IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2013/2761

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Majang Ngor

Delivered On:	29 May 2015
Delivered At:	65 Kavanagh Street Southbank 3006
Hearing Dates:	18-19 February 2015
Findings of:	PETER WHITE, CORONER
Representation:	Mr J Goetz of Counsel for Forensicare Mr S Cash of Counsel for Peter Barnett Mr T Ngor in person for the family of Majang Ngor
Police Coronial Support Unit	LSC King Taylor

I, PETER WHITE, Coroner having investigated the death of Majang Ngor

AND having held an inquest in relation to this death on 18-19 February 2015
At Melbourne
find that the identity of the deceased was Majang Ngor
born on 10 December 1989
and the death occurred 24 June 2013
at the Argyle Unit, Thomas Embling Hospital, Fairfield, Victoria
from:

1 (a) HANGING

in the following circumstances:

BACKGROUND

1. On 28 March 2013 Majang Ngor (Majang) was arrested by Victoria Police and charged with one count of murder and two counts of attempted murder. Victoria Police had been called to Majang's home address by neighbours where they found Majang's mother deceased.

2. Due to the circumstances of his arrest, Majang was taken to the Melbourne Assessment Prison and immediately placed in the psychiatric unit. He was reviewed by the Consultant Psychiatrist, Dr Clare McInerney, who formed the opinion that Majang's presentation was consistent with that of psychosis, and that he required urgent treatment. Dr McInerney recommended that Majang be transferred to the Thomas Embling Hospital (TEH) under section 16(3)(b) of the *Mental Health Act 1986.* He was subsequently admitted to the Argyle Unit at TEH on 3 April 2013. The Argyle Unit is a high security unit accommodating acutely ill male patients

3. On admission the TEH, Majang was assessed by Consultant Psychiatrist, Dr Prashant Pandurangi. Dr Pandurangi reported that Majang expressed a number or "bizarre beliefs including that he was related to snakes".[1] Majang also expressed thoughts of needing to kill four more people. Based on his

[1] Statement of Dr Pandurangi, IB p57

presentation on admission, he was placed in seclusion due to a high level of arousal and agitation and threats of interpersonal violence towards staff. While in seclusion he was reluctant to take his medication.

4. He remained in seclusion until 22 April 2013.[2] He was then accommodated in room 10 of the Argyle Unit and placed on 15-minute observations.

5. Majang was placed in seclusion again on 9 May 2013 following staff concerns that his mental state was deteriorating. He stayed in seclusion until 27 May 2013. On 11 June 2013, he had a video conference with his lawyers that upset him greatly, as he was informed that the Court process could take over 12 months and that he may remain at TEH for a number of years.

The Argyle Unit is a 15-bed unit. It has a small bathroom with showers that patients can use at any time. There is a disabled bathroom that was required to be locked and patients were to ask staff to unlock it if they wished to use it. The disabled bathroom contained a bath, a toilet and a separate shower with a detachable shower hose.

24 June 2013

On 24 June 2013, Majang woke at 8.15am.[3] He was administered his medication by Registered Nurse Matthew Tanti at 8.30am and then went to the dining room to eat his breakfast. Mr Tanti observed that Majang appeared euthymic in mood, he was compliant with taking his medication and was polite. He did not observe any 'signs of depressive mood or dramatic mood changes in the past 24 hours'.[4]

6. At approximately 10.15 am, Psychiatric Nurse Suzanne Egass collected the patients for morning quiz time. She was unable to find Majang and looked for him in his bedroom, the small bathroom and in the surrounding corridors. Ms Egass then checked the disabled bathroom. She found Majang:

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[2] His total of 21days in seclusion in April and 18days in May were described by Consultant Psychiatrist Dr Pandurangi, as an unusually lengthy stay, *'by the average'*.

According to Dr Pandurangi this may have contributed to his level mental illness. See transcript pages 140-41.

[3] Statement of Matthew Tanti IB p 42

[4] Ibid page 42

'Lying on the floor slightly to his right side with his head and upper body raised above the floor. There was a shower hose around his neck which was supporting his upper body.'[5]

7. Ms Egaas summonsed help from the nurses station. Ms Egaas' evidence is that she pressed her duress buzzer. Evidence of the other nurses/doctors is that she ran out to the nurses station to get help. Barrie Janson (RNdiv1), Matthew Tanti (RNdiv1), Stephen McLoughlin (shift leader), Ros Jennings (Occupational Therapist), Dr Sergei Yukhnevich (Psychiatric Registrar) and Meera Aurora (psychologist), were at the nurses' station when Ms Egaas raised the alarm.[6] Mr Janson and Mr Tanti ran to the bathroom and went to assist Majang by supporting his weight. They then removed the shower hose from his neck.

8. A number of TEH staff members attended the bathroom to render assistance. Ms Aurora started a time log of the resuscitation efforts. RN div 1 Janet Dalgleish took over the note taking. Dr Yukhnevich commenced chest compressions at approximately 10.22 am. Majang vomited in response to CPR. Emergency services were called at approximately 10.29 am. TEH staff continued resuscitation attempts until paramedics arrived at approximately 10.36am.[7] Resuscitation efforts continued until approximately 11.15am, when Majang was pronounced deceased.

Coronial Investigation

9. I was required under section 52(2)(b) of the Coroners Act 2008 to hold an inquest into Majang's death as at the time of his death he was detained in a designated mental health service.

10. I note that Majang died before the charges against him, could be heard.

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[5] Statement of Suzanne Egass IB p28

[6] Statement of Barrie Janson IB p26

[7] VACIS electronic Patient Care Report IB p107.

I received a coronial brief of evidence from the coroner's investigator containing statements relating to the circumstances of Majang's death. I also received TEH's medical records for Majang. On 18 February 2015, I conducted a site view of the Argyle Unit.[8]

Medical Investigation

11. Forensic Pathology Fellow Dr Kate Strachan of the Victorian Institute of Forensic Medicine performed a post mortem medical examination on 27 June 2013. Dr Stachan prepared a report of her findings at autopsy. Dr Strachan found multiple healed scars over the forearms, hands and lower limbs, patterned linear areas of discolouration over the anterior neck, bilateral sternocleidomastoid muscle bruising and left sternohyoid muscle bruising, left hyoid fracture and sternal and bilateral rib fractures (most likely resuscitation related).[9] Post mortem toxicological analysis of blood showed the presence of amisulpride at 3.6mg/L, (also detected in the stomach), Zuclopenthixol at 90mg/mL, valproic acid and Amiodarone. Dr Strachan noted that the level of amisulpride detected in his stomach was not suggestive of ingestion of a very large amount prior to death. She also noted that amisulpride can have a sedative effect.

Dr Strachan concluded that the cause of Majang's death was 1(a) hanging. I adopt Dr Strachan's findings in relation to the cause of death.

12. The issues explored at the inquest were

a. How Majang was able to access the bathroom.

b. Hanging points at the Argyle Unit, TEH.

c. Changes in policy or practice relating to 15 minute observations and suicide risk assessment

d. Nurse Barnett's incorrect entry on Majang's Close observation sheet

Access to the disabled bathroom

[8] See notes at transcript page 3.

[9] Autopsy Report p12

13. Nurse Egaas told the inquest that the assisted bathroom was a locked bathroom and not meant to be used. Sometimes…

'it is used'.. 'so a staff member has to open up that door'.[10]

She herself would never allow a patient to be in there by himself and would close the door after he came out, as the door did not have a self-closing mechanism and had to be closed,- which action then locks the door to those outside.[11]

Nurse Egaas further offered several hypotheses as to how Majang was able to access the bathroom. The first was that it was left ajar by someone,

'It could have been the cleaner... or another patient, who had been given access... but no one admitted to having given someone access to that room'. [12]

Another possibility was that Majang had asked a Nurse to give him access, by unlocking the door, and that the nurse just left the scene later forgetting that Majang was in there. This was considered unlikely, according to Nurse Egaas.

14. According to Nurse Barnett however, the room was in fact in regular use as a bathroom, over the period in question.

'I can't remember it not being used, (and later), but I don't think there would be a consistency among all staff.'[13]

15. Dr Magner, Consultant psychiatrist and the Clinical Director of Forensicare, offered a similar appraisal, suggesting that the policy in regard to the use of the bathroom was not certain at the time of Majang's death, and was not part of a specific written policy,

'*although it was not intended that the rooms be used while patients were unsupervised'.*[14]

Dr Magner further testified that the root cause analysis established that,

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[10] See transcript page 23.

[11] See transcript page 25.

[12] See transcript page 41.

[13] See transcript page 95-97.

[14] See transcript page 159-60.

'Patients were able to use these rooms without the supervision of staff. [15]*... We-my understanding of it was that (unlike other units), the door was left open and that sometimes patients were allowed to use the room. It was not clear whether they were supervised or not, and it was not clear to me how often that occurred.'*[16]

16. From all of the evidence I find myself satisfied that on the morning of 24 June 2013, the disabled bathroom door was inadvertently left either unlocked, or was unlocked by a staff member specifically to allow Majang's entry. I further record that I accept Counsel for Forensicare submission and find that at the relevant time Forensicare staff working in the unit (including Nurses Egaas and Barnett), undertook their supervision and care responsibilities, in what was for the most part a diligent and sensitive manner.

17. However, it is also the case that this was an acute care unit and the bathroom was situated immediately opposite to the units nursing station. While I note that there was no written policy concerning this matter, the duty to undertake appropriate risk analysis is ongoing and not dependent on the existence of a written policy. Given the practises described by Nurse Barnett, and the hypothesis offered by Nurse Egaas, each confirmed by the findings of Dr Magner, (involving sometimes-unsupervised visits to the disabled bathroom and the leaving of its door unlocked), I conclude that the management of this issue by the responsible manager, was sub-optimal.

Hanging points at TEH

18. The relevant evidence concerning hanging points within the Argyle unit focused on the disabled bathroom where Majang died, and his ability to obtain entry to that room is dealt with above. Clearly and it was not in dispute, once access was obtained the shower hose within the room provided an easily employable means of self harm, for any patient so minded to act.[17]

Changes in observation policy

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[15] See transcript page 160.

[16] See transcript 161.

[17] See Recommendation discussed below.

19. As a result of the investigation launched into Majang's death, changes were made by Forensicare to seek to ensure that,

'staff complete timed observations properly rather than just signing off that they have'.[18]

I note with approval that since the death of Majang, Forensicare has also introduced new patient observation procedures, and new assessments for the risk of self-harm, and the management of physical environment, intended to minimise the risk of self-harm.

A working party (The Nursing Observations Working Group), recommended that the practice of timed observations (15/60's) be replaced by a system of three specific levels of observation.

The three levels of observation are:

a) General – The staff on duty should have knowledge of the patients general whereabouts at all times, whether in or out of the unit;

b) Constant – The staff member should be constantly aware of the precise whereabouts of the patient through visual observation and hearing;

c) Special – The patient should be in sight and within arms reach of a staff member at all times and in all circumstances.

Further and significantly, there is now a focus on actually engaging with the patient rather than just observing patient movements and behaviour. All patients are under General observation at all times. Increased levels of patient observation may be prescribed by the Consultant Psychiatrist and assigned to patients according to a number of factors, including assessed clinical need, assessed risk of self harm or violent behaviour to others, assessed mental state and environmental issues, which are particular to each patient. Review of the need for ongoing constant observation occurs a minimum of once every 24 hours. The nurse in charge is responsible for organising the clinicians on the unit to ensure the appropriate level of observation is maintained.

Procedures have been developed for constant and special observations, which require the nurse in charge to allocate a designated clinical staff member to undertake constant or special observation of a patient for each two hour period. For each such period of observation, the designated staff member is required to:

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[18] See letter from Dr Magner, at exhibit 6, page 1.

a) Report any changes in the patients' mental state, state of mind and behaviour to the Nurse in Charge, immediately upon such change;

b) Write a report in the patients' clinical notes detailing such change and addressing each of the following issues:

i) Mental state and state of mind assessment;

ii) Changes to the level of risk;

iii) Description of level of engagement;

iv) Description of activities and rest periods.[19]

I have reviewed these policies with the assistance of Dr Magner and Counsel and welcome the considerable efforts of those responsible. I am satisfied by Dr Magner's assurances concerning the introduction of this intiative, and see no reason to believe that the changes will do other than continue to improve the quality of the observations, and the standard of clinical care.

Nurse Barnett's incorrect entry on Majang's Close Observation Checklist

20. Later that morning, Nurse Peter Barnett, (a psychiatric nurse level 2) spoke to Psychiatric Nurse Suzanne Egaas in the Argyle Wards nurses station and informed her that the record indicating that he had observed Majang in his room at 10.15 am was incorrect, and that he hadn't observed him at that time. It was common ground between them that Nurse Barnett approached her approximately one hour (or so), after Majang was found deceased in the bathroom, and said words to the effect that,

'I must admit to what I have done, otherwise I won't be able to live with myself'.

And I said,

'You need to do what you have to do.' [20]

Nurse Barnett similarly spoke to Nurse Chris Quinn informing him that he had been in charge of 15-minute observations from 10 am and that he had signed the observation sheet for 10.15 to indicate that he had seen Majang, but that in fact he had not sighted

[19] See exhibit 6 page 1-2 and exhibit 6(a)

[20] See transcript page 18.

Majang at 10.15.[21] Mr Barnett also provided a statement to that effect. Nurse Barnett again confirmed this matter in his testimony.[22]

21. Nurse Barnett further stated that at that time he was doing observations of patients in the seclusion units and had returned to the nurses office to document those observations, and then wrote on Majang's (near by) observation chart immediately afterwards.

> *' I'd written in Majang's, as I done it. And to be honest like, I actually realised it straight away that "Oh wait a second," I hadn't actually verified that. I had not actually seen him. But like it's been mentioned a lot of staff felt at that time that Majang was much more settled, in a much better frame of mind, so I didn't feel that he was,-it was probably OK to give it a miss at this time'.*[23]

22. Nurse Barnett said that on discovering his error he did not immediately go and check on Majang because he felt confident that Majang was OK.[24] He further testified that he made this recording several minutes before Majang was found hanged.[25]

23. Nurse Egaas gave evidence of a different belief, concerning the point at which the false 10.15 am entry had been recorded, suggesting in fact that she believed that Nurse Barnett's record was made only after she discovered Majang's self-harm.[26] She stated that she noticed at 10.15 am, that there was in fact no entry made concerning a 10.15 observation of Majang. She further testified that (appreciating that an observation coupled with a recorded entry was due at 10.15), that she went looking for him. It was also her evidence that an additional purpose at that time was to have Majang come and participate in a quiz she had organised for residents.[27]

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[21] Statement of Chris Quinn IB p38

[22] See transcript page

[23] See transcript page 70.

[24] I note that at the handover meeting that morning there had, according to Nurse Barnett, been talk of ceasing 15-minute observation in respect of Majang on the basis of his seemingly improved mental state. See also the evidence of the unit manager Nurse Andrew Jackson, concerning this matter at exhibit 7 page 46. I further note that Nurse Egaas agreed that Majang appeared to be in a better frame of mind. See transcript page 34.

[25] See transcript page 69.

[26] See transcript page 17.

[27] See exhibit 2 at brief page 28.

24. I draw from this evidence that even though Nurse Barnett did not attempt to observe Majang, at 10.15 am, that Nurse Egaas did in fact attempt to do so.

25. Nurse Egaas further stated that after she discovered Majang, she remained with him during resuscitation attempts in the bathroom, for about half an hour before she returned to the nurses station, at which time she noticed that he had filled in the 10.15 am observation.

26. I also note that according to the time line record taken at the nurses station later that morning, that Majang was discovered at approximately 10.20 am, and released from the shower cord shortly afterwards. Compressions were said to have commenced at around 10.22 am and the Ambulance was called at 10.24 am.[28] Prior to her unexpected discovery of Majang in the bathroom, it is also relevant that Nurse Egaas had searched the corridors and his room without success, having on her testimony departed the nursing station at 10.15.

27. Nurse Egaas also referred to the fact that she had successfully undertaken an observation of Majang at in his bedroom at approximately 10.02 am, after she discovered that the 10 am observation, also the duty of Nurse Barnett, had not been completed.[29]

As he was not in his room at approximately 10.15.30 am, or found elsewhere immediately thereafter, it follows that Majang must have left his room at sometime between 10.02.30 and 10.15 am, and made his way to the bathroom, where he obtained entry and hanged himself. I am satisfied that this occurred at between say 10.03 am, and his discovery by Nurse Egaas, at approximately 10.20 am.

28. I further note that Nurse Egaas was not in the nurses station for a continuous period of more than 35 minutes immediately after 10.15 am, and that there was ample time after her departure, in which Nurse Barnett may have entered the station and commenced his recording of observations ie, without her knowledge.

29. In regard to Nurse Barnett's observations and notes of same, and to all of the rest of the evidence, I find that both Nurses Barnett and Egaas were honest in

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[28] See exhibit 3(a).

[29] It is not in dispute that Nurse Barnett was making an observation round in the seclusion units at or about this time.

their testimony, but that Nurse Egaas has misinterpreted the evidence as establishing precisely when Nurse Barnett made his record. I further find that his false entry was made in the circumstance he described, that is before Nurse Egaas entered the adjacent bathroom, and discovered Majang, and what had earlier occurred.[30]

30. It follows, and I further find, that had Nurse Barnett actually attempted to make contact with Majang at or around 10.15 am, that it is highly likely that he would have encountered the same difficulties in locating him as those experienced at that time by Nurse Egaas.

Recommendation

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

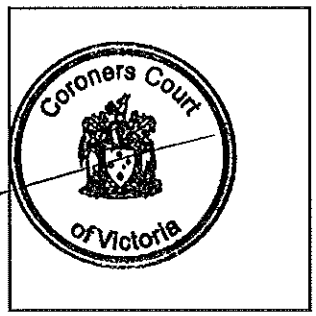
I note with approval that annual reviews are conducted at Thomas Embling Hospital to seek to identify any further hanging points within the hospital. To assist this process and in consultation with the Clinical Director I recommend that an appropriately skilled analyst, who is otherwise independent of the hospital, be invited to join that review.

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

The Secretary, Department of Health and Human Services, in the State of Victoria.
CEO Forensicare
Clinical Director Forensicare.
Nurse Andrew Jackson
Nurse Suzanne Egaas
Nurse Peter Barnett

[30] See transcript page 95-96

Signature:



PETER WHITE
CORONER
Date: 29 May, 2015