IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 0655

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: Maree Rosalie Jones

Delivered On:	26 February 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Melbourne 3006
Hearing Dates:	Directions: 30 April 2015 Inquest: 23 & 24 June 2015
Findings of:	Coroner Caitlin English
Counsel Assisting the Coroner:	Leading Senior Constable Amanda Maybury
Representation:	Mr Michael Regos for St Vincent's Hospital Limited

I, Caitlin English, Coroner, having investigated the death of Maree Rosalie Jones

and having held an inquest in relation to her death on 23 & 24 June 2015
at Melbourne
find that the identity of the deceased was Maree Rosalie Jones
born on 27 September 1965
and the death occurred on 14 February 2013
at St Vincent's Mental Health Acute Inpatient Service, Fitzroy, Victoria

from:

1 (a) PLASTIC BAG ASPHYXIA

in the following circumstances:

Introduction

1. On 11 February 2013, Maree Jones was made an involuntary patient pursuant to section 10 of the *Mental Health Act 1986* (Vic) and admitted to the Extra Care Unit of the Acute Inpatient Service at St Vincent's Mental Health. On 13 February 2013, following psychiatric review, she was transitioned to the Low Dependency Unit of the Acute Inpatient Service and continued on 15 minute observations. On 14 February 2013 at 0150, Ms Jones was found by a nurse with a plastic bag, tied with a cord, over her head. Resuscitation attempts were unsuccessful and Ms Jones died from plastic bag asphyxia.
2. An inquest was held into Ms Jones' death on 24 and 25 June 2015. Six witnesses gave evidence.
3. The main issue explored at inquest concerned the management of Ms Jones' risk of self-harm.

Background

4. Ms Jones was 47 years of age at the time of her death. She resided in Richmond with her husband, Andrew Crosby. They had been in a relationship for eighteen years and married in 2005. Ms Jones worked as a finance clerk.
5. On 13 July 2012, Mr Crosby told Ms Jones that he wanted to end their relationship. This came as a shock to her and led to a rapid decline in her mental health.

Reportable Death

6. Ms Jones' death is a reportable death pursuant to section 4(2) *Coroners Act* 2008 (Vic) as it is a death that appears to have been '*unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury*'.

Mandatory Inquest

7. As Ms Jones was an involuntary patient pursuant to the *Mental Health Act* 1986 (Vic), she was '*in care*' at the time of her death. As such, an inquest is mandated by section 57(2) *Coroners Act* 2008 (Vic).

Focus of the Inquest

8. The purpose of a coronial investigation is to ascertain if possible, the identity of the deceased, the medical cause of death and the circumstances in which the death occurred, in accordance with section 67 of the *Coroners Act* 2008 (Vic).

9. In this case, identity and cause of death are not in issue.

10. The inquest focused on the circumstances in which Ms Jones' death occurred.

11. The circumstances refer to the background and events proximate to the death. Whilst the inquiry is not confined to matters of strict causation, neither does it extend to include all circumstances, which might be part of the narrative culminating in death. [1]

12. The main issue considered at inquest was the management of Ms Jones' risk of self-harm and there were three aspects to this consideration:

- How Ms Jones had access to the plastic bag and cord;
- How patient's belongings were managed in the two units of the Acute In-patient Service and the applicable policies; and,
- An exploration of how 15 minute observations are conducted and recorded.

[1] Thales Australia Limited v The Coroners Court of Victoria and Anor [2011] VSC 133 (11 April 2011).

Sources of Evidence

13. Witnesses called at inquest were the coroner's investigator, Sergeant Mercovich, and from St Vincent's Mental Health, Consultant Psychiatrist Dr Susan Ong, Nurses Hannah Stephenson, Isabel Kiel, Soomintra Ramjagsingh and the Director of Clinical Services, Associate Professor Peter Bosanac. Mr Crosby made three statements which were part of the coronial brief and also addressed the court at the conclusion of evidence.

14. The evidence comprised the contents of the coronial brief, the oral testimony and the tendered exhibits. I have also had regard to the Chief Psychiatrist's investigation of inpatient deaths 2008-2010[2] and specifically the Chief Psychiatrist's Guideline on *Criteria for searches to maintain safety in an in-patient unit for patients, visitors and staff* referred to in the evidence of Associate Professor Bosanac.

Cause of Death

15. Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine conducted an autopsy on 18 February 2013. Dr Burke determined the cause of death as 'Plastic Bag Asphyxia.' I accept his opinion.

Health and Relationship History

16. Mr Crosby advised Ms Jones of his desire to separate, and shortly afterwards he moved from their house in Richmond to a rented flat in St Kilda. When it became apparent Ms Jones was struggling with the separation, he decided to move back home to support her.

17. From 29 July 2011, Ms Jones' GP was Dr David Marsh at Richmond Heights Medical Centre. Dr Marsh treated Ms Jones for anxiety disorder and depression following her separation from Mr Crosby.

18. Dr Marsh referred Ms Jones to clinical psychologist Paula Alexopoulos who saw her twice in August 2012, before Ms Jones requested they cease contact. Ms Alexopolous stated that Ms Jones presented as "*perplexed, angry and distressed*"[3] about the separation.

19. On 30 August 2012, Ms Jones saw psychiatrist Dr Brett Wilson. Dr Wilson noted that Ms Jones reported suicidal thoughts but they were fleeting and she had no plans. Dr Wilson diagnosed Ms Jones as experiencing a grief reaction to the end of her relationship which was

---

[2] Department of Health (Victoria) January 2012.

[3] Coronial Brief, 92.

a major depressive episode. Dr Wilson advised Dr Marsh to continue with Temazepam 10mg nocte but cease the prescribed Frisium as it was ineffective.

20. Dr Wilson stated:

> *"Although I consider Maree's emotional response as primarily a grief reaction that appears to be improving, I am keeping an open mind to the possibility that it [is] a depressive response and that she will need an antidepressant in the future. Given her recent reaction to Lexapro I believe it is appropriate to wait."*[4]

21. Mr Crosby stated:

> *"Maree had darker and more frequent thoughts about ending her life. She would speak to me about it and tell me that she wanted to kill herself...she specifically discussed putting a plastic bag over her head. "*[5]

22. Mr Crosby detailed that Ms Jones had several episodes which indicated she had suicidal intent. On one occasion she had been taken to hospital after having taken alcohol and sleeping tablets, as well as an occasion when he located her on the Monash freeway apparently contemplating driving into a pole. He stated that at the end of 2012 the CAT Team (CATT) had been to their house half a dozen times. In January 2013, there was an unsuccessful attempt to admit her to a private psychiatric facility. Ms Jones refused to stay and walked out.

Events proximate to death

23. On 10 February 2013, whilst driving home from Warnambool, (where they had been visiting Ms Jones' mother), Mr Crosby stated that Ms Jones had a further episode. She threatened to throw herself out of the moving car into traffic. She requested he take her to St Vincent's Hospital. They arrived at the hospital in the evening and she remained in the Emergency Department with a view to being admitted the next day.

24. Mr Crosby went home and returned to St Vincent's Hospital the next morning, 11 February 2013. Dr James Lay (whom Mr Crosby knew from the CATT visits) took him aside and said to tell Ms Jones that their relationship was over for good. This caused Ms Jones to become hysterical and a code blue was called. She was agitated, distressed and attempted to leave.

---

[4] Coronial Brief, 95.

[5] Coronial Brief, 12.

25. At 1100 she was recommended as an involuntary patient. At 1500 she was admitted to the Extra Care Unit of the Acute In-patient Service, as an involuntary patient, by the psychiatric registrar Dr Sarah Latowicz. Her risk of suicide and self-harm was assessed as high. The Extra Care Unit is a secure unit.

26. Mr Crosby stated that he later returned to the hospital to bring some personal items into Ms Jones including pyjamas, which had a yellow cord in them.

27. From 11 February 2013 to 13 February 2013, Ms Jones remained in the Extra Care Unit.

28. On the afternoon of 13 February 2013, Ms Jones was reviewed by Dr Susan Ong, the Consultant Psychiatrist. After that assessment she was transferred to the Low Dependency Unit and continued on 15 minute observations.

