IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 0829

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: MARIA TERESA NIGRO

Hearing Dates:	12 – 13 June 2013
Appearances:	Mr M. Regos on behalf of Mercy Health
	Ms E. Coates on behalf of Ms Lesley Pace
Police Coronial Support Unit:	Senior Constable King Taylor - Assisting the Coroner
Findings of:	AUDREY JAMIESON, CORONER
Delivered on:	2 April 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank 3006

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

I, AUDREY JAMIESON, Coroner having investigated the death of **MARIA TERESA NIGRO**

AND having held an inquest in relation to this death on 12 – 13 June 2013

at the Coroner's Court of Victoria sitting at MELBOURNE

find that the identity of the deceased was **MARIA (also known as Mary) TERESA NIGRO**

born on 15 July 1955

and the death occurred on 10 February 2009

at Werribee Mercy Hospital, 300 Princes Highway, Werribee 3030

from:

1(a) HANGING[2]

in the following summary of circumstances:

1. On 12 June 2013, a mandatory inquest under section 52(2)(b) of the *Coroners Act 2008* (Vic)[3] (the Act) began into the death of Ms Maria (Mary) Teresa Nigro, because immediately before her death, Ms Nigro was "a person placed in....care" as it is defined in the Act. Prior to her death, Ms Nigro was a patient in an approved mental health service within the meaning of the *Mental Health Act 1986* (Vic)[4] (the Mental Health Act).
2. On 2 February 2009, Ms Nigro took an overdose of medication and was admitted to the Western General Hospital (WGH). She had an ongoing suicide plan and would not accept home treatment. She was admitted as an involuntary patient under the Mental Health Act. On 4 February 2009, Ms Nigro's care was transferred to Werribee Mercy Hospital (WMH) Psychiatric Inpatient Unit where her involuntary status was confirmed. She was assessed

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[2] Death in hanging is the result of compression of the arteries and veins supplying and draining the head and neck, compression of the large airway, pressure on the carotid sinuses, or, as is often the case, a combination of all of the above.

[3] See below discussion under the heading of "Jurisdiction" for further explanation.

[4] The *Mental Health Act 1986* (Vic) has been repealed and replaced by the *Mental Health Act 2014* (Vic).

and placed under observation in the unit. On 9 February 2009, nursing staff reported Ms Nigro appeared distressed after a visit from her family and Ms Lesley Pace. There was conflict during the visit. On 10 February 2009 at approximately 2.09am, nursing staff observed that Ms Nigro was not in bed. She was found inside her room's ensuite unresponsive, with a dressing gown cord tied around her neck. Nursing staff called a Code Blue and commenced cardiopulmonary resuscitation (CPR). She was transferred to the Emergency Department, however was unable to be revived. Ms Nigro was pronounced deceased at 2.49am on 10 February 2009.

BACKGROUND CIRCUMSTANCES

3. Ms Nigro was born on 15 July 1955. She was 53 years old at the time of her death. She lived in Footscray West with Ms Pace.

4. Ms Nigro had a family history of mental ill health. She was diagnosed with depression in 1999. Her past medical history also included ovarian cyst with haemorrhage and intrauterine fibroid, herpes zoster opthalmicus, post-herpic neuralgia, hiatus hernia, haemorrhoidectomy, post menopause and atrial fibrillation and flutter. Ms Pace reported that Ms Nigro had previously been addicted to Diazepam[5] and had overdosed on a number of occasions.[6]

5. Ms Nigro started menopause in approximately April 2008, and suffered from symptoms including night sweats, severe chills and sleep disruption. She sought treatment from a number of medical professionals. Ms Pace reported that between August and December 2008, Ms Nigro's condition worsened; her symptoms had not improved, she had lost approximately 10 kilograms and suffered from joint pain and exhaustion. Ms Nigro later reported to Psychiatrist, Dr Tejraj Tawde, that she had been feeling low since the onset of menopause.[7]

6. On 12 December 2008, Ms Pace contacted the Mercy Mental Health Triage, concerning Ms Nigro's worsening mental state. A Crisis Assessment and Treatment Team (CATT) assessed her on this day and diagnosed Ms Nigro to have a Major Depressive Disorder with no acute

[5] Diazepam is a sedative/hypnotic drug of the benzodiazepines class. Available as Valium.

[6] Exhibit 5 – Statement of Ms Lesley Pace, dated 7 June 2013, p 2.

