour in Ward 2 all suggest that while from a point in time immediately prior to admission she had become acutely unwell,- that she did not also become suicidal.

119. Accordingly, I find myself satisfied that during the relevant period she did not contemplate a destructive course and rather in the fullness of time would otherwise have achieved a return to better times in the company of family, friends and her much-loved dog.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

1. It is axiomatic that patients in a psychiatric ward may suffer from a range of complex illnesses which are hard to diagnose and hard to treat, with outcomes nearly always uncertain, and a challenge to predict. Equally, the degree of difficulty faced by psychiatric ward patients

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observation at 4.30 pm, and that Nurse Gwynne spoke to Amy again at 4.35pm and for the last time at soon after 4.45pm. Later at 4.50pm, Nurse Hendry made an unscheduled visit, and spoke to Amy, who again said she was OK.

This was the last communications with Amy prior to Nurse Gwynn's discovery of her unconscious in the bath soon after 5.00pm, and from this evidence, I draw the inference that Amy got into the difficulty, which led to her death, at a point between these last two events.

[34] See Exhibit 21(a) at page 3. I also note here that I am in agreement with Dr Walton's opinion that this would be a difficult and extremely unusual method of killing oneself, and that there was no evidence that Amy had deteriorated to the point of being acutely suicidal, before she took the bath.

engaging in seemingly simple tasks is also hard to measure, and often exacerbated, as in Amy's case, by the impact of a physical injury or illness.

2. Recognising the problems such a presentation may present to accurate risk assessment, Frankston Hospital has withdrawn the bath option from its high dependency psychiatric ward.

3. Having regard to the particular difficulties in 2008, concerning 'special' staffing for patients undertaking a bath within the unit, I am satisfied that this was an appropriate response to this tragic episode.

4. However, circumstances may change and in the event that such an option again becomes a possibility I consider, (and Hospital authorities now clearly recognize), that a bath should only be offered in Ward 2 in conjunction with improved training, plus mandatory and continual nursing supervision.

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

Mr Colin Hauserman.
Mrs Christine Hauserman.
Nurse Newman
The Secretary Department of Health in the State of Victoria.
The Chief Psychiatrist in the State of Victoria.
The CEO Peninsula Health.

Signature:

PETER WHITE
CORONER
Date: 26 July 2013

Coroners Court of Victoria