29. Ms Jones was prescribed Temazapam, a hypnotic medicine for insomnia and Diazepam, an anti-anxiety medication. She declined a therapeutic trial of anti-depressant medication.

30. On 14 February 2013 from 1215 to 0145 in the documented 15 minute observations, Ms Jones was reported to be asleep in her bedroom where she was the sole occupant.

31. At 0150 that morning Ms Jones was located by Nurse Ramjagsingh with a plastic bag tied with a cord, over her head.

32. A code blue was called and the plastic bag was removed. Ms Jones was unresponsive but there was possibly a faint pulse noted. Resuscitation efforts were commenced which were discontinued by the code blue team at 0215 and Ms Jones was declared deceased.

Risk management:

- **Plastic bag & yellow cord**

33. Coroner's Investigator, Sergeant Justin Mercovich gave evidence that he attended St Vincent's Hospital on the morning 14 February 2013, after taking the report of Ms Jones' death. Whilst walking through the Acute In-patient Unit, he noticed plastic bags used as bin liners throughout the ward.

34. In Ms Jones' room, he noticed and photographed a number of knotted black garbage bags on a shelf.

35. He gave evidence that he had a conversation with Associate Nurse Unit Manager (ANUM) Smith who told him there was a policy of no plastic bags on the ward. ANUM Smith was not called to give evidence and it appears this information was incorrect. Evidence at the inquest

confirmed that only since Ms Jones' death, have plastic bags been deemed to be a dangerous item and are prohibited in the Low Dependency Unit.[6]

36. In cross examination Sergeant Mercovich described the bag used by Ms Jones to asphyxiate herself as '*clear or white*'.[7]

37. Sergeant Mercovich could not say the bag used by Ms Jones was the same as the bags used as bin liners, but he was able to confirm that the bags he located on her shelves in her bedroom were not the same as the one Ms Jones had used.

38. The evidence suggested the knotted bags on a shelf in Ms Jones' room were on the shelving unit next to the vacant bed in Ms Jones' room and did not belong to Ms Jones.

39. Nurse Soomintra Ramjagsingh was the nurse who discovered Ms Jones and ripped the plastic bag off her face. Nurse Ramjagsingh did not recognise the plastic bag and could not recollect if it was similar to the plastic bag bin liners.

40. Nurse Hannah Stephenson stated that she thought it looked like thinner material than a bin liner, and that she could not be 100% sure it was not a bin liner.[8]

41. Nurse Stephenson was asked whether the possession of a plastic bag was at the discretion of the attending nurses. She noted: Yes, and '*...it was difficult -obviously being such a common item, difficult to monitor with the open door and the flow of clients going on leave and family members bringing items in.*'[9]

42. Nurse Stephenson was not sure where the knotted plastic bags found in Ms Jones shelves came from. She described three different types of plastic bags: white bin liners in the patient rooms, bigger bins in the tea and coffee room which had larger sort of black bags, and in the nurses station and medication room, a larger black bag used to discard medication cups and other rubbish. She added: '*...it is possible it could have been removed from the communal lounge area.*'

43. Nurse Isobel Kiel searched Ms Jones' belongings in her presence after she was transferred from the Extra Care Unit to the Low Dependency Unit. She did not recall seeing either a plastic bag or a yellow fabric cord amongst the belongings.

---

[6] Inquest transcript, p 87.

[7] Inquest transcript, p 11.

[8] Inquest transcript, p 80.

[9] Inquest transcript, p 82.

44. Associate Professor Bosanac confirmed that in February 2013, potential ligatures (such as shoelaces, belts and cords) were allowed for patients in the Low Dependency Unit, unless they were identified as potentially dangerous given the person's risks. Since then plastic bags have been specifically prohibited as a contraband item.

45. The evidence is inconclusive as to where and how Ms Jones obtained the plastic bag. I accept plastic bags were not a prohibited item in the Low Dependency Unit at the time of Ms Jones' death.

46. The yellow cord has been identified by Mr Crosby as from the pyjama pants he brought in for Ms Jones after her admission.[10]

47. The evidence suggests that the cord was in her belongings when they were returned to her when she transferred from the Extra Care Unit to the Low Dependency Unit. See further discussion below.

- **Extra Care Unit**

48. The Extra Care Unit is a three bed secure unit, meaning patients cannot leave. At the beginning of each shift, the Extra Care Unit is thoroughly searched, to ensure it is safe, including ligature proof.

49. Dr Ong gave evidence that in the Extra Care Unit, a patient's personal belongings are placed in locked cupboards. When patients are transferred back to the open ward, their belongings are returned.

50. Nurse Stephenson confirmed that she conducted the search of Ms Jones' person when she was admitted to the Extra Care Unit. Later, after Ms Jones was settled and orientated to the ward, she searched Ms Jones' belongings. She did not find any plastic bags. She advised Ms Jones that *'...all sharp objects, strings and ties from clothing and shoes must be removed.'*[11]

---

[10] Statement by Andrew Crosby dated 17/6/2015 Coronial Brief p. 18-3a

[11] Exhibit 3, Statement Hannah Stephenson dated 13/2/2015 (as amended) p 2.

51. She recalled Ms Jones as '*resistive*' to the process and that she asked to keep a pair of pyjamas, the pants for which had a yellow string cord around the waist. Nurse Stephenson stated:

> '*I was able to obtain Ms Jones' consent to remove the cord and, once I had done so, I placed it with her belongings in a locked room. I cannot recall all items in her bag but they consisted mainly of clothing and makeup.*' [12]

52. Nurse Stephenson's evidence was very clear about normal practice in the Extra Care Unit: '*...clients that are admitted there are highly distressed, so due to the risk of assault on staff or self- harm, we don't allow cords or plastic bags in ECU...its meant to be a suicide proof environment.*'[13]

- **Transfer process between Extra Care Unit and Low Dependency Unit**

53. Dr Ong assessed Ms Jones on 13 February 2013, from 1630 – 1800. She made the decision to transfer her from the Extra Care Unit based on her assessment of Ms Jones' risk. Dr Ong stated the primary factors that influenced her decision were that Ms Jones had not tried to abscond from the Extra Care Unit, she had made no attempts at self-harm whilst in the Extra Care Unit, she engaged with Dr Ong during the assessment and stated she would seek help from nurses if needed. Dr Ong stated that she wanted to manage Ms Jones in the least restrictive environment, to develop a therapeutic alliance with her and gain her trust.[14]

54. The medical records indicate Dr Ong and Nurse Isobel Kiel completed a Clinical Risk Assessment at 1800 on 13 February 2013. Under Suicide/Self harm it notes a history of '*OD*' and '*increased thoughts of self-harm.*' Under strategies to address Indicator of Risk: '*to approach staff if thoughts escalate; feels safer/calm with diazepam/valium.*'[15]

55. As part of her risk management, Ms Jones was continued on 15 minute observations in the Low Dependency Unit. Dr Ong described her risk of emotional dysregulation[16] which could

---

[12] Exhibit 3, p 2.

[13] Inquest transcript, p 63.

[14] Inquest transcript, p. 44.

[15] St Vincent's Health Medical Records. Coronial Brief p 289.

[16] Dr Ong described emotional dysregulation as a poorly modulated emotive response, which is out of the range of the conventional response to a particular stress.

come on suddenly, '*within minutes and within seconds and that's why she would need the 15 minute obs until she has developed the strategy of self-regulation.*'[17]

56. The decision to transfer Ms Jones to the Low Dependency Unit appears to have been a reasonable one.

57. On 13 February 2013, Nurse Kiel was the nurse in charge of the first floor ward, which includes the Extra Care Unit and the Low Dependency Unit. Her shift started at 1300. She was aware Dr Ong was reviewing Ms Jones in an interview room and had made a decision to transfer her from the Extra Care Unit to the Low Dependency Unit, to continue on 15 minute observations.

58. Nurse Kiel recalled an Extra Care Unit nurse collected Ms Jones' belongings from the Extra Care Unit locker room and took them to the nurse's station in the Low Dependency Unit to be searched.[18]

59. Nurse Kiel described searching Ms Jones' belongings in her presence. She did not recall seeing either a plastic bag or a yellow fabric cord. Although plastic bags were not prohibited on the Low Dependency Unit at the time, Nurse Kiel stated that it was her practice to remove such an item from a patient's possession if there was no reason for them to have it.[19]

60. Nurse Kiel noted that whilst items such as pyjama cords were not allowed in Extra Care Unit, they were allowed in the Low Dependency Unit.

61. Nurse Kiel was asked what she would have done had she found the pyjama cord. She stated: '*She is entitled to have it...if it was in her pants, I certainly would not take it from someone on low dependency...if I felt she might have harmed with it, I might have taken it away, but I don't remember feeling that at the time...*'[20]

62. Nurse Kiel recalled finding some medication in Ms Jones' belongings. She explained to Ms Jones it was hospital policy for all medication to be kept in the medication room. On that basis she retained it and returned everything else to Ms Jones.

63. Nurse Kiel was asked what she knew about Ms Jones' history of suicide attempts when she started her shift. She stated:

---

[17] Inquest transcript, p. 45.

[18] Exhibit 4 Statement of Isobel Kiel dated 11/2/2015, as amended.

[19] Exhibit 4.

[20] Inquest transcript, p 103.

'I can't really remember specifically...how much I knew before, like during that shift...but we would definitely have a good overview of the situation for the patient and also...we have the risk assessment in the folder...that would state if people have had prior attempts and having suicidal thoughts and thing like that...'[21]

64. Nurse Kiel explained that she would have a general idea of the entire ward once handover was finished, *'...but if you didn't know the clients very well...generally people would go and look in the file and get themselves more information about who they were looking after.'*[22]

65. Nurse Kiel was asked what she was looking for when she searched Ms Jones' belongings. She answered: *'...just anything that is prohibited in low dependency.'*[23]

- **Low Dependency Unit**

66. The Low Dependency Unit has 19 beds and 14 rooms.

67. The locked storage room in the Low Dependency Unit includes patient possessions and sometimes items a nurse may consider inappropriate for some patients to have, such as potential ligatures. These items, such as phone chargers and belts are not automatically taken away from patients. Dr Ong stated: *'...it would depend on the patient.'*[24]

68. Personal items in the Low Dependency Unit are risk assessed by the nurses. At the time of Ms Jones death there was no specific policy in relation to plastic bags. The safety of non-prohibited items was at the discretion of the nursing staff. Nurse Stephenson described balancing positive risk taking and people's dignity. This is the policy that applied to items such as pyjama cords and plastic bags. The default position is allowing patients to retain such items.[25]

69. When he was asked about assessing personal items allowed to remain with a patient, Associate Professor Bosanac stated that a risk assessment and an intervention process or a management plan is optimal. He mentioned the importance of checking historical and dynamic risk factors to identify what actual risks might be.

---

[21] Inquest transcript, p 101.

[22] Inquest transcript, p 101.

[23] Inquest transcript, p 110.

[24] Inquest transcript, p 51.

[25] Inquest transcript p 84.

70. In the Low Dependency Unit, potentially dangerous items needed to be viewed in the context of the personal risk posed by each patient. In this instance, neither the pyjama cord nor the plastic bag was seen by Nurse Kiel. However, I did not get the sense from Nurse Kiel's evidence that she assessed Ms Jones' belongings against her personal risk history. She stated that she was looking for was '*anything prohibited in Low Dependency.*'

71. Associate Professor Bosanac noted that although plastic bags were in the Office of Chief Psychiatrist's Guidelines [26]as discretionary items, and that the use of a plastic bag as a ligature to facilitate asphyxiation may be quite rare, *'...it wasn't so much the likelihood but just the fact that it had occurred ...that made us specifically highlight that item.'*[27]

72. Nurse Stephenson referred to a 'default position' of allowing potentially dangerous items to remain with patients in the Low Dependency Unit. The problem with a 'default position' is that it is at odds with the independent scrutiny and assessment of belongings that Associate Professor Bosanac stated should be part of the process when returning belongings to a patient who is transferred out of the Extra Care Unit to the Low Dependency Unit.

- **Procedure and recording the 15 minute observations**

73. Nurse Ramjagsingh commenced duty on 13 February 2013 at 2100 and was the associate nurse unit manager that shift. Ms Jones was on 15 minute observations, *'...meaning I or other staff had to sight her four times an hour to see where she was and what her activity was at the time.'*[28]

74. Nurse Ramjagsingh stated observations were made between 2330 - 0145 that Ms Jones was resting in bed.

75. She confirmed that the recording of the observation was not made simultaneously but shortly after the observation. She stated at about 0150 she assisted a naked patient back to bed and then resumed observations. It was around this time that she entered Ms Jones' room and discovered her with a plastic bag over her head tied, with a yellow cord, around her neck.

---

[26] Chief Psychiatrist's Guideline: Criteria for searches to maintain safety in an in-patient unit – for patients, visitors and staff, Department of Health (Victoria) 2014.

[27] Inquest Transcript p 213

[28] Exhibit 5, Inquest transcript, p 120.

76. Dr Ong's evidence was that 15 minute observations are conducted within the 15 minute time slot. She stated: *'...a human being is not possible to be robotic, that at 1.45 all patients will have that done.'*[29]

77. Her evidence suggests that the observations were not necessarily made at the time noted in the observation record: *'It's not possible to do the actual accurate time, because we tend sometimes to round it up.'*[30]

78. Nurse Stephenson's evidence concurred with Dr Ong's. She gave detailed evidence about how observations occur, with a designated nurse being allocated observation duties for a period of their shift. She described: *'...it's difficult to attend on an eight hour shift to be doing visuals all the time whilst attending to clinical matters...if you were allocated you'd be responsible for that time period...'*[31]

79. When asked by Mr Regos whether it would take four minutes to observe six patients, Nurse Stephenson stated: *'...there's a lot of external factors...I don't think you could actually give a specific time frame of how long it takes you to do visuals, because you might start your visuals but then you might have two clients that are arguing so you might have a highly distressed client, or you might need to enter a room where somebody's actually placing a ligature around their neck so...you can be interrupted during that process...'*[32]

80. Nurse Ramjagsingh also confirmed in her evidence that 15 minute observations means the patient is sighted four times during the hour and that the recording of the observation is not made simultaneously but shortly thereafter.

81. Nurse Ramjagsingh confirmed she did not pre-fill observations on the register. *'...we don't pre-record any of the observations. The observations are done when they're meant to be done or close to the time.'*[33] In cross-examination by Mr Regos, Nurse Ramjagsingh confirmed she had entered the times of the observations in advance. She described how to ensure the actual observation matched the time pre-recorded:

---

[29] Inquest transcript, p 36.

[30] Inquest transcript, p 57.

[31] Inquest transcript, p 76.

[32] Inquest transcript, p 94.

[33] Inquest transcript, p 139.

'It's closest or nearest to that time. We cannot say that you entered somebody's room at the quarter past or the half past, because if you going around the ward checking, it depends on how many people are on 15/60 observation...'[34]

82. It was put to Nurse Ramjagsingh that it was possible for greater than 15 minutes to elapse between observations, if for example someone was observed at 1031 for the 1030 observation and the next observation, due at 1100 was done 14 minutes late. Nurse Ramjagsingh stated that the time between observations would not exceed 15 minutes unless there is an intervening *'incident.'*[35]

83. She was asked about doing observations at night when someone is in bed. She described taking a torch and entering a bedroom, she will observe a patient's *'respiration'*, the movement of their chest. She stated they write *'asleep'* in the observations and they do not shake people to check if they are asleep.[36]

84. On the night of Ms Jones' death, Nurse Ramjagsingh was one of three nursing staff on the ward who covered the Extra Care Unit and the Low Dependency Unit. In contrast to a day shift, where a staff member is allocated observations for a given period, they shared the task of observations. Nurse Ramjagsingh's last check on Ms Jones was at 0100 and she appeared to be asleep. The next three observations were by Nurse Tia Delamara, who was not called as a witness at the inquest but her statement is on the coronial brief.

85. Associate Professor Peter Bosanac noted that since Ms Jones' death, with respect to observations, *'consistency and vigilance around that has been particularly heightened...'*[37] He agreed however there was *'...no synchrony*[38]*with how...it is written and, what actually occurs to ensure that people do have their reviews in the designated time frame between the recording and the observation...there may be some variance in the time that's actually noted and the time the person was actually physically seen to...have their behaviour and their presence recorded in the observation chart.'*[39]

---

[34] Inquest transcript, p 156.

[35] Inquest transcript, 157.

[36] Inquest transcript, p 141.

[37] Transcript p 194.

[38] Simultaneous action, development or occurrence.

[39] Transcript pp 194-5.

86. In cross examination by Mr Regos, Associate Professor Bosanac conceded he would consider amending the observations form so that it reflected the exact time an observation was done. Indeed he stated he would accept *'...any recommendation that could improve the consistency or clarity regarding the practice of observations.'* [40]

87. There was nothing in the evidence to suggest that observations were not carried out every 15 minutes as required. However it was the recording of the observations that was inaccurate. The evidence has confirmed the times are often entered as a block in advance. The observation details are entered after all observations have been made and the nurse is back at the nurse's station where the record is kept. The staff do not carry the paperwork with them.

88. It is more accurate to say the observation records are records of the frequency (for example, four times per hour) and their regularity, rather than a record of exactly when they occurred. The practice is inconsistent with the form in the medical records (Functional and Visual Observations') on which observations are entered as the time column states 'Exact time'.

89. Associate Professor Bosanac was satisfied that the nightly observations were in accordance with his expectations, namely noting the presence of respiration and eye movement, whilst not disrupting sleep which would have been counter therapeutic.

90. I am satisfied the observations were made at the appropriate intervals and that any discrepancy between the observation and the recording is adequately explained by the necessity to make numerous observations and then to separately record them. I am satisfied there are adequate systems in place to ensure they are conducted as required by the medical direction.

Changes following Ms Jones' death

91. Nurse Stephenson indicated in her evidence that a number of changes had occurred in the Low Dependency Unit since Ms Jones' death and following an unrelated assault of a staff member by a patient.

92. Firstly, there is now a structured environmental check of the Low Dependency Unit at the beginning of each shift by two staff members.

93. Secondly, the location of the front door has changed, requiring anyone entering the unit to be greeted by a nurse.

---

[40] Inquest Transcript p 214.

94. Thirdly, there are now lockers for visitors to place their bags.

95. Fourthly, plastic bags are prohibited and all bins are lined with paper bags.[41]

96. The following changes have been made to St Vincent's Hospital policies:;

- Plastic bags in the Low Dependency Unit.
    - Plastic bags were not specified as dangerous items and therefore not strictly prohibited in February 2013. From October 2014, plastic bags are listed as dangerous items and patients are not entitled to have access to them. No plastic bags are used or stored at the Acute In-patient Service.
- Searches made of patients when transferring from the Extra Care Unit to the Low Dependency Unit.
    - Previous policy did not specify that patients be searched when transferred from the Extra Care Unit. There is now the requirement for a search of all consumer belongings when leaving the Extra Care Unit. In addition, all consumer searches are to be signed by two members of the clinical team.[42]
- Searches conducted of patients, their belongings and rooms in the Low Dependency Unit.
    - Previous policy dictated that patient's rooms were searched upon admission and did not mandate a search following return from leave. At present, a routine search of all rooms is conducted at the commencement and end of each shift.
- An environment check has been introduced to the Low Dependency Unit since Ms Jones' death. Associate Professor Peter Bosanac described the check as follows.
    - Two staff members walk around patient bedrooms, bathrooms and key living and therapeutic areas of both the Low Dependency Unit and the Extra Care Unit. The two staff are usually a staff member finishing a shift and a member of the in-coming shift. This occurs at each shift change, three times per day and is countersigned. Any concerns about the specific environment, including unwanted materials, can be addressed and documented at this time.

---

[41] The exception being sanitary disposal units.

[42] Statement of Associate Professor Bosanac Coronial Brief p 48-3.Coronial brief

97. Associate Professor Bosanac also noted that from June 2014, staffing on the night shift increased from three to four staff members.

98. With respect to the environmental searches, Associate Professor Bosanac stated, the new searches instituted at St Vincent's Hospital were introduced in October 2014. The new search policy was influenced by the tragedy of Ms Jones' death[43] as well as the Office of the Chief Psychiatrist Guidelines which were produced in 2014.[44]

Conclusion

99. While capacity to predict which patients are at risk of inpatient suicide is poor, the literature does suggest precautions that can be taken by inpatient facilities to reduce the risk of inpatient suicide.[45]

100. Ms Jones had access to the cord from her pyjamas which she used as a ligature. The cord was described by Nurse Ramjagsingh as *'tied firmly enough to seal the bag around Ms Jones' head, but it was not tied so tightly as to actually cause a mark on her skin.'*[46]

101. As a result of the recommendations in the Chief Psychiatrist's investigation of inpatient deaths 2008-2010, in 2014 the Chief Psychiatrist developed Guidelines - *'Criteria for searches to maintain safety in an in-patient unit - for patients, visitors and staff.'*

102. The Chief Psychiatrist from time to time issues guidelines to provide specialist advice on various aspects of clinical service and to inform mental health practitioners and services about the operation and clinical issues in relation to the *Mental Health Act 2014*.[47]

103. The Guidelines, *'Criteria for searches to maintain safety in an in-patient unit - for patients, visitors and staff'* state that for patients admitted to an inpatient service; *'Dangerous and inappropriate items are objects or substances that are seen as 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.'*[48]

---

[43] Transcript p 211.

[44] Transcript p 212.

[45] Chief Psychiatrist's investigation of inpatient deaths 2008-2010, Department of Health , p 12

[46] Statement of Soomintra Ramjagsingh dated 23 October 2013.

[47] www.health.vic.gov.au

[48] Chief Psychiatrist Criteria for searches to maintain safety in an inpatient unit - for patients, visitors and staff, p 5.

Dangerous items may include any objects that could be used to assist in a suicide attempt (for example, plastic bags, scarves, belts, shoelaces or head phone cords).

104. On 2 February 2015, Coroner Spanos handed down her *Finding Without Inquest into the Death of CB*[49]. In that case a young woman died from hanging by a scarf from a wardrobe door in the Broadmeadows In-patient Unit, North Western Mental Health.

105. Coroner Spanos made the following recommendation:

'I recommend that North West Mental Health change its policy that presently allows patients of the LDU to retain items that are capable of being used as a ligature to ensure that it complies with the Chief Psychiatrist Guideline on Criteria for searches to maintain safety in an in-patient unit for patients, visitors and staff.'

106. The response received from North West Mental Health dated 29 April 2015 stated that;

'On 3 September 2014 a memorandum (attachment 1) was issued to all NWMH staff outlining the removal of hazardous items in inpatient units which clearly addresses the need for staff to be vigilant regarding scarves and adhere to the Chief Psychiatrist Guideline on Criteria for searches to maintain safety in an in-patient unit for patients, visitors and staff.

107. St Vincent's Mental Health is congratulated for deeming plastic bags to be dangerous items and thus prohibited from the Acute In-patient Unit.

FINDING

I find that Maree Jones died from plastic bag asphyxia in circumstances where she intended to end her own life.

[49] COR 2012 4587. A copy of this finding and responses to recommendations can be found on the Coroners Court of Victoria website.

RECOMMENDATIONS

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

I adopt Coroner Spanos' recommendation 1 in the *Finding Without Inquest into the Death of CB*[50] and urge St Vincent's Mental Health to change its current policy that allows patients in the Low Dependency Unit to retain items that are capable of being used as a ligature.

Further, to avoid confusion it is preferable for Acute In-patient Units to take a consistent approach on this point and I urge St Vincent's follows the position adopted by North West Mental Health.

I direct a copy of this finding be distributed to:

Andrew Crosby

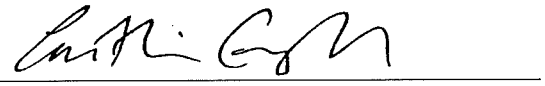
Adrian Jones

Michael Regos, DLA Piper Australia

Acting Sergeant Justin Mercovich

Interested Parties

Signature:



CAITLIN ENGLISH
CORONER
Date: 26 February 2016

[50] COR 2012 4587. A copy of this finding and responses to recommendations can be found on the Coroners Court of Victoria website.