[7] Exhibit 2 – Statement of Dr Tejraj Tawde, dated 29 May 2009.

suicidal risks at the time. She was prescribed Sertraline,[8] Lorazepam[9] and Zopiclone.[10] CATT notes indicate stressors affecting Ms Nigro at the time of assessment included family and financial issues; however she would not elaborate to the clinicians.[11] She was treated by CATT until 29 December 2008, when her care was handed over to her General Practitioner.

7. On 25 January 2009, Ms Nigro presented to the WGH Emergency Department with complaints of diarrhoea, weight loss and rapid pulse. A Mental State Examination and Risk Assessment were completed. Ms Nigro reported she felt depressed; "worse than before."[12] She admitted to having thoughts of harming herself however was guarded when questioned about suicidal ideation and stated she was worried she would be admitted to hospital.[13] A plan was formulated for Ms Nigro to be referred to CATT for home treatment. She was discharged into the care of her GP on 29 January 2009.

8. Prior to the contact with Mercy Mental Health Triage on 12 December 2008, Ms Nigro had no other documented past involvement with mental health services

SURROUNDING CIRCUMSTANCES

9. On 2 February 2009, Ms Nigro threatened to take an overdose of prescription medication. Ms Pace called Mercy Mental Health Triage and emergency services. Ms Nigro was taken by ambulance to the WGH. A mental state examination was conducted. Registered Psychiatric Nurse Rhonda McCormack performed the assessment. RPN McCormack documented Ms Nigro appeared anxious and that she complained of multiple physical discomforts. She expressed she was sick of being in her own body.[14] No formal thought disorder or perceptual disorders were evident. She thought her physical problems were side effects of taking Zoloft. It was determined she had fleeting suicidal ideation with no plan or intent. She was agreeable to support and a review of her medication. A plan was formulated

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[8] Sertraline is an antidepressant drug used for the treatment of depression, obsessive-compulsive disorder, panic disorder, anxiety disorders, post-traumatic stress disorder (PTSD), and premenstrual dysphoric disorder (PMDD). Available as Zoloft.

[9] Lorazepam is a benzodiazepine used for the treatment of anxiety disorders.

[10] Zopiclone is a sedative-hypnotic drug. It is used for the short-term and symptomatic relief of sleep disturbances. It is available as Imovane.

[11] Werribee Mercy Hospital Medical Records, Initial Assessment Sheet 1, dated 12 December 2008.

[12] Werribee Mercy Hospital Medical Records, Triage Contact Form, dated 25 January 2009 at 1.30am.

[13] Werribee Mercy Hospital Medical Records, Mental State Examination, dated 25 January 2009.

[14] Werribee Mercy Hospital Medical Records, Summary and Management form, dated 2 January 2009.

for Ms Nigro to be discharged following medical review. A referral was made to CATT for a review of medication the next morning.

10. In the evening of 2 February 2009, Ms Nigro took an overdose of prescription medication including Temazepam.[15] She was taken to the WGH emergency department and treated. On 3 February 2009, a mental state examination was conducted by RPN McCormack. Ms Nigro expressed an ongoing suicide plan with intent. She was unable to guarantee her safety or accept CATT home treatment. She was admitted as an involuntary patient under s12AA of the Mental Health Act.

11. On 4 February 2009, Psychiatrist Dr Kirthi Kumar assessed Ms Nigro. She was found to have major depression with suicide risk and was not be in a position to give informed consent. Dr Kumar confirmed the involuntary treatment order. Ms Nigro was transferred from the WGH Emergency Department to the Short Stay Unit of WMH Inpatient Psychiatric Unit. On arrival she was assessed by Psychiatry Registrar Dr Prasad Mohotti. Dr Mohotti noted she presented as anxious, agitated and depressed. She denied having suicidal ideas and was not happy to be in hospital. A plan was formulated for Ms Nigro to be admitted to the Low Dependency Unit (LDU) of the psychiatric unit. She was prescribed Mirtazapine[16] 30mg orally at night, Omeprazole[17] 20mg orally in the morning and Clonazepam[18] 0.5mg – 2mg as required. On 5 February 2009, she commenced Metoprolol[19] 25mg orally in the morning

12. On 6 February 2009, Ms Nigro was admitted to the LDU. While nursed in the LDU, visual observations occurred half hourly during the day and hourly at night. Risk assessments were conducted twice a day. Nursing observations in the LDU noted Ms Nigro to be vague, perplexed, distracted and thought blocking.[20] Her mood varied greatly; on 7 February 2009, she rated her mood as 8 out of 10, however on 8 February 2009, at her afternoon assessment

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[15] Temazepam is a sedative/hypnotic drug of the benzodiazepine class.

[16] Mirtazapine is indicated for the treatment of depression. It is available as Avanza, Mirtazon, Sandoz, Rameron and Axit.

[17] Omeprazole belongs to group of drugs called proton pump inhibitors. It decreases the amount of acid produced in the stomach. It is used to treat symptoms of gastroesophageal reflux disease and other conditions caused by excess stomach acid.

[18] Clonazepam is a benzodiazepine related to diazepam possessing sedative and anticonvulsant properties. It is available in Australia as Rivotril and Paxam.

[19] Metoprolol is a beta-blocker that affects the heart and circulation.

[20] Thought blocking refers to the sudden arrest in the flow of thoughts. The previous idea may then be taken up again or replaced by another thought.

she was unable to rate her mood. On 8 February 2009, nursing notes indicate Ms Nigro had visitors which she enjoyed. On this nursing entry, staff also noted Ms Nigro was a little concerned about going back to her accommodation in Footscray.

13. Ms Nigro was given personal belongings when she was admitted as an inpatient, including a chenille dressing gown with the cord attached. Ms Pace reported she was not informed of any items not to bring to hospital and that none of the items she brought were searched by nursing staff. [21]

14. On 9 February 2009, Ms Nigro was reviewed by Dr Tawde. Ms Nigro reported she had lost weight and suffered from poor sleep, appetite and energy for the past six months. She described experiencing forgetfulness and difficulty in thinking, being unsure of the future and what she wanted to do. Dr Tawde conducted a mental state examination and noted her attention was difficult to sustain, observing her to have a vacant stare at times and only had occasional eye contact. She described her mood to be four out of 10, saying she felt numb and sad. Dr Tawde found she did not have intentions of suicide, delusions or hallucinations at the time. She had insight into her mood problems but was unsure that she needed an inpatient hospital stay.[22] Dr Tawde reported that Ms Nigro had major depression and wanted to rule out an organic cause. A plan was formulated to continue antidepressants, arrange for a CT scan of the brain, order blood tests and liaise with family and carers regarding her progress.[23] Dr Tawde telephoned Ms Pace later that afternoon, as she was listed as Ms Nigro's primary carer. Ms Pace explained Ms Nigro's background. They scheduled a meeting for the next day.

15. RPN Bridget Officer entered nursing observations into Ms Nigro's medical records at approximately 9.30pm. It was noted that Ms Nigro appeared preoccupied, suspicious and paranoid. She had a blank stare and was perplexed, vague, odd and fearful. She had been visited by her family, Ms Pace and Mrs Lucy Pace, Ms Pace's ex sister-in-law. Nursing notes indicate 'conflict evident...stressful for Mary'.[24] RPN Officer reported that Ms Nigro

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[21] Exhibit 5 – Statement of Ms Lesley Pace, dated 7 June 2013.

[22] Exhibit 2 – Statement of Dr Tejraj Tawde, dated 29 May 2009.

[23] Ibid.

[24] Werribee Mercy Hospital Medical Records, Progress Report, 9 February 2009.

appeared concerned after the visits but said Ms Nigro did not disclose what had occurred between her family and Ms Pace.[25]

16. RPN Officer also conducted a risk assessment at approximately 9.30pm. She scored[26] Ms Nigro to have nil suicidal ideation, self harm and ideas of harm to others. For her risk of self neglect / accidental self harm she found Ms Nigro to have "nil evidence of risk, currently untreated and may be at risk if untreated." [27] For risk of vulnerability / harm from others she scored two, interpreted as "recent evidence of vulnerability / harm from others."[28] She scored one in the category "risk of absconding / non compliance with treatment" meaning she was "ambivalent, however willing to accept treatment."[29] Regarding the risk of impulsivity / level of distress Ms Nigro scored "2-3."[30] A score of two is interpreted as "moderately distressed / nil immediate or recent past history of impulsivity."[31] A score of three is interpreted as "acutely distressed with nil plans to act on internal stimuli / immediate or recent history of poor impulse control."[32] Ms Nigro's observations remained half hourly during the day and hourly at night.

17. Hourly observations commenced at 10pm. According to the sleep chart in Ms Nigro's medical records and the statement of RPN Claire Jenkins, between 10pm and 1am she was asleep.[33] Enrolled Nurse Mulugeta Abay reported that he used a 'tick list'[34] when completing observation rounds. The tick list had every patient's name on the ward with columns for the time. EN Abay reported he "tick[ed] the list the time each patient was checked."[35] He further reported checking Ms Nigro at 10pm and 1am and also once between these checks, but could not recall the exact time of the round. EN Abay reported he conducted his observation rounds by knocking on the door and asking Ms Nigro if she was

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[25] Exhibit 1 – Statement of RPN Bridget Officer, dated 28 May 2009.

[26] Patients are given a score between 0-4.

[27] Werribee Mercy Hospital Medical Records, Visual Observations/Risk Assessment Form, 9 February 2009.

[28] Ibid.

[29] Ibid.

[30] Ibid.

[31] Ibid.

[32] Ibid.

[33] Werribee Mercy Hospital Medical Records, 'W.M.M.H.P Sleep Chart.'

[34] Also referred to as a sleep chart.

[35] Exhibit 3 – Statement of Mulugeta Abay, dated 27 May 2009, p 2.

alright.[36] Each time he checked Ms Nigro, he reported she was in bed and responded "yeah, I'm alright."[37]

18. At approximately 2.09am, RPN Jenkins conducted the observation round. Ms Nigro was not in bed; staff entered her room and knocked on the ensuite door. Staff pushed the door open, heard a noise and found Ms Nigro on the floor with her dressing gown cord tied tightly around her neck. She was not breathing, had no evident carotid pulse or signs of life. A Code Blue was called and staff commenced CPR until the Code Blue team arrived. On their arrival, Ms Nigro was cyanosed and in respiratory and cardiac arrest. She was intubated, had an intravenous (IV) cannula inserted and was administered one milligram of adrenalin. The cardiac monitor showed she was asystole.[38] CPR was continued and another milligram of adrenalin was administered. At approximately 2.30am, she was transferred to the Emergency Department. More adrenalin was administered, as was sodium bicarbonate. Despite all resuscitation attempts Ms Nigro remained in asystole. She was pronounced deceased at 2.49am.

JURISDICTION

19. At the time of Ms Nigro's death, the *Coroners Act 1985* (Vic) (the old Act) applied. From 1 November 2009, the *Coroners Act 2008* (Vic) (the new Act) has applied to the finalisation of investigations into deaths that occurred prior to the new Act commencement[39]

20. In the preamble to the new Act, the role of the coronial system in Victoria is stated to involve the independent investigation of deaths for finding the causes of those deaths and to contribute to the reduction of the number of preventable deaths and the promotion of public health and safety and the administration of justice. Reference to preventable deaths and public health and safety is found in other sections of the new Act.[40]

21. Section 67 of the new Act describes the ambit of the Coroner's Findings in relation to a death investigation. A Coroner is required to find, if possible, the identity of the deceased,

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[36] Ibid.

[37] Ibid.

[38] Asystole is where there is no cardiac electrical activity; hence no contractions of the myocardium and no cardiac output or blood flow.

[39] Section 119 and Schedule 1 - *Coroners Act 2008*.

[40] See for example, sections 67(3) and 72 (1) & (2).

the cause of death and, in some cases, the circumstances in which the death occurred.[41] The 'cause of death' generally relates to the *medical cause of death* and the 'circumstances' relates to the *context* in which the death occurred.

22. A Coroner may also comment on any matter connected with the death, including matters relating to public health and safety and the administration of justice.[42] A Coroner may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with a death, which the Coroner has investigated including recommendations relating to public health and safety or the administration of justice.[43]

INVESTIGATION

Identification

23. The identity of Maria Teresa Nigro was without dispute and required no additional investigation.

The medical investigation

24. On 11 February 2009, Dr Noel Woodford, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), performed an external examination on the body of Ms Nigro and reviewed a post mortem CT scan, medical records and the Form 83 Victorian Police Report of Death. Anatomical findings included a ligature mark around her neck. The post mortem CT scan showed focal coronary calcification and an intact laryngeal skeleton. Dr Woodford ascribed the cause of Ms Nigro's death to hanging.

INQUEST

25. Directions Hearings were held on 4 December 2012 and 14 January 2013.

26. The Inquest into the death of Ms Nigro was held on 12 and 13 June 2013.

Viva Voce evidence at inquest

27. *Viva voce* evidence was obtained from the following witnesses at the Inquest:

    a. Bridget Officer , Registered Psychiatric Nurse;

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[41] Section 67(1).

[42] Section 67(3).

[43] Section 72(1) & (2).

b. Dr Tejraj Tawde, Psychiatrist;

c. Mulugeta Abay,[44] Enrolled Nurse; and

d. Clare Jenkins, Registered Psychiatric Nurse

28. Statements from Ms Pace were also tendered as evidence as part of the balance of the Inquest brief.[45]

Issues investigated at Inquest

29. The issues identified regarding the care provided to Ms Nigro requiring exploration included:

a. the information given to night shift staff at the handover of shift;

b. what observations were made overnight on 9 February 2009;

c. Ms Nigro's access to a dressing gown cord; and

d. communication

Risk assessments

30. Dr Tawde gave evidence that when he saw Ms Nigro on 9 February 2009, he had no major concerns about her mental state or that she was being nursed in the LDU.[46] He stated that if Ms Nigro:

> "*wasn't able to guarantee her safety, or she was expressing ongoing intentions or plans to hurt herself, I would have been concerned enough for her to be needing nursing care in a more confined and restricted manner.*"[47]

31. He further stated that if he was concerned about imminent risk of Ms Nigro hurting herself, he would have preferred her to be nursed in the High Dependency Unit (HDU), rather than increasing her observations in the LDU.[48] Based on his assessment he said Ms Nigro did not

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[44] At the time of inquest Mulugeta Abay had changed his name to Mulugeta Gerbru. For consistency I will continue to refer to him by the former.

[45] Exhibit 5.

[46] Transcript of evidence, pp 32-33.

[47] Transcript, p 33.

[48] Transcript, p 34.

need to be nursed in the HDU. [49] Dr Tawde also stated that on reflection, after Ms Nigro's death, he still found no reasons for Ms Nigro to be nursed in the HDU.[50] He stated that regarding the risk of self harm or suicide; her risk profile did not rise on the evening of 9 February 2009.[51]

32. Dr Tawde acknowledged the visit from Ms Pace and Ms Nigro's family and that the conflict that ensued would have been stressful for Ms Nigro at the time. He gave evidence that it would be the nurse who was having interactions with Ms Nigro to make the call whether the on-call Psychiatrist needed to be informed, further saying that it was concluded Ms Nigro had no significant management issues.[52] If there were management issues, he believed the nurse would have been able to call the on-call Psychiatrist.

33. RPN Officer gave evidence that she conducted a risk assessment for Ms Nigro during the afternoon shift on 9 February 2009. She stated that this was an ongoing assessment which she documented at the end of the shift in the form titled 'visual observations / risk assessment form'.[53] Given that she filled out the risk assessment form at the end of her shift, as well as making her nursing notes at the same time, RPN Officer agreed she had time to talk to Ms Nigro after the visit from Ms Pace and her family.[54] The risk assessment takes into account how Ms Nigro presented during the afternoon shift and after the visit.[55] RPN Officer gave evidence that by marking "2-3" on the risk assessment she meant Ms Nigro scored "between a two and a three," and that this score would have been based on her distress more than impulsivity.[56] The mandatory management strategies for risk assessments state "if a client has scored a 3 or 4 in one or more categories an immediate intervention is required and risk management plan documented."[57] A score of zero or one requires hourly visual observations and a score of two in any one category requires hourly to half hourly visual observations. A score of three in any one category notes "strategies to implement are:

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[49] Transcript, p 33.

[50] Transcript, p 34.

[51] Transcript p 37.

[52] Transcript, pp 36-37.

[53] Transcript, p 8.

[54] Ibid.

[55] Transcript, pp 8 & 24.

[56] Transcript, p 22.

[57] Werribee Mercy Hospital Medical Records, Visual Observations/Risk Assessment Form, 9 February 2009, Exhibit 4-Statement of RPN Claire Jenkins, dated 1 June 2009, p 1.

inform treating doctor and discuss interventions (if risk is upgraded), commence half hourly to 15 minute visual observations."[58] A score of four in any one category requires in addition "visual observations to be 15 minute to constant with no physical barrier between patient and nurse; specialling or HDU."[59] RPN Officer stated that the mandatory management strategies to commence 15 minute observations and inform the treating doctor when there is a score of three on the risk assessment came into effect if risk was upgraded. She stated it was at her discretion, saying; "If I felt she was at high risk, I would have made that decision."[60] She gave evidence that despite scoring "between a two and three" for distress, she did not think Ms Nigro was at a higher risk level.[61] Ms Nigro's observations remained the same.[62]

34. RPN Jenkins gave evidence that risk assessments are not completed at night because nurses are not interacting with patients because they are normally sleeping.[63] However she did state that if a patient is awake overnight, generally she will speak to them and depending on their presentation, consider doing a mental state examination.[64] RPN Jenkins discussed the importance of sleep for patients; nurses would never wake a patient to conduct a mental state examination or ask how a patient was feeling. RPN Jenkins stated that a score of "2-3" on a risk assessment doesn't necessarily mean a patient should be transferred to the HDU and their observations increased.[65] She spoke of using other techniques if a patient is awake overnight and had a risk assessment similar to Ms Nigro's including; talking to the patient, reassuring them, de-escalating any stressful situation and to consider administering medication.[66] Having read Dr Tawde's notes, RPN Jenkins again affirmed that she would not have taken any action, regarding her mood score of four out of 10, because Ms Nigro was reported to be asleep at observation rounds overnight on 9 February 2009. RPN Jenkins

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[58] Ibid.

[59] Ibid.

[60] Transcript, p 23.

[61] Transcript, p 24.

[62] Transcript, pp 23-24.

[63] Transcript, p 94.

[64] Transcript, pp 108 & 118.

[65] Transcript, p 101.

[66] Ibid

stated that Ms Nigro's mood score was not surprising in the LDU, saying it was still a significant score and that she was an involuntary patient for a reason.[67]

Handover

35. RPN Jenkins gave evidence about the difference between a day shift and the night shift. She stated she was the nurse in charge of the night shift on 9 February 2009. There were four nurses in total working the shift and they managed the 30 patients on the ward as a team.[68] At the time of Ms Nigro's death, nurses were not allocated patients overnight.[69] She stated a night shift is not like a normal shift, patients are sleeping and there are reduced staff numbers.[70]

36. RPN Jenkins gave evidence about how a handover normally works. She stated the nurse in charge of the afternoon shift will give a handover of every patient which includes information about their mental state, additional medications they may have received, any issues for the patient from the shift and any visitors they may have had.[71] At handover all nurses on the night shift are in the room. A handover is verbal, however a typed 'handover sheet' is also circulated. RPN Jenkins stated this is an overview of each patient and that if a nurse was so inclined, they could make their own notes on that sheet, which is her common practice.[72] Handover sheets are always prepared on the night shift, meaning a handover sheet presented at the start of a night shift was prepared the night before.[73] They are internal documents which are shredded at the end of each shift. RPN Jenkins stated if a patient had special needs or needed special attention, this information would normally be conveyed at handover and would be in the patients' notes.

37. RPN Jenkins explained that most nurses do not routinely read patient notes before handover or at the start of a shift. Sometimes patient notes are read during a shift; for example, RPN Jenkins would read the notes if there was a "significant issue" where she would "like to

[67] Transcript, p 107.

[68] Transcript, pp 116 & 119.

[69] Transcript, p 89.

[70] Transcript, p 90.

[71] Transcript, p 89.

[72] Transcript, p 120.

[73] Ibid.

know more information...or what was documented."[74] In line with this statement RPN Jenkins stated nurses don't generally look at the risk assessments conducted during the day and the risk reflected in the assessment would be communicated at handover, as well as any other issue regarding a patient.[75] She stated that she was aware that Dr Tawde had seen Ms Nigro on 9 February 2009, and that she read the notes Dr Tawde entered.[76] RPN Jenkins could not recall at what time she read his notes but assumed it was probably when she was preparing the handover sheet which she normally started at the beginning of a shift.[77] RPN Officer's note, entered at 9.30pm, detailing Ms Nigro's mental state, that conflict was evident at the family visit and that she found the visit stressful, follows directly after Dr Tawde's note. RPN Jenkins gave evidence that she could not recall whether she was informed about the family conflict or whether any special information regarding Ms Nigro was communicated at handover on 9 February 2009.[78] EN Abay also reported "from what I recall of the handover their [sic] were no incidents to report," this was confirmed in evidence.[79]

Nursing observations

38. RPN Officer gave evidence that it was standard in the LDU that all patients were on half hourly observations during the day and hourly observations at night.[80] RPN Jenkins stated 15 minute observations are only ever done in the HDU not LDU; "that's just hospital policy."[81] EN Abay gave evidence that from his experience hourly observations were usually standard overnight.[82] Dr Tawde gave evidence he had no concerns about Ms Nigro being on half hourly observations during the day and hourly observations at night.[83]

39. RPN Jenkins gave evidence about conducting observations at night. She stated at the time of Ms Nigro's death, observations were not a job designated to one staff member and that

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[74] Transcript, p 98.

[75] Transcript, pp 89, 99 & 100.

[76] Transcript, pp 98-99 & 107.

[77] Transcript, p 119.

[78] Transcript, p 90 & 98.

[79] Exhibit 3 – Statement of Mulugeta Abay, dated 27 May 2009, p 2 & Transcript of evidence p 78.

[80] Transcript, p 18.

[81] Transcript, p 101.

[82] Transcript, p 81.

[83] Transcript, p 37.

every nurse on duty conducted observations at different times.[84] The usual processes was to walk to the room, open the door, shine a light on the person and make an assessment as to whether the patient was awake or asleep. This was normally determined by whether they responded or their eyes are open.[85] RPN Jenkins said EN Abay's technique of knocking and asking if a patient was alright, was not normal practice and had she known she would have instructed him on the correct technique, so as not to disturb sleeping patients.[86] At the time of Ms Nigro's death, nursing staff filled out a 'sleep chart,'[87] when conducting observations at night. RPN Jenkins stated that the information in the sleep chart was then transcribed into each patient's chart.[88] She completed Ms Nigro's sleep chart on 9 February 2009, and interpreted the marks made, which looked like ticks or slashes,[89] to mean Ms Nigro was asleep on all observations before 2am. She stated that following a discussion with staff and because the markings on the sleep chart were not an 'X'[90] or 'OB,'[91] that Ms Nigro was asleep.[92]

Dressing gown cord

40. RPN Officer gave evidence that cords are not removed in the LDU. She stated that there is less risk in the LDU so they do not remove such items.[93] Articles of clothing that could be used to harm are removed in the HDU. RPN Officer stated she did not anticipate Ms Nigro's actions.[94] She was unaware Ms Nigro had a dressing gown with a cord in her possession and said that even if she did know, she would not have removed the cord.[95] She gave evidence that it is still policy to allow cords, or articles of clothing capable of being used as a ligature, in the LDU.[96]

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[84] Transcript, pp 91 & 113.

[85] Transcript, p 92.

[86] Transcript, p 93.

[87] Also known as a tick list.

[88] Transcript, pp 95,103 & 114.

[89] A dash (-) mark on the W.M.M.H.P Sleep Chart signifies the patient was asleep.

[90] 'X' mark on the W.M.M.H.P Sleep Chart signifies the patient was 'awake in bed.'

[91] 'OB' mark on the W.M.M.H.P Sleep Chart signifies the patient was 'out of bed.'

[92] Transcript, p 103.

[93] Transcript, pp 26-27.

[94] Transcript, p 27.

[95] Transcript, p 26.

[96] Transcript, p 28.

41. RPN Jenkins gave evidence that confirmed the evidence of RPN Officer regarding hospital policies about items being removed from patients' belongings.[97] She stated that if patients are deemed to be at a significant risk, they would be transferred to the HDU and all concerning personal items would be removed; she explained that patients in the HDU have a higher risk; they may be more impulsive, aggressive or distressed.[98] She conceded that patients in the LDU are still at risk and gave the explanation that they have access to personal items that may be capable of harm to "help maintain the least restrictive environment...and...to maintain some patient dignity."[99] She also stated that she could remove, or seek permission to remove, articles of clothing capable of being used as a ligature from a patient in the LDU if she considered them to be at risk.[100]

Communication

42. Dr Tawde gave evidence that next of kin should be notified when a patient is admitted as an involuntary patient.[101] He stated that the first point of contact is normally with the person listed as primary carer and that it is not uncommon for a patient to have multiple next of kin. In circumstances of conflict between next of kins, Dr Tawde said he would go with the patient's wishes and would look for consistency in their response before coming to a decision about who to make contact with.[102] This position takes into consideration their vulnerability and mental state.

43. Dr Tawde stated that:

> "*collecting collateral information...would need to be done as soon as possible. I had to initiate getting more information as soon as I'd seen [Ms Nigro], which is why I did make phone contact with Ms Pace and I believe there's only limited amount of information you can share or exchange, which is why we had to have the meeting the next day.*" [103]

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[97] Transcript, p 96.

[98] Transcript, p 111.

[99] Ibid.

[100] Transcript, p 97.

[101] Transcript, p 46.

[102] Transcript, pp 49 & 50.

[103] Transcript, p 47.

44. Dr Tawde stated this call on 9 February 2009 was his first opportunity to call Ms Pace. He gave evidence that when a patient's care is transferred to his team; the practice is to wait for the next ward round to occur to review them and this occurred on 9 February 2009.[104] Dr Tawde was unsure whether next of kin was contacted by the Short Stay Unit, where Ms Nigro was first admitted. He stated that nursing notes record communication with Ms Pace after Ms Nigro's admission and that there was an attempt made to contact someone described as "a flatmate" without success around the time of her admission.[105]

45. RPN Jenkins gave evidence that she would expect a patient's primary carer to be contacted when the hospital needs to speak to next of kin.[106] She said this information would be found in the patients' notes. RPN Jenkins stated she does not always familiarise herself with who is listed as primary carer and next of kin, because it is on a need to know basis and night shift nursing staff do not have a lot of contact with families.[107] RPN Jenkins gave evidence that she was not aware of the tension between Ms Nigro's family and Ms Pace.[108] Nursing staff can use interventions when there is tension such as restrict access to a patient, monitor visits and restrict phone calls. She stated they would need to be guided by the wishes of the patient.

Submissions

46. Counsels acting on behalf of the Interested Parties provided final submissions, which I have considered for the purpose of this Finding.

IMPROVEMENTS TO THE DELIVERY OF HEALTH SERVICES

47. I am satisfied that Mercy Health undertook a systems review after Ms Nigro's death, and in response to identified shortcomings have instituted a number of changes including but not limited to:

    a. Possible ligature points in the building:

        i. ensuite doors were cut down to reduce ligature potential;

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[104] Transcript, p 44.

[105] Transcript, pp 64-65.

[106] Transcript, p 104.

[107] Transcript, p 112.

[108] Transcript, p 102.

ii. door handles were changed to a handle that reduces ligature risk on all doors in bedrooms.[109]

b. The implementation[110] of a new risk assessment tool, including a risk assessment and visual observation form.

i. Associate Professor Dean Stevenson, Clinical Services Director of Mental Health Services, Mercy Health, provided a statement to the court. He outlined the new risk assessment and visual observation form "links risk assessment to current management and the level of visual observations in order to develop adequate risk management strategies."[111]

c. A primary nursing model was introduced to the inpatient unit in May 2013. This model is a team nursing approach, where dedicated nurses carry out visual observations for a specific allocated group of patients.[112]

i. the sleep chart was withdrawn from use and the 'observed visual observation arousal level' is entered directly into the inpatient risk assessment and visual observation form.

ii. during a shift the risk assessment and visual observation form is kept in a team folder which contains forms for each allocated patient.[113]

48. I note some of these changes were not made in response to Ms Nigro's death, rather following the death of a patient in April 2011.

FINDINGS

1. I find the identity of the deceased is Maria (Mary) Teresa Nigro.
2. I acknowledge the difficulty for health clinicians to manage and treat individuals with a mental illness.

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[109] Statement of Dean Stevenson, dated 1 July 2013. Changes were made during July/August 2011.

[110] Implemented in September 2012.

[111] Statement of Dean Stevenson, dated 1 July 2013.

[112] Due to reduced staff numbers at night, nurses still share the observation duties. At the end of a shift the risk assessment and visual observation form is discussed at the morning handover then filed into the patient's clinical record.

[113] Statement of Dean Stevenson, dated 1 July 2013.

3. I acknowledge predicting and preventing inpatient suicides is extremely difficult. I accept there is an ongoing tension between creating an environment that is therapeutic and comforting to the patient and one that is 'suicide proof.' Nevertheless, precautions can be taken by mental health clinicians to reduce the risk of inpatient suicide.

4. I accept the evidence that on 9 February 2009, Ms Nigro was assessed as having no risk of suicide. She did not express intent or a plan to self harm. I therefore accept the evidence that Ms Nigro did not need to be nursed in the HDU.

5. I find that there was a lack of communication between nursing staff at handover and between nursing staff on the night shift. I note the conflicting evidence presented by EN Abay and RPN Jenkins concerning observations conducted overnight on 9 February 2009. EN Abay's practices were questionable. If EN Abay found Ms Nigro awake on three occasions and RPN Jenkins was informed, perhaps nursing staff could have implemented interventions.

6. EN Abay was a division two nurse on his first night shift in the psychiatric ward. He should have been monitored and mentored. EN Abay removed from WMH and retained in his possession, the sleep chart / tick list. This was a confidential document for internal use only. The fact that he considered this appropriate reflects he did not receive appropriate induction into the procedures and policies of WMH.

7. The sleep chart / tick list that was used by nursing staff was confusing and difficult to interpret. In coronial matters where the circumstances surrounding a death are associated with medical management, the standard of communication and documentation invariably comes under scrutiny. In many circumstances, the absences or inaccuracies of recordings of observations become the focus of enquiry and a significant issue in an inquest, so that the deceased patient's clinical course can be factually understood. To make a recommendation that health care professionals be more diligent with their documentation would be somewhat banal but as in other matters, [114] I again make the comment that clinicians be reminded that their documentation is a means of communication between treating healthcare professionals, is a legal document and should act as an *aid·memoir*. I acknowledge this chart is no longer in use.

[114] Inquest into the death of Judith McDonald 2005 3907, Inquest into the death of Mary Korzeniewski 2004 4579

8. Nursing staff need to remain alert to the significance of the impact of external stressors, like family conflict. I am satisfied that there was family conflict on 9 February 2009, that caused Ms Nigro a certain level of distress. It appears that her distress has neither been appreciated nor recognised by nursing staff. I accept the submission that EN Abay and RPN Jenkins could not recall details of the handover and therefore I cