IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 4823

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

Amended pursuant to s76 of the *Coroners Act 2008*

On 14 February 2017 at 2:25 pm

Inquest into the Death of: ESTHER NG KIT CHING

Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank,Vic3006
Hearing Dates:	June 1-3 and June 21-24, 2015 (**hearing dates corrected to June 22-24, 2015**)
Findings of:	PETER WHITE CORONER
Representation:	Ms Tracey Riddell of Counsel on behalf of Eastern Health
Counsel Assisting the Coroner:	Senior Constable Tracey Ramsey, Police Coronial Support Unit
Catchwords:	Hanging by involuntary patient within Low Dependency Unit of psychiatric hospital. Response to presentation in period prior to death. Approach to the presence of potentially dangerous items within the unit. Independent review of safety precautions.

I, PETER WHITE, Coroner having investigated the death of ESTHER NG KIT CHING

AND having held an inquest in relation to this death on June 1-3 and June 22-24, 2015
at Southbank, Melbourne.
find that the identity of the deceased was ESTHER NG KIT CHING
born on 3 December 1958, aged 53
and the death occurred on 13 November 2012
at the Box Hill Hospital Intensive Care Unit, Box Hill, Victoria

From:

1 (a) HYPOXIC BRAIN INJURY

1 (b) HANGING

In the following circumstances:

Esther Ng Kit Ching known as Esther to her family and friends, died on 13 November 2012 in the Box Hill Hospital Intensive Care Unit, having on the 6 November 2012, hung herself from the bathroom door of her room in Upton House, at Box Hill Hospital.

During the period of her stay at Upton House Esther was an involuntary patient admitted under section 12 of the *Mental Health Act 1986*. As such, Esther was before her death a person placed in custody or care for the purposes of the *Coroners Act 2008* (the Act). Section 52(b) of the Act requires me to hold an inquest in to Esther death given her status as an involuntary patient. I note here that the 1986 Mental Health Act required that patients in a psychiatric facility were to be detained in accordance with the principles of *least restrictive practise.* [1]

---

[1] See Mental Health Act 1986. Sect 4 Sub Sect 2, (which applies to the consideration of rights and duties in this inquest),

It is the intention of Parliament that the provisions of the Act are interpreted and that every function,

power, authority, discretion, jurisdiction and duty conferred or imposed by this Act is to be exercised or performed so that –

a) People with a mental disorder are given the best possible care and treatment appropriate to their needs in the least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that care and treatment.

b) in providing for the care and treatment of people with a mental disorder and the protection of members of the public, any restriction upon the liberty of patients… and any interference with their rights, privacy, dignity and self- respect are kept to the minimum necessary in the circumstances.

See also the mental health principals at Section 11 of the 2014 Act.

Sub section 1(g) of that Act requires that, persons receiving mental health services should have their individual needs (whether as to culture, language, communication, age, disability, religion, gender, sexuality or other matters) recognised or responded to;

Background

1. Esther was a 53 year old female who lived in Doncaster with her husband David Mok and their two children. She was a qualified surveyor having studied at the University of Hong Kong and at RMIT. She and her children had moved to Australia from Hong Kong in 2007. It is not known whether she practised as a surveyor in Australia. Her husband moved to Australia in 2010. He described Esther as being very intelligent and optimistic for most of the time he knew her. She did volunteer work with her church and had many friends. He further described that from July 2012 she began to have difficulty sleeping and started to have panic attacks.

2. On 19 April 2012 Esther presented to General Practitioner, Dr Sandra Wu of the Box Hill Mall Medical Centre. Dr Wu created a Mental Health Care Plan for her and on 26 April 2012, referred her to Ms Siew Lee, a Clinical Psychologist. Dr Wu had prescribed antidepressants and requested that she return in two weeks. Esther did not go back to see Dr Wu.

3. Ms Siew Lee provided a statement to the Court. Ms Lee saw Esther on 10 May 2012 and 17 May 2012. On 10 May 2012, Esther completed the Kessler Psychological Distress Scale questionnaire, which seeks to rate psychological distress at a level of between 10 and 50. She scored 35, a score indicating severe levels of psychological distress. She reported feeling anxious and nervous, with increased stress following her relocation from Hong Kong with her two children in 2007. Ms Lee reported that Esther, was experiencing severe levels of psychological stress but, *did not present with any clinical symptoms of depression and did not express any suicidal thoughts at that time.* [2]

4. Before their third meeting, Esther said she was not improving with seeing Ms Lee and that she wanted to find another psychologist.

5. Esther subsequently changed general practitioners and in May 2012 saw Dr Simon Chee-Kit Tong, to whom she reported fear and anxiety. Dr Tong considered that she had slight anxiety and slight depression and he recommended St John's Wort and to review her in two weeks.[3] He saw her again on 28 May 2012 and Esther stated that she still *felt stressed and was feeling down*. He advised that she continue to use St John's Wort and that she attend meetings with

---

The emphasis is mine.

[2] See Statement of Siew Lin Lee Exhibit 12 page 33 (Inquest Brief).

[3] St John's Wort is a herbal remedy considered to be helpful in the treatment of depression.

social groups. In August 2012 Dr Tong prescribed her the antidepressant Mirtazapine, 15mg daily. On 24 August 2012 Esther attended again with her husband and Mr Mok described his wife's anxiety and panic attacks. Dr Tong asked Esther if he could speak to psychologist, Ms Siew Lee and subsequently had a conversation with Ms Lee about the two sessions Esther had with her. He later continued Mirtazapine for anxiety and prescribed 2mg of Valium daily. Dr Tong also referred her to Psychiatrist, Dr Michael Wong as on 1 September 2012, she reported feeling, *numb, hopeless and alone.* He further prescribed Temazepam 10mg at night, to assist with sleep.

6. In respect of this period Mrs Ng's friend Jenny Shaw stated, s*he had previously talked to me about her life ending in July August. She hinted that she had thought of suicide, but then assured me she was not doing so.*[4]

7. Dr Michael Wong saw Esther on 19 September 2012. He found her,

   Anxious, depressed, distressed and frustrated. She was forthcoming and coherent and readily described her anxiety, depression and negative and guilty ruminations. There was no phobia, obsession or compulsion. No psychotic or manic symptoms were elicited. She denied any suicidal plan.[5]

8. Dr Wong diagnosed her with a Major Depressive Episode with prominent anxiety. He suggested she remain on Mirtazapine and Diazepam but changed her sleeping medication from Temazepam to Imovane. He also commenced her on the antipsychotic, Olanzapine (Zyprexa), as anti-anxiety medication.

9. On 10 October 2012, Dr Wong increased her antidepressant dosage. He last saw her on 24 October 2012 and noted that Esther, c*ontinued to be anxious depressed and distressed but did not admit to feeling suicidal.*

10. On 13 October 2012 Mr Mok took Esther to the Emergency Department of Box Hill Hospital, as she was anxious and was having suicidal thoughts. She was seen by a Registered Nurse and a Doctor and after assessment was admitted to the hospital's psychiatric unit, Upton House. Upton House was divided into two units, the High Dependency Unit (HDU) now

---

[4] Statement of Jenny Shaw Exhibit 12 page 17.

[5] See statement of Dr Wong Exhibit 12 page 35.

called the Intensive Care Area (ICA) and the Low Dependency Unit (LDU), which normally comprised of 20 beds.

11. On admission to the LDU Esther was noted to have a high level of anxiety with suicidal thoughts. She was given 2.5mg diazepam and was assessed later in the evening with no acute risks identified. She had negative views about taking the medication prescribed and she was encouraged to take it and make an earlier appointment with her psychiatrist. Esther and her husband were given the psychiatric triage 1300 number and she was discharged.

12. Esther contacted Eastern Health Triage around 17 October 2012, again in distress. She was subsequently seen by Central East Crisis Assessment and Treatment Team (CE CATT) at her home on 21 October. She was noted to be, *ruminating repetitive negative thoughts ++, anxious and worried ++... Believes she will never get better and medication is not helpful to her. Numerous attempts by clinicians and husband to explain and educate on medications with nil effect, low in mood and expressed negative thoughts... Husband reports this AM she tried to jump over the top banister but was unsure as to why, or what she was doing.* She was noted to have, *poor insight, impaired judgment and did not want CE CATT support to continue, but husband enforcing same and wanting CE CATT to visit again.*[6]

13. CE CATT reviewed her at home again on 23 October 2012. She continued to display anxiety ++, *very limited insight, judgement impaired. Reluctant to continue medication* and negative thoughts but denied thoughts of harm to herself or others. On 24 October 2012, she was reviewed by Dr Wong who advised that she should continue to work with the CATT team, *to ensure close monitoring of her mental state for admission if necessary.*

    She was discharged by the CATT team on 24 October 2012, with the Discharge Summary stating that she had, *Poor self-care... Looks tired and worried... and was experiencing distress... and anxious ++ in affect.* She was also described as, *having very limited insight, judgement impaired, reluctant to continue medication stating medication was making her worse, and not wanting CAT to engage with her.* The CAT team determined that there was, *nil acute self-harm risk.* Recommendations for future non-institutional management were also made.[7]

---

[6] Exhibit 12, (rest of brief) at page 189.

[7] Exhibit 12 page 127-29.

14. On the afternoon of 26 October 2012, Esther went missing from her home while being cared for by a responsible family member. Her husband together with her immediate family and friends spent the day looking for her without success. In the early hours of 27 October 2012, she returned home with bruises and scratches and told her husband that she had tried to kill herself by jumping from a road bridge between Doncaster and Balwyn, near the Eastern freeway.[8] That afternoon Mr Mok resigned from his position to look after Esther. He recalled that she had never previously told him that she wished to kill herself but had from around August, September 2012, begun to tell him that, *he should look after their children if she was not around.* [9]

Inpatient stay at Upton House

15. Later on the morning of 27 October 2012, Mr Mok took Esther to Upton House where she was admitted as an involuntary patient under Section 12 of the Mental Health Act, 1986.

16. On call medical officer, Dr Thinear Phyo implemented the Mental Health Inpatient Form and recorded a diagnosis of major depression with suicidal ideation. Dr Phyo noted that Esther was anxious and was obsessed about her medication and resistive to hospital treatment. Esther was admitted to Upton House's Low Dependency Unit (LDU). Dr Phyo completed the Clinical and Risk Assessment noting that Esther was a medium risk of self-harm and placed her on 15 minute observations. Nursing notes made at 12.30pm on 27 October 2012 record that she was reluctant to speak to clinicians, *fearful about hospital, ruminating that she will be tied up in hospital.*[10]

17. Consultant Psychiatrist Dr Jenny Babb reviewed Esther on 28 October 2012. Dr Babb noted that she was suffering from *a major depressive episode with prominent anxiety.* Dr Babb planned to decrease the Mirtazapine due to its limited effect and to commence Esther on Fluoxetine, which is often prescribed in connection with a major depressive disorder. Despite the earlier risk assessment she was nursed on a 30 minute regimen that day. [11]

---

[8] She told her husband that barriers prevented her from jumping off the bridge and that she had jumped from the ramp leading to the bridge.

[9] Exhibit 1 page 8.

[10] Exhibit 12, page 278. From my own knowledge I note that strait-jackets continued in use in Hong Kong mental hospitals this at least from 1983 until mid-2002.

[11] Exhibit 12, 283-84

18. On 29 October 2012 Esther was seen by Consultant Psychiatrist Dr Simone Keogh. Psychiatric Registrar Dr Kwong Yeang also attended the review.[12] Dr Keogh's statement indicated that Esther presented as very guarded of her mental state and refused to answer some questions saying that, *you'll keep me in hospital.*

19. She kept reiterating that she was fine and wanted to go home. Her judgement was described as impaired, and her insight as poor. Dr Keogh reported that it was difficult to accurately assess but diagnosed Esther as suffering from, *a major depressive disorder possibly with psychotic features.*

20. Dr Keogh requested further investigations to ensure that there were no serious injuries from Esther's fall and blood tests to investigate any organic causes of her psychiatric symptoms. Dr Keogh directed that Esther be continued on Mirtazapine as an antidepressant and Benzodiazepine as necessary. Due to concerns about weight loss she was to be weighed every second day. The LDU Clinical and Risk Assessment undertaken by Dr Keogh recommended that she remain on 15 or 30 minute observations, until 3 November 2012.

21. Esther did not improve and by 1 November 2012 was refusing food and most fluids, stating that she could not eat due to her anxiety. Her husband observed that,

    After the first few days Upton House was too much for Esther. All the other patients they scream, they cry, they talk irrational thoughts. Esther cannot stand this, it is all foreign to her because she still has her mind and she cannot stand being in there. The first few days were OK... but after this it got too much and Esther began to lose her appetite. The panic attacks came back and became very frequent. Esther was in a female ward so I could only spend time with her in the lobby. I think she was probably most afraid at night when she was all alone in the room by herself. [13]

22. According to staff, Esther was also isolating herself within her room. In the circumstances Dr Keogh considered that her depression was demonstrating agitated features and possible psychotic features and therefore that Electro Convulsive Therapy (ECT) was appropriate. A second opinion on the suitability of ECT was sought from Consultant Psychiatrist, Dr Amit Zutshi.

---

[12] See Statement of Dr Keogh for details of assessment and notes of assessment, Exhibit 12, pages 287 to 290.

[13] Exhibit 1 page 9.

23. Dr Zutshi reviewed Esther and recommended ECT. Both Esther and her husband were worried about her undertaking such a course.

This was a very traumatic decision for me to make. Even when my wife was being told about this she jumped in fear... For my wife and I we cry and then we make the decision that it is too hard and too much to make this sort of decision. After two more consultations with other doctors, who also recommended the ECT treatment would be good for my wife, we agreed for her to have the treatment.[14]

24. Esther was also noted by staff to be *very anxious and afraid about ECT*, but the treatment went ahead and she received her first ECT on 2 November 2012. Dr Keogh did not see Esther again.

25. Psychiatric Registrar Dr Yeang reported that prior to her ECT on 2 November 2012, Esther was extremely anxious. Dr Yeang reviewed her again with her husband, after the ECT and found that she was still +++ *anxious and catastrophizing with minimal insight but clearly an early response. Had an improved level of agitation and was more able to sit and discuss treatment logically. Esther also ate lunch in the dining room with other patients. She remained perplexed and preoccupied.* She commenced her on oral Olanzapine as discussed with Dr Zutshi. Following her second ECT on 5 November 2012, Dr Yeang reviewed her again and noted, *a slight decrease in her degree of anxiety but remains perplexed, preoccupied.*

In a later observation he *observed her with her husband David very briefly to provide feed-back and I felt she was improved with treatment. I specifically pointed out that she had smiled for the first time that staff on the ward had seen.* [15]

26. Prior to this time Mr Mok had brought her items from home. These included a belt, this because she had complained she had lost a lot of weight and that her jeans kept falling down. On arrival Mr Mok became worried about leaving Esther with a belt.

27. He then recovered the belt intending to take it home. Esther saw him doing this and took it back.

---

[14] Exhibit 1 page 10.

[15] See exhibit 3 page 4.

I know this might have been a mistake on my behalf but at this time I was so exhausted and worried for my wife and family that I do not believe that I was able to think rationally. Upton House did not check the items I took in for my wife and there were no guidelines provided to me or my family as to what I could or could not bring.[16]

6 November 2012 [17]

David Mok.

28. On Tuesday 6 November 2012, Mr Mok arrived at Upton House at an uncertain time, which he testified was in the morning. I note here that it has been recorded in the clinical notes that, *he visited all afternoon*. I also note the visual observations of Esther for the morning of 6 November.[18] Having regard to the limits on the areas Mr Mok was allowed to access within the ward and the visual observation record together with the rest of the evidence, I find that I am not satisfied that Mr Mok was present during the morning, but that I am satisfied that he was present continuously during the afternoon.

29. He reported that she was unstable over this period.

30. He had to leave at 6.30 pm in order to look after their children and not at his usual departure time of 9 pm. His son had a Year 12 exam the following day and his intention was to take both children to his mother's home for dinner.

31. On departure he told the nurse Tim that Esther had not been well and that she needed to be looked after and monitored.

I also reminded him to give Esther her Valium, and to stabilize her. My wife was very agitated, pacing on the spot. She asked me to stay and keep her company. This was the first time she had asked me to stay. I was walking to my car when I received a call from my wife asking me to return. I told her I had to take our son to my mother's for dinner so he could prepare for his exam the next day.[19] The emphasis is mine.

---

[16] See Exhibit 1 page 11.

[17] 6 November 2012 was a public holiday in Victoria, celebrating the running of the Melbourne Cup.

[18] Exhibit 12, page 277.

[19] Exhibit 1 page 11. See also his further evidence in regard to Esther's newly observed pacing behaviour at transcript 33, where he stated reference the pacing, *keep on stepping on herself and then keep on talking…* Question: stepping up and down in the one place? *Yep. Yep.* Question: So she was sort of pacing but on the one spot? *Yep. That is the first time I see her doing like that.* Question that was the Tuesday? *That was the evening... When I left the hospital, before she commit suicide.* (And later)… *For that day but for the whole day I see her do something like that for just a very short*

She called him again about ten minutes later to ask him to return but he was unable to. At 9.30 pm when he and his children had returned to the house Mr Mok received a call from Upton House informing that Esther had committed suicide. This was kept from his children until his son had finished his exams a few days later.

Upton House never told me what had happened to my wife and the full details of how she had killed herself... We asked him how my wife killed herself and the general manager told us, that he could not tell us. We still have not been told the full circumstance. I do not know how my wife hung herself and what she used. I can only guess that she may have used the belt I gave her.[20]

Nurse Tim Lengyel.[21]

32. In his written statement Nurse Lengyel (Tim) stated that on 6 November 2012, he was the afternoon shift duty nurse responsible for the care of Esther. This was the first occasion on which he had nursed her. Her husband was with her for most of the afternoon and departed at around 6.30 pm. Before leaving he approached the nurse's station and stated that she wasn't well. *Esther appeared anxious and hyper-vigilant but denied feeling this way. I offered her PRN medication but she refused.* [22]

---

period... But before I leave the hospital she had been like that for more than an hour. And you hadn't seen that behaviour before? *No, not before that day.*

[20] See Exhibit 1 page 12. Mr Mok was informed that the available evidence did not support the suggestion that his wife had used the belt he had brought from his home, to carry out her purpose.

[21] RN Lengyel (Tim) testified that he had 16 years' experience as a nurse, and was a Registered Nurse Grade 2. Transcript 138 and 159. During this time he worked mainly in psychiatric care. By the period under examination he had worked in psychiatric care at Upton House for a period of 10 years. Transcript 160-1. I further note that he was described by Associate Professor Katz as a very experienced psychiatric nurse and as someone who approached his work in a *diligent manner*.

On 6 November 2012 he was on duty between 1.30 pm and 10 pm. He was at the time a medication endorsed Division Nurse responsible for the care of Esther. His duties included handling a case load of 5 patients, ensuring that they received appropriate medications and making sure that visual observations for the whole of the LDU were carried out and chartered on time, this during rotating hourly periods shared with colleagues over the course of the shift. His duties also included relieving in the High Dependency Unit (HDU) and attending Code Grey calls to provide a security backup as required. See exhibit 2 page 1 and transcript from page 102.

[22] Hypervigilance is described as an enhanced state of sensory activity accompanied by an exaggerated intensity of behaviors whose purpose is to detect threats. Hypervigilance is also accompanied by a state of increased anxiety which can cause exhaustion. Other symptoms include: abnormally increased arousal, a high responsiveness to stimuli, and a constant scanning of the environment for threats.[1]

In hypervigilance, there is a perpetual scanning of the environment to search for sights, sounds, people, behaviors, smells, or anything else that is reminiscent of threat or trauma. The individual is placed on high alert in order to be certain danger is not near. Hypervigilance can lead to a variety of obsessive behavior patterns, as well as producing difficulties with social interaction and relationships.

33. At 8.00 pm he gave her 5mg of Olanzapine as chartered on her drug chart. He noted in his statement that she was difficult to engage at length and was guarded about her mental state, but denied any psychotic disturbance.

34. He further stated that she was sighted by her bedroom *at 9.00 pm and also at 9.10 pm by night staff. At approximately 9.23 pm, she was seen hanging by a cord on her bathroom door. A Code Blue was called and on arrival he lifted her off the door and commenced Cardio Pulmonary Resuscitation (CPR).* After arrival of the Code Blue team, CPR was continued for a period and later she was transferred to the ICU.[23]

35. In oral testimony Tim further testified that part of his duty while working with Esther included visual observation, *and part interaction with the client to assess their wellbeing, their mental state... and to document that in the notes.*[24]

36. At that time in the LDU a duty nurse would do all of the visual observations for each of the 20-21 patients over a particular time period and record the fact of those observations on each patients observation record. As Esther was one of his allocated patients on 6 November 2012 his duties also called upon him to interact with her so that he might assess her mental state and wellbeing.

37. *Some patients were on 60 minute observations and some on 30 minute observations, probably there wouldn't have been too many on 15.* [25]

38. He received a handover in respect of Esther at approximately 1.30 pm. He had access to her file but was unable to say whether he had familiarized himself with it.[26] He was aware that Esther had had ECT and was also aware of her medication. He further testified that he introduced himself to her at around 3.30 pm having not previously spoken to her. *At the time they were in the family room and her husband was present. She seemed mildly anxious ... she looked quite tense. She was standing up. She didn't want me in the room. She was sort of ushering me out, saying no, no. She didn't want me to talk to her... I said well OK. I will come back later.*

---

[23] Ibid page 2. The Code Blue team were called to provide specialist resuscitation services.

[24] Transcript 74.

[25] Ibid and 75 also at Transcript 180.

[26] Transcript 77.

39. At around 6.30 pm Esther came to the nurse's station with her husband. Mr Mok spoke with Tim about his concerns and belief that his wife was unstable. Tim then let Mr Mok out of the ward. At this time, Tim observed she appeared, *clingy to her husband because she didn't want him to leave.*

40. I note here that this approach and Mr Mok's comments and his request (to Tim), as well as their brief discussion at 3.30 pm, were not documented in the clinical notes but were both referred to in his undated statement to the court, which was made soon after the events under review. I also note that the 7 pm visit to Esther was not referred to in either his first or second witness statement, but was referred to in the relevant visual observation chart.[27]

41. Tim was asked whether he had undertaken a mental state assessment. Tim again stated that he had only very limited discussions with her. He could not say that he asked if she was feeling suicidal or if she was so asked that she had actually volunteered a response to such a question.[28]

42. Question: *Was there a difference in her presentation from the time that you observed her (at the nurses' desk) to when you had initially seen her in the family room?*

    Answer: *Yeah she was more anxious at the time. I didn't actually overtly notice her... it's called "hypervigilant", very restless... I believe her husband described it. I didn't notice her wringing her hands...she was walking around but as far as her really lifting her feet up and down and pacing up and down on the spot, I don't recall noticing that... I know he was concerned he spoke to me about that... He said he wanted her looked after and I said I would... And I offered her at the time, PRN medication and she didn't want it.*

41 Tim was further questioned about Mr Mok's earlier testimony that upon his departure Esther went to her room and that he had seen a lot of nurses congregate at the nurses station, this as he was leaving the ward. He had no recollection but felt it may have been in connection with the calling of a Code.

42 He was then asked about the suggestion of a colleague Nurse Sophie Palace, who stated that she was asked to continue on visual observations due to an incident occurring in the HDU, a

---

[27] Tim's statements exhibit 2 and 10, do not refer to contact with Esther in her room at 7 pm. However the visual observation chart at exhibit 12 page 277 at 7.00 pm does include an initial identified by him as his own, (suggesting that he did make contact with Esther at this time). See transcript page 98.

[28] Transcript 87-88.

Code Grey requiring staff assistance.[29] According to Tim this was not related to what occurred or may have been observed when Mr Mok left the unit.

43 Later Tim testified that he returned to Esther's room at 7 pm, which was his first opportunity to observe her following his attention to other matters. He was on observation duty in respect of Esther and others for one hour from that time.[30] She seemed guarded in her presentation and stated that her husband, *made her feel anxious. She didn't want to talk to me... The only thing I did get out of her was this... statement that she made,* (concerning her husband).

44 Tim next saw her at 8.00 pm and administered her prescribed Olanzapine. 5mg. *She said she was OK but again she wouldn't elaborate. It was a very superficial type of interaction with her.*[31]

45 *She appeared calm.* There were no verbal communication problems between them but again, *she didn't want to talk to me. The only thing I got out of her was that... her husband made her feel nervous... She didn't want to communicate.*[32]

She was sitting on her bed and took the medication without apparent difficulty. At this time he did not observe her display her previous level of agitation or hyper-vigilance... *At 6.30 pm she did seem more anxious and agitated... and restless.*[33]

46 Tim was then asked whether he agreed that he was not able to make a *good* mental state assessment of Esther at the time of his observations.

Answer... *but I feel that I was experienced enough to understand that she wasn't doing very well on the ward. Her anxiety levels were high. She was not wanting to engage with anyone. She wasn't really participating in the ward. She was keeping to herself. She was in her room a lot, or with her husband.*[34]

47 Tim was also questioned about the Clinical and Risk Assessment form dated 6 November 2012 and marked exhibit 2(a) 8.30 am, which had been marked with Esther's full name and

---

[29] Transcript 102-103. See further evidence at transcript 202 concerning his offer of PRN medication at 6.30 pm. *Well I believe I did offer- I said I can offer her a PRN and she refused it. I mean she was very anxious.*

[30] Transcript 98. He was responsible for the observation of all 20 patients in the LDU for one hour from 7.00 pm.

[31] Transcript 81-85.

[32] Transcript 87.

[33] Transcript 88-89.

[34] Transcript 92. An Eastern Health LDU Clinical Risk Assessment form was not filled out in respect of Esther. See exhibit 2 (a).

that she was on 60 minute observations, but with the assessment itself not otherwise completed. This document had been initiated by the contact nurse responsible for Esther during the morning shift, Gael Balogh and was not part of the handover. [35]

48 Tim further stated that in any event the (incomplete) Clinical Risk Assessment would not have been with Esther's file, but rather on a separate clip board, with 20 other assessments.[36]

49 Tim was then asked about his statement that Esther was later sighted in her room at 9 pm and later found at 9.23 pm, hanging by a cord on her bathroom door.[37] He was not the person who made the 9 pm observation or found her at 9.23 pm, but answered the code blue alarm and came to the scene.

50 He found Esther hanging from what he described as a dressing gown cord light in colour, which had been draped over the partly closed bathroom door. Later Esther was taken to the ICU where she remained until her death on 13 November 2012.

51 Tim observed that, s*he was wearing jeans and a top, a t-shirt or something. The cord was hanging across the right side of the door as he faced it and was tied with a knot and looped around Esther's neck and over the top of the door above her head.*[38]

52 The cord was thought by Tim, to be from a dressing gown. Aware from the evidence of her husband that she did not bring such an item from home Tim believed that, *it might have come from someone else's room as we don't give out dressing gowns.*[39]

---

[35] Transcript 177-9.

See also RN1 Balogh's statement, exhibit 5 and evidence from 371, in which she agreed that she commenced but did not complete, the Clinical risk assessment form exhibit 2(a).

The Clinical risk assessment form was supposed to be completed each morning and was a mental state assessment undertaken by each patients am shift contact nurse. See transcript 140. Nurse Balogh testified that she could not explain why exhibit 2(a) had not been completed. I note here that Nurse Balogh did not give a statement about the matter until one was requested through EH solicitors in June 2015, some two and one half years after the events in question. I further record that at 2.50 pm on 12 November 2012, she completed progress notes where it is stated,

nursing am Esther nursed in LDU 60/60 visual observations, appears hypervigilant, but can be encouraged into communal areas, also encouraged to play table tennis for a short period, appears to be slightly less anxious but stating "I am scared," and holding back when encouraged to leave gender sensitive area with some interaction with co patients selectively. See exhibit 12 page 307.

This note was not (and does not purport to be) a mental state assessment. See finding in regard to Nurse Balogh's post 2.50 observations, at paragraph 141 below.

[36] Transcript 98.

[37] Transcript 109.

[38] Transcript 109-113. The cord itself was not leather and was not a belt. It was made of a light fleece like material.

53 His later testimony was that in his opinion, given her presentation it was not likely that Esther would have entered another patients' room and taken away a dressing gown cord.[40]

54 Tim was then asked about changes introduced in ward design since that time and spoke of the extensive alterations designed to remove hanging points. In response he further testified about the process change under which a duty nurse would be allocated up to five patients on any one shift, and take on all responsibility for observations and risk analysis for those patients (only), over that period. [41]

55 Additional questions were then put concerning Tim's interaction with colleague Nurse Palace. He recalled that during the evening shift she had conducted some of the observations of Esther, following his own. He had no recollection of conveying to her the concerns expressed to him by Esther's husband on his departure, or any similar concerns he had for her well-being. *I can't recall saying anything to her.* If he had communicated such a message to a colleague he, *would probably not have documented that fact.*[42]

56 His further testimony was that he was not familiar with the clinical aspects of ECT, but that *there had been talk among his colleagues about the risks for an increase in suicidality following ECT.*

57 He did not know if Esther's bag had been searched on her admission. Items from such a search, which might constitute a threat would not necessarily be confiscated and may be left with the patient with such items now only prohibited within the High Dependency Unit. (HDU).[43]

58 In response to further questioning by Mr Mok, Tim stated that he did offer Esther medication when he (Mr Mok) left, and again when he did his 7 pm visual observation. He was then

---

[39] Transcript 110. The cord may have been obtained from another patient and at that time patient wardrobes were not provided with locks. Transcript 150, and that belts were commonly possessed and used by patients within the LDU, Transcript 152.

[40] Transcript 154. See again discussion at transcript 183 concerning the clinical record for 6 November 2012, am where Esther is reported by RN Balogh as saying that she, *was scared,* and of her, h*olding back when encouraged to leave a gender sensitive area with some interaction with co-patients selectively.*

[41] Transcript 114. These included alterations to bathroom doors as well as to handles and tap wear. See also the statement and evidence of John Daley the Upton House Manager, concerning alterations and improvements made within the unit, found at exhibit 7 and transcript from 692.

[42] Transcript 115.

[43] Transcript 120.

asked what the hospital should do if a patient rejects medication. Tim answered that she, *refused the medication.*

59 Mr Mok had stated that he regarded Tim, to whom he chose to speak, as a supervisor of the nurse that looks after Esther... *I was just looking for someone who had great authority to do something*... In response Tim agreed that he conveyed that he had a lot of concerns over his wife... *I couldn't force medication upon her short of holding her down and injecting her... that wasn't warranted... She didn't refuse her medication at 8 o'clock (and) seemed a lot less anxious. She was sitting in her room. She wasn't pacing.*[44]

60 Coroner: *Are there any circumstances in which such concern from a close family member might result in the calling of a doctor to review the patient...*

Answer. *There could be circumstances where that's done... I understand there were lots of concerns about the patient... I was extremely upset and surprised by what happened.*[45]

61 Mr Mok further questioned the witness about what he described as the failure to provide immediate attention, after his departure. Tim confirmed that during the 25 minutes to 7 pm, *there were a lot of people in the office as you said... at some point there was a Code Grey going on. I don't know what the reason was for not directly speaking to her was... possibly an oversight.*

62 Mr Mok: *My words were not paid attention to by you?* Answer. *No that's not the case. I couldn't sit with your wife one on one... up until that point she was quite um, not wanting to engage with the nursing staff.* [46]

63 Coroner: *What about transfer to the HDU?* Answer... *Oh well a Consultant would have to be informed... Would have to speak to the on-call consultant and there would have to be justification for doing that.*

64 Mr Mok then asked whether someone on 60 minute observations might be put on more frequent observations (having regard to a changed mental state). Tim agreed that such it could have been changed to 30 minutes, *but then a similar situation could have arisen.*[47] Each patient was required to be sighted with particular regularity during the course of their

---

[44] Transcript 128.

[45] Transcript 128-9 and 143.

[46] Transcript 130.

[47] Transcript 131 and 146-7.

inpatient admission and these sightings documented. The sighting involved a general check that the patient was alright, some interaction with the patient where appropriate and observation on what the patient was doing. The frequency of the observations was determined by the treating Consultant on admission and thereafter as determined by the Consultant and Registrar in conjunction with nursing and allied health staff.

65 The witness was then referred to a document headed The Mental Health Program Clinical Assessment and Management Practise Guideline, exhibit 2(c).[48] Tim was not familiar with the document, which was later admitted by consent as the applicable guideline at Upton House relating to clinical assessment at the time of Esther's death.[49]

66 His later testimony was that he was not unfamiliar with the risk assessment criteria set out in exhibit 2(c). He further testified that he had training in the conduct of mental state assessments and the completion of risk assessment forms like the incomplete form at exhibit 2(a).

67 One such assessment would be carried out within the LDU on each day and the previous days assessment would be considered during a morning handover.

68 Tim was then questioned about his visit to her room at 7 pm when she was said to have appeared calmer and whether this appearance may have masked the fact that she had already decided to commit suicide. Tim was unable to offer an opinion on this matter and stated that this was the first time he had, *come across someone committing suicide.*

69 Tim was further questioned about the new arrangements which existed at Eastern Health and confirmed that there were a total of 25 beds within the unit with 20 within the LDU and 4 within the newly named Intensive Care Area (ICA) with one swinging bed. Under present arrangements the handover is now performed by the outgoing shift supervisor to all incoming staff with outgoing staff remaining on the ward to continue to care for the patients.[50]

70 Tim also felt it important under the new arrangements to try to make contact with the outgoing contact nurse in respect of each of his five allocated patients.[51]

71 He might also be called to provide relief within the ICA.[52]

---

[48] See exhibit 2(c) and transcript 155-6.

[49] Transcript 136-7, including discussion as to reference to, *last review date (26/07/2013).*

[50] Transcript 165-6.

[51] Transcript 168.

72 Under the old system in use at the time under examination Tim reiterated that as the contact nurse he would have access to her file, but that file would not include the current day's observation sheet. The frequency of the visual observations would also be recorded, with the entry on 2 November 2012, (page 304) stating that Esther has been nursed in LDU on 60/60 visual observations. This change was approved by Dr Yeang.[53]

Each patients clinical file would be kept at the nurses station and he would familiarise himself with these, if I haven't nursed them before, after he had received a hand over.[54]

73 Tim further confirmed that he took Mr Mok's' concerns about his wife seriously, *because of his unique position as a regularly visiting family member. They know the person better.*

74 This concern was not conveyed to incoming night shift staff, but under the new arrangements for a bedside handover, a discussion now takes place between the incoming and outgoing contact nurse at which such matters might be passed on, in addition to the handover by the outgoing shift manager.[55]

75 Tim was then taken to his first statement, which was undated. His testimony was that he signed it approximately four days after the events under examination. He also confirmed that the medication Olanzapine was given by him at 8.00 pm, and that his initials appear on the record of that intake.[56]

76 Following the receipt of further evidence concerning his involvement in responding to an uncertain number of Code Grey calls that evening, Tim was requested to make a second statement concerning that matter. In that statement,[57] he stated that on the PM shift, on 6 November 2012, he was assigned to the Code Grey role along with one other nurse. There were three Code Grey's involving staff from Upton House. These codes occurred between 7.10 pm and 8.39 pm.

77 From the security incident report, Tim stated that the codes in which he was involved occurred between 7.10 pm and 7.51 pm, relating to a patient who had to be transferred from

---

[52] ICA is a reference to the Intensive care area within Upton House. Transcript 169.

[53] Transcript 172-3. Dr Young in the transcript is a reference to Dr Yeang

[54] Transcript 175.

[55] Transcript 187.

[56] Exhibit 2(f) and Transcript 210.

[57] Exhibit 10.

the seclusion room; 19.11 and 19.14 in the Adolescent Unit, (*I have no recollection of attending this code. It is possible that my colleague "JC" attended the code in the Adolescent Unit as I would have been involved in the ongoing code in Upton House*); and between 8.31 pm and 8.39 pm, which involved the escorting of a female patient.

78 His further evidence was that he believed that his involvement with these codes would not have impacted upon his interactions with Esther.

Registered Nurse Sophia Pallis, (Sophia)[58]

79 Sophia stated that at approximately 1.30 pm on 6 November 2012 she received a handover on all of the Upton House in patients including Esther. She was not specifically allocated Esther as a contact patient. Sometime prior to her commencing visual observations (at approximately 7.45 pm) she had her first contact with Esther when she was walking in the hallway near the staff base and saw her standing with a male now known to be her husband, David Mok. Mr Mok approached her asking to be let out of the unit, which after making appropriate enquiries, she then arranged.

80 Sophia next observed Esther at approximately 8.00 pm in her room. Thereafter at approximately 9.00 pm, she completed her final round of visual observation on all patients and saw Esther resting on her bed.

81 Sophia was due to hand over observations to another nurse Jenny Ung, who had been allocated to undertake the 9.00 pm to 10 pm observations, but due to a Code Grey occurring in the HDU requiring all staff assistance she continued on visual observations. At 9.10 pm Sophia observed Esther standing in her room.

82 She completed another round of half hourly observations as she felt this was necessary for the safety of the patients and at approximately 9.29 pm she observed Esther hanging from the bathroom door in her room. She called a Code Blue and staff responded immediately. Tim Lengyel arrived (according to him at 9.23 pm), and helped move Esther to the floor and commenced CPR. Esther was later transferred to the ICU of Box Hill Hospital.

83 Esther did not regain consciousness and passed away on 13 November 2012 in the ICU of the Box Hill Hospital.

---

[58] Sophia Pallis is a registered nurse who at the time of making her statement, (see exhibit 10 page 48, dated 30/1/2013), was completing her nursing graduate programme with Eastern Health Mental Health Program.

Associate Professor Paul Katz [59]

84 Associate Professor Katz described conditions within Upton House and its purpose as at November 2012. There were 25 beds in the LDU with a nursing staffing ratio of two to five. In reference to patients thought to be at risk of suicide, at the relevant time the Unit operated under the Mental Health Clinical Risk Assessment and Management Practice Guideline.[60] In the LDU, the risk assessment outcome carried out under the Practice Guideline, determined whether patients were managed at Upton House in the LDU or rather within the intensive care area (ICA). According to the witness Esther's suitability for ongoing management in the LDU was reassessed in accordance with the guidelines on a daily basis.[61]

Ligature points

85 As of 2012 modifications have been made to the en-suite bathrooms including recession of basin taps and toilet holders. Further, all shower screen curtains were removed. Subsequently, the sash windows in the bedroom were replaced with fixed aluminium windows with internal venetian blinds.

86 Following the death of Esther, Eastern Health also made the decision to modify the doors to the en-suite bathrooms. This involved removing on an angle, approximately 50 cm and from both the top and base of the door.[62]

87 Eastern Health has conducted annual ligature audits in all of its inpatient units.

Personal possessions deemed to contribute to risk.

88 In respect of personal possessions there was no policy in place that required visitors to submit clothing items they brought into the LDU, to be searched and assessed by staff. In the event that a carer or visitor did bring in a belt for a client in the LDU to wear it was not the policy or practise of staff to remove it.[63]

---

[59] Professor Katz is the Executive Clinical Director of the Mental Health Program at Eastern Health and the Clinical Director of Adult Mental Health at Eastern Health. He did not see or otherwise provide treatment to Esther.

[60] See exhibit 2(c) also attached to witness's supplementary statement at exhibit 8(a). The guideline was introduced in July 2012.

[61] Exhibit 8(a) page 3.

[62] Exhibit 8(a) page 3. The audit committee is comprised of a maximum of three people normally a quality director, the manager of the unit in this case the nurse unit manager and an unspecified third person. Transcript 521-22.

[63] This policy guideline has now been changed to include belts. The 2014 Eastern Health policy, Conducting searches of Consumers and their Belongings and Inpatient Units ...extended the category of inappropriate items to include belts. Exhibit 8(a) page 4.

89 In further oral evidence Associate Professor Katz stated that a new policy, entitled *Conducting searches of consumers and their belongings in inpatient units (Mental Health Programme) practise guideline*, now used at Upton House, listed belts as an inappropriate item to be brought into the unit. Families are however not searched for belts, families might be asked if they are unsure of the suitability of a particular item they should seek advice from a member of staff... *We don't routinely search visitors or family members who visit the LDU.*[64]

90 Associate Professor Katz was then questioned about the Chief Psychiatrist's guideline for searches to maintain safety in an inpatient unit, introduced post the introduction of the Mental Health Act 2014. He was specifically referred to the Overview section and to its reference to, *dangerous and* inappropriate items,

Which *are objects or substances that are seen to be unacceptable possessions for patients receiving treatment and care from a public mental health service because they have the potential to place themselves, visitors, and staff at risk of harm to self or others... the list includes drugs of addiction, weapons, explosives, chemicals and other hazardous substances... For patients admitted to an inpatient service, dangerous items may also include prescription over the counter medication and any objects that may assist a suicide attempt, for example plastic bags, scarves, belts, shoelaces, and headphone cords.* The emphasis is mine.

91 In response, Associate Professor Katz stated that it remained a balancing act between having a safe and a therapeutic environment and later touched on prediction of suicide and the prevention of that... *the practise currently is not to routinely search every single visitor to inpatients specifically in the low dependency unit ... and I would feel really uncomfortable with that if that was going to be introduced.*[65] And later, *we certainly don't remove belts and dressing gown cords from patients in the low dependency area. Careful consideration would be given to once again removing it from a particular patient. My response to that would be*

---

[64] Transcript 119 and 525-6 and Eastern Health Searching Practise Guideline at page 2, an attachment to Associate Professor Katz second statement at exhibit 8(a).

[65] Transcript 531-2. For completeness I now attach a copy of the Chief Psychiatrists guidelines to the exhibits list at exhibit 11. The remainder of the Brief will now become exhibit 12.

that if a patient is such a severe risk then certainly if it was my patient I would want them in the intensive care area.[66]

92 In regard to the searching of patient's possessions to take away potentially dangerous items like a belt, Associate Professor Katz further testified however that, *this might occur during admission at what might be a particularly acute crisis. If there were a discerning and discreet approach I certainly would be supportive of that. If it is going to happen on a weekly basis then I would have a concern with that:* [67]

Risk of self-harm.

93 Coroner. *Is the risk of self-harm the major risk you are guarding against for people at Upton House?* Answer. *Someone who is actively suicidal that simply would be the most serious risk. That would comprise... I don't want to minimise that but that would comprise an absolute minority of patients that would be in the ward at any one time.*[68]

94 In regard to Esther, Associate Professor Katz stated that she presented as having had a major depressive episode with suicidal ideation and previous suicide attempts, *so it's the constellation of all of those not just the suicidal risk itself...*

95 Coroner. *But this was more than that... this was someone who had actually committed an act which was viewed as attempted suicide... the primary threat that was presented in her case was one of suicide, was it not?* Answer. *I would accept that that would be part of it, I would see her major depressive episodes... I'd want to tackle the major depressive episodes and try and address that as quickly as possible in the hope that that would alleviate some of the suicidal ideation. The concern would be around her suicidal ideation and we'd put in the appropriate measures to monitor that, whether it be the nursing observations, frequent reviews, but it certainly wouldn't dictate that she would go into the intensive care area... The majority of the people that I deal with in my clinical sessions in the LDU are people who are psychotic... a schizophrenic illness with substance abuse often involving ice unfortunately:* [69]

96 In answer to a further question Associate Professor Katz agreed that of patients housed in the LDU, Esther was higher up on the list of those who might commit suicide. He further agreed

---

[66] Transcript 545.

[67] Transcript 541.

[68] Transcript 534.

[69] Transcript 535-7.

that such a person would be at additional risk if she visited someone who was not identified as constituting a risk of self-harm, who lent an item such as a belt or dressing gown cord… *that patient would then ideally be placed in an intensive care area if she was actively going out to seek a means to hang herself.*

97 Coroner: *She didn't bring it (the dressing gown cord), into the hospital and we understand it wasn't brought in for her... so what should be done to try and alleviate this possibility?* Answer. *There wasn't a failure here... The system didn't identify her as someone who was about to commit suicide, or else she would have been in the HDU... it comes back to prediction of suicide and as I've mentioned... the prediction of suicide is notoriously unreliable even in the most experienced of hands. So this suicide very tragically was not predictable. She was admitted into the ward, she was seen... she went through the admission. She was seen on a regular basis by a senior registrar plus a consultant. She was observed by nursing staff. She had thorough nursing observations done. So it is exceptionally tragic what's happened but this prediction... the suicide was not predictable... So I'm not particularly optimistic about what could have been done to prevent this very tragic development:* [70]

Esther's mental state.

98 Coroner: *Some of the nursing staff during the course of her stay noted that Esther was guarded in her presentation. She was not speaking in a manner, which allowed for a (mental state) analysis to take place because she was protecting information. Does that increase the need to be conservative in connection with the items that she might have access to?* Answer: *If the patient was guarded I'd be slightly more concerned... I'd (also) have a concern if it was going to be a blanket rule, to search (other) patients. It would impact adversely on our patients who are already distressed about having to be on an inpatient unit.* [71]

99 Associate Professor Katz further stated that his understanding was that other than in exceptional circumstances, *which clinically were not indicated here, that there is no restriction at all on people wearing belts around their pants, jeans or if they do have a*

[70] Transcript 538-40.

[71] Transcript 547-9.

dressing gown. Having a cord in a low dependency unit there is simply no restriction that I am aware of in any of the metropolitan area mental health services.[72]

In respect of persons who were of concern, *the hospital might increase the observations from 60 minute to 30 minute, or 15 minutes or by transferring such persons to the HDU for intensive monitoring, but we wouldn't remove the dressing gown cord from a patient in an adjacent ward.*[73]

100 Associate Professor Katz further spoke about the importance of mental state assessments. These would be initially carried out in the emergency department usually by a senior clinician. Then once in the (LDU) ward a comprehensive mental state assessment done by one of the registrars.

Generally it will take a lengthy period to improve a psychiatric condition, if its drug induced it can take a couple of days. If it's somebody with a schizophrenic illness who has relapsed, a couple of weeks... if not much longer. In regard to depressive illness Associate Professor Katz testified that such patients, *may well fluctuate and often can fluctuate from day to day. Certainly someone with a depressive illness unless they are sharing that, that doesn't fluctuate within a day or two, so if they're major depressive illnesses if they are not sharing it, that wouldn't fluctuate.*[74] His further testimony was that staff were meant to carry out mental state assessments during the day, depending on who the staff members were.

The registrar would do a very comprehensive mental state assessment and similarly if the consultant or the patient... he would do a very formal comprehensive one and the nursing staff would certainly do an assessment um, concentrating on the areas that are being identified.[75]

101 In regard to nursing responsibilities Associate Professor Katz also testified that he would expect handovers to take place in a comprehensive and dynamic way with information handed over on an ongoing basis from shift to shift. And if things had changed of a significant nature, there should be feedback. *Nursing staff could come to a registrar or psychiatrist, pointing out concerns or changes... leading to a new approach*

---

[72] Transcript 550.

[73] Transcript 551-3.

[74] Transcript 554.

[75] Transcript 555.

102 Concerning the hourly observations Associate Professor Katz stated that he would have expected the nurse to touch base with the patient and have some interaction. Nurses would learn about mental state assessment from training and from duty. *So there is lots of formal teaching and up skilling... for both staff that have had the training and perhaps for some who have not had the training.*[76]

Electro Convulsive Therapy (ECT).

103 In regard to ECT, Associate Professor Katz testified that there were many risks associated with the use of the therapy. This had more to do with the use of anaesthetic than ECT itself. *One of those risks had to do with recovery by persons receiving the treatment to meet a depressive illness. Such persons may have experienced suicidal ideation but not have the awareness at that point in time as to how to plan and carry out an act of self-harm. It was quickly determined that ECT was an appropriate treatment for Esther...*

So what happens with ECT because of the efficacy as the depression lifts, it's false that the patients then become more energised and have the ability (to attempt suicide). So it flows out of the paradox that... that the clinical recovery from depression (not the ECT per se)... that somebody with a psycho-motor retarded depression going for ECT, there certainly would be a heightened awareness of the possibility that if they came out of this depressive illness... that would be a time of increased risk... as they are recovering from a psycho-motor retarded depression... so we would certainly raise that with our staff... [77] *Staff would be expected to be aware of a patient with a psychomotor depression. Such a patient may also display increased levels of agitation following ECT.*[78]

104 Associate Professor Katz's later evidence was that he would not be surprised in a large organisation like Eastern Health if staff were not aware of the possible connection between psychomotor retarded depression, ECT and an increased risk of suicide.[79]

It was common ground that Esther was not eating and was very quiet and contained during the early stages of her stay at Upton House.

---

[76] Transcript 599. Associate Professor Katz further testified that he was not able to state from hospital records who on staff had had appropriate training in respect of mental state assessments, and who had not. *I can't say confidently that there is an audit* (of who has had such training).

[77] Transcript 562.

[78] Ibid.

[79] Transcript 566.

105 Associate Professor Katz expressed difficulty in commenting on this issue having not seen Esther himself and because of the difficulty in closely defining the exact nature of a particular diagnosis within the spectrum of depressive illness. His view from the clinical notes was however that it was more likely that Esther was suffering from a form of agitated depression rather than a psychomotor retarded depression and that it was therefore less likely that her suicide was related to her earlier ECT.[80] (I further note here that in her initial assessment Dr Keogh, while referring to difficulties in communication with Esther, referred to Esther's agitated state and possible psychosis, but did not refer to finding evidence of psychomotor retardation).

106 Associate Professor Katz was then asked about the particular nursing clinical notes made in respect of Esther over the 1, 2 and 3 of November... *Recent suicidal ideation. Poor ideation. Poor insight. Isolates self. Past history of poor self-care... Wishes for it to end. Guarded ++ Minimising seriousness. Conscious. Unhappy with admission. Isolative. That's for the second with the third very much the same.*

107 Associate Professor Katz felt that this did not necessarily show evidence of either an agitated or a retarded depression, but that it did show she was extremely anxious.

108 He also considered that after the ECT that she had become more engaging, but that you would normally expect improvement only after three or four treatments and that it was therefore too early to attribute any improvement to the treatment.[81]

109 Associate Professor Katz further stated his view that the directions to staff on being cautious with patients who had recently undertaken ECT as directed by the Chief Psychiatrist, were broad because of the need to make people aware that people with depressive illness arising from psychomotor retarded depression may well have the energy to complete an act of suicide following ECT.[82]

110 Associate Professor Katz was then asked about Registrar, Dr Yeang's review on 2 November 2012.

---

[80] Transcript 563-4. See also exchange between Associate Professor Katz and the Coroners officer at transcript 592 where the witness maintained his view that the emergence of suicidality following ECT could not be excluded, but was not obvious from his reading of the clinical notes.

[81] Transcript 589-90.

[82] Transcript 592.

111 Officer Assisting. *On 2 November 2012, she was originally on 30 minute observations and it was decreased to hourly observations at some stage...this was during the period of time when she had received ECT therapy ... Answer so Dr Yeang records,*

"Seen after ECT with husband. Presents as still at plus plus anxious, and catastrophizing with minimal insight, but clearly an early response... A much improved level of agitation. More able to sit and discuss treatments. Not as opposed to ECT just scared. Able to have a meal at lunchtime. Husband also feels there's a slight improvement already".

So I guess based on Dr Yeang's clinical assessment, with some collateral from Mr Mok, Dr Yeung made a clinical decision to decrease the frequency of the observations.[83]

Investigation and missing dressing gown cord.

112 Associate Professor Katz was not aware of any previous case where the item used in a self-harm case within a psychiatric unit, had gone missing. He explained that in all such cases the MET team would then appropriately focus on the resuscitation. Following resuscitation the MET team would then focus on stabilising the patient and getting her to the ICU.

113 While noting the extremely rare nature of such a mishap Associate Professor Katz agreed that it would be appropriate for the Nurse Unit Manager (ANUM) to be made responsible for the collection of such an item and for the ANUM to then remain in possession of such evidence, (until otherwise informed).[84]

Observation frequency.

114 Associate Professor Katz explained that patient observation frequency is determined in a collaborative fashion by the Consultant together with the Registrar and the Contact Nurse, based upon collateral information, the mental state assessment and the assessment at that point in time based on overall risk. [85]

Further, that it does not require the nursing staff to wait for the Consultant and a Registrar to increase the frequency of observations. It is a more fluid process with nurses able to go from less frequent to 30 minute or 15 minute observations, as may be required.

---

[83] Transcript 613-14.

[84] Anum is the Nurse Unit manager. Transcript 573-74.

[85] Transcript 579.

Usually staff will be informed of such changes by way of clinical notes made by the nursing staff accompanying the Consultant on a ward round.

Such changes would be confirmed at each of the three handovers during the course of a 24 hour period. It will also form part of a handover spreadsheet, which has all patient details, their working diagnosis, their differential diagnosis, whether they are voluntary or involuntary and their level of nursing observations.

115 Associate Professor Katz further explained that when ECT is given, all patients are reviewed by the Registrar and a clinical decision is taken in respect of each patient about the frequency of observations, which may then be called for. *There are no hard and fast rules.*[86]

In regards to observations made by nursing staff, there is now a requirement that those observations not just remain on a clip board, but that they be discussed by the duty nurse with a more senior clinician and or a member of medical staff.

116 Associate Professor Katz commented, *I can't really tell you that was happening in 2012.* [87]

Bedside reviews.

117 Bedside reviews were introduced in 2014. *As explained bedside reviews are a nursing review, it is not a clinical review process, but an addition to the handover process.* The process was introduced with a view to include discussion between responsible nursing staff at handover and also to ensure the patient was part of the handover process.[88]

Anxiety level and nursing response.

118 Associate Professor Katz was then taken to Esther's level of anxiety and agitated behaviour, and her husband's plea to Tim on the evening of 6 November 2012, before he left the unit. Associate Professor Katz felt that it would have been possible for the nurse to have sat down with Esther and tried to contain her anxiety and or establish the reasons for triggering off that anxiety... *they could have shared with her some relaxation techniques to deal with the anxiety, things like progressive muscle relaxation. We've got a room, a sensory modulation room that she could have entered... a relaxing kind of ambience, including a massage chair.*[89]

---

[86] Transcript 580-4.

[87] Transcript 585 and 587.

[88] Transcript 617-18.

[89] Transcript 622.

119 Associate Professor Katz further offered that he would have expected *a non-pharmacological intervention* and then proceeded with the medication, in the event that the non-pharmacological mechanisms have been tried and exhausted.[90] Noting that she had been offered PRN medication and refused it and then gone into her room,

I think next she was quite guarded as well in terms of her wanting to communicate.[91]

120 In such circumstances Associate Professor Katz suggested that if her particular agitated behaviour was a new development he would have expected the nurse to elevate the matter to the ANUM. If he had seen it before then it may have been less of a concern. Esther's pacing on the spot such as that described earlier in evidence, *if very different, then I expect it would be escalated.*[92]

Questions to Associate Professor Katz by Mr Mok.

121 In response to questions from Mr Mok, Associate Professor Katz informed that the Hospitals psychiatric units had experienced 5 suicides since 2010, that's from January 2010 to December 2014, and that there were approximately 4000 patients that move through the unit(s) annually.

122 Concerning the question of whether Tim actually offered medication at 7.00 pm, Mr Mok suggested that Tim's failure to document his offer and Esther's refusal suggested that the medication had not been offered at all. Associate Professor Katz replied that he was unable to comment but agreed that there should have been documentation of both the offer and the refusal.[93]

123 Mr Mok then asked whether the evidence established that Esther had suffered from a high level of anxiety for the whole of the day. From the medical record Associate Professor Katz agreed with Mr Mok's suggestion. [94]

---

[90] Transcript 623.

[91] Transcript 624.

[92] Transcript 625-26. See also Mr Mok's evidence of her *pacing* on the spot behaviour observed in the hour before 6.30 pm on 6 November 2012 (at transcript 33), and further discussion at paragraph 142 below.

[93] Transcript 632.

[94] See evidence of Dr Yeung who saw her following her ECT and the observations of both Tim and Mr Mok, concerning their 6.30 pm meeting.

124 He disagreed however with the proposition that this should necessarily have led to an order for more frequent observations, or transfer to the HDU. He also disagreed with the suggestion that the matter should have been escalated to the ANUM.

It might have but I can't definitely say that should have happened.[95]

125 Mr Mok also questioned the suggestion that Esther had played table tennis and bet on the Melbourne Cup.

I was there the whole day... given her mental state, given her ECT, how can she go up to actually bet, to play table tennis and actually bet. So that's a mystery? Answer. *I can't comment on that.*[96]

126 Mr Mok then questioned whether Closed Circuit TV should be introduced into the ward. Associate Professor Katz was firm in his disapproval of this suggestion.

127 Finally Mr Mok asked, *on behalf of my family what failed Esther, the level of observations, hospital policies and procedures, the prediction of suicide, nurse training*?

128 In an emotional response Associate Professor Katz stated that,

If we stand back and look at it then we failed. But we failed because she committed suicide... We have all the processes in place as I've mentioned before but unfortunately... and this isn't going to comfort you unfortunately... There is a mortality wherever we go. One of the big complications is suicide... We have patients with those illnesses that unfortunately commit suicide... [97]

129 In later questioning by the Court, Associate Professor Katz also stated that he did not know whether Tim had been distracted from attending to Esther by other duties, following Mr Mok's departure from the ward at 6.30 pm.[98]

Finding

130 Having reviewed the evidence and the submissions made on behalf of Eastern Health, I find that on admission to Upton House on 27 October 2012, Esther Ng Kit Ching had just recently attempted to commit suicide by jumping off the ramp leading to a freeway pedestrian bridge

---

[95] Transcript 632.

[96] Transcript 635-36.

[97] Transcript 640.

[98] Transcript 641-42.

near her home. This incident occurred against a background of an increasingly severe anxiety and depression and included a brief Upton House admission some 14 days earlier. It also included a later again brief, CAT team home management, and an earlier mental health history which is set out above. I further note that over this period Esther had consistently presented with continuing deterioration and little or no insight, as well as a resistance to treatment.

131 On admission as an involuntary patient Esther demonstrated anxiety and a resistance to admission. She was assessed as being of medium risk of self- harm and placed on 15 minute observations.

132 In the circumstances Esther initially coped reasonably well, but after a few days her condition began to deteriorate.[99] This deterioration was demonstrated by increasingly guarded behaviour towards both nursing and clinical staff, a significant loss of appetite and increased levels of anxiety and agitation. It is also the case that she became very quiet and sought to isolate herself from both staff and co-patients.

133 Following discussion within the Unit Esther was subsequently reviewed by two Consultant Psychiatrists who considered that she was likely to further deteriorate towards a psychotic condition without ECT, and they therefore determined that it was necessary that she be required to undertake such a course.

134 This determination was discussed with Esther and her husband and for social and cultural reasons both found the suggestion implicit to them in the recommendation, (that she was so ill and so endangered), extremely confronting.[100] Coming from Hong Kong where ECT is less commonly employed than in this country, I find that their mutual fear and angst arising from the conclusion of the two Psychiatrists that ECT was appropriate, weighed heavily upon them both.[101]

135 Esther had been resistive to the idea that she required hospital treatment and the introduction of ECT while she was in hospital is likely to have further amplified this fixation. Her resistance to treatment and her guarded dealings with hospital staff are also likely to have

---

[99] See paragraph 21 above.

[100] See paragraphs 23 and 24.

[101] See Mr Mok's reference to this matter at transcript 41-2 where he testified to their belief as to the nature of, *shock treatment,* provided in Hong Kong Mental Health Institutions.

followed from her wish, misconceived, not to further complicate her chance of an early release by acceptance of ECT.

136 On 5 November 2012, Esther undertook her second ECT treatment and observations concerning her behaviour on that day are set out above.

137 In respect of Tuesday 6 November 2012, I have reviewed the evidence of observations made of Esther over the course of that day and find that she was anxious with sometimes agitated behaviour continuing in the afternoon. At approximately 3.30 pm Tim as her PM shift duty nurse, had attended briefly on her while she was sitting with her husband outside the female ward. His objective at this time was to attempt to undertake a mental state assessment. He was unsuccessful in this matter and was literally turned away by Esther. As a result it is clear that he recognised that Esther was avoiding contact and was not willing to speak to him in any meaningful way. [102]

138 I further note the evidence of Mr Mok concerning Esther's pacing up and down on the one spot in the approximately one hour period prior to his own departure from the ward at 6.30 pm. I have also considered the submission of Eastern Health reference that later behaviour and the submissions reliance on the evidence as to Esther's later well-being, of her morning shift duty nurse RN Balogh, whose shift finished at 3.30 pm, and to a lesser extent the submissions further reliance on the evidence of Dr Yeang, who saw Esther following her ECT on 5 November 2012 and later that evening, but not after that time.[103]

139 I have also considered the evidence of Associate Professor Katz as to the potential significance of a *new* agitated behaviour. The further evidence of Dr Keogh that pacing around the ward is to be distinguished from pacing up and down on the one spot, the latter viewed as a higher level of agitation, is also relevant.[104]

---

[102] Tim had not previously acted as Esther's shift duty Nurse and was therefore not particularly familiar with her. At this time Esther refused to engage with him leading to his 3.30 pm mental state assessment not being able to be conducted. This also occurred on a day after her second ECT treatment and when Mr Mok's concern over his wife's condition and plea for special attention was made directly to him. It was also the case that unbeknown to staff generally, Esther's morning formal mental state assessment begun by shift duty Nurse Balogh, (for unknown reason) was not completed. See exhibit 2(a).

Distinguish mental state assessments, completed each morning by the shift duty Nurse in respect of their 5 allocated patients, from nurses frequently timed visual observations and the completion of associated forms and Associate Professor Katz view of the questionable value of the later at transcript 552-53 and later at 668.

[103] Exhibit 3 page 1.

[104] Transcript 343-44. See also Dr Keogh's evidence of Esther's earlier agitated behaviour, which included 'clucking' at her, pacing around the ward and the wringing of her hands. Transcript 344-45.

140 In reference to the testimony of Nurse Balogh, apart from her observation recorded at 2.50 pm, and having regard to the lapse of time before her statement was made, I find that I can attach little or no weight to her additional evidence concerning her alleged observations after 2.50 pm.

141 I additionally note that it was Mr Mok who had spent the afternoon with Esther on 6 November 2012 and that it was he who was in the best position to observe her behaviour and comment upon changes that he observed at that time.[105] Tim's own belief based upon a limited observation that her behaviour was consistent with *hypervigilance* is also relevant. Having reviewed all of the evidence I find that I accept Mr Mok's evidence of his observations of his wife's different agitated and new pacing on the one spot, behaviour.[106]

142 At 6.30 pm Esther was taken to the nursing station by her husband who was deeply concerned about her unusual pacing behaviour and the thought of having to leave her to return home to care for their school aged children. Mr Mok took these concerns to Tim whom he reasonably saw as a person of authority in regard to his wife.

143 In response Tim told Mr Mok that he would look after her to which end he offered her PRN medication (and I am satisfied at 7 pm also), which offers she refused. Under pressure to attend to other responsibilities Tim then left Esther to deal with those matters.[107]

144 Tim later saw Esther at 8.00 pm and administered the medication due at that time. Thereafter the task of visual observation was allocated to Sophie Pallis, that is between 8.00 pm and 9.00 pm, a task which she continued until after 9.00 pm, upon Jenny Ung's request. The evidence does not suggest that Esther's earlier presentation and medication refusals were conveyed to Nurse Pallis. I further note that Nurse Pallis had increased the frequency of her own observations in light of her concern for patient safety, whilst the later Code Grey was continuing in the High Dependency Unit.

---

[105] See evidence discussed above and finding at paragraph 28 that Mr Mok was present during the afternoon of 6 November. See also Tim's rather pertinent observation concerning the need to take notice of family members discussed at paragraph 73 above.

[106] This observation took place over the approximately one hour period before his departure at 6.30 pm. Mr Mok's also testified of a similar such observation which occurred briefly earlier that day. See transcript 33 as discussed at f/n 19.

[107] See paragraphs 39 and 40 above.

145 I additionally note the Eastern Health submission that even if Esther had been placed on 15 minute observations, the incident could not have been prevented because the evidence suggests that Esther had managed to hang herself in the space of three minutes only.

146 While reminding myself that it is easy to be wise in hindsight, I find however that given Tim's failure (through no fault of his own) to obtain Esther's co-operation to achieve a reasonable mental state assessment at their 3.30pm encounter and given her history following admission and continued level of anxiety and her different and worsening agitation as evidenced by the pacing up and down on the spot not previously evident, (and her refusal of PIN medication in the setting of her husband's concerns), that there was by 6.30 pm a sufficient reason for Tim to immediately elevate this matter to the ANUM, or alternatively to himself initiate a one to one non-pharmacological intervention intended to interrupt her state of mind, and encourage her to refocus on those matters that were positive to her. I further find that such an intervention should have occurred.[108]

147 Failing Tim's availability to proceed in that manner, or Esther's favourable response to such a course of action, I find that her presentation should then have been escalated either to the ANUM, or directly to a Consultant Psychiatrist.

148 We know of course that Tim was called to other duties and no one on one care was provided to Esther at this time. I also find that it is more probable than not that Tim was called to attend to a Code Grey security related issue arising at or near the nursing station, which was also part of his ongoing responsibility. It is also the case however that in the final analysis it does not matter why Tim was called away. Clearly he left the scene to assist by addressing the Units concerns in respect of another patient care related issue. As a result the fact that he was unavailable to provide ongoing non pharmacological care to Esther and did not inform a

---

[108] See discussion by Associate Professor Katz at paragraphs 119-21, and also at 125 above.

In so finding I do not accept Associate Professor Katz opinion that by 6.30 pm, Esther's condition remained one where staff might reasonably remain confident as to her mental state and that an attempt to self-harm would not take place, or that any such attempt was therefore, *unpredictable.* See paragraph 98 above.

See also discussion by Dr Keogh about the challenges for staff, *to provide what they think is good clinical care at the same time as these other requirements*... Transcript page 329.

I note here that the evidence does not suggest that the fact that these events occurred on a public holiday was also relevant to the pressures upon nursing staff described by Dr Keogh.

superior as to what I find was Esther's by then uncertain mental state, became the critical issue as far as her care was concerned.

149 As Associate Professor Katz pointed out the prediction of suicidality is notoriously unreliable. I further find that Esther's earlier history together with the absence of what was a sufficiently stringent approach to the introduction of potentially dangerous personal items to the LDU section of the ward carried out in accord with Eastern Health practise, as well as the then availability of accessible hanging points in her room, combined to further heighten the importance of the management choices made by staff at this time.

150 It was in these challenging circumstances then that I find that insufficient consideration was given to Esther's deteriorating mental state and the need for an immediate nurse driven response to same.

151 The evidence does not establish that ECT was a factor in Esther's behaviour on the day of her death. It is the case however that Esther's general level of distress was accentuated by the need for such treatments and I am satisfied a belief that they made the possibility of her early release more remote.

152 I also find that although Esther's depressive illness has been characterized as a form of agitated depression, rather than psycho motor retarded depression that that does not reflect that she would respond to her early ECT's in a manner which made an attempt at self-harm either more or less probable.[109]

153 I additionally find that the fact that Esther acquired and employed a dressing gown cord, which was not her own and had not been brought into the ward by either herself or her husband (or other family member), underscores the need for all patients within the LDU to be managed in a uniform manner. This includes a need to henceforward recognise that all patients must be protected and that belts, cords and the like should be viewed as potentially *dangerous items* in accordance with the Chief Psychiatrist's 2014 directive, rather than as *sometimes inappropriate* as reflected in the Eastern Health LDU protocol and practise, effective at the relevant time.

154 I am further satisfied that patients lawfully admitted to the LDU are themselves suffering from serious mental illness, which matter necessarily follows from *the least restrictive*

---

[109] On the evidence only a minimal effect of the early ECT treatments could be reasonably expected.

method approach directed by the 1986 Mental Health Act. While I am mindful of Associate Professor Katz's contrary opinion I find that patients generally, as well as their families and Unit staff, should now be prevailed upon to accommodate certain personal limitations in respect of those LDU patients who are not themselves immediately at risk of self-harm, this in the interests of all patients and that Upton House LDU staff should hence forward arrange for carefully supervised admission with periodic searches of personal property in a manner that best supports this priority.

155 In conclusion I find that Esther NG Kit Ching aged 53, died as a result of a self-inflicted injury caused or substantially contributed to by a severe depressive illness. This occurred notwithstanding the support of a devoted husband and loving family who did what they could to support their much loved wife and mother. It also occurred in a setting where staff worked hard to care for patients, but under a system which I find was sub-optimal.

156 In so finding I appreciate that Upton House was and remains a very busy place and a challenging working environment with unpredictable behaviours requiring immediate attention.[110] This however was not a case where such a tragedy was inevitable.

157 Rather I find that failures in management of process some of which have now been repaired, coupled with the availability of potentially dangerous personal items, plus hanging points which might together be used to self-harm, and a management approach that allowed staff to become distracted from maintaining an appropriate level of focus on Esther's mental state, also contributed. [111]

Recommendations

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

1) I recommend that Eastern Health amends its protocol to emphasize the dangerous aspects of allowing patients accommodated within the LDU to bring in belts, cords or like, which may be employed as a ligature and henceforward institute admission and periodic search policies, which will help ensure a rigorous management of this amendment.

---

[110] See evidence of Associate Professor Katz at transcript, 671-74.

[111] As to amendments to process successfully introduced see the discussion above at paragraphs 54, 69, 70, 72, 74, 85-87, 115 and 117.

2) I recommend that Eastern Health maintains its ligature review process but seeks to ensure that a person properly qualified in psychiatric unit risk management analysis who is not part of Eastern Health hospital administration, is engaged to assist in that work.

3) I recommend that Eastern Health provide direction to senior staff in regard to the nomination of a designated person within each particular unit, to collect, preserve and provide safekeeping of all materials which are or maybe relevant to any (future) investigation into a suspected incident of self-harm. I accept Associate Professor Katz view that the ANUM in each particular Unit would be a suitable designated person.

4) I further recommend that Upton House nursing staff be counselled as to the importance of making clinical notes and completing clinical records.

In conclusion I wish to thank Counsel and Solicitors as well as the Coroners Officer and Investigator, for their assistance. I also thank all of the witnesses who appeared and particularly Mr Mok for his own participation in what for him could only have been a deeply painful exercise.

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

The family of Esther NG Kit Ching.

The Chief Executive of Eastern Health.

Associate Professor Paul Katz.

John Daley Manager Upton House.

Registered Nurse Tim Lengyel.

Registered Nurse Gael Balogh.

The Chief Psychiatrist, in the State of Victoria.

The Health Services Commissioner, in the State of Victoria.

Leading Senior Constable Tracey Ramsey.

Amended on 14 February 2017 at 2:25 pm

Signature:

Peter White
CORONER
Date: February 7, 2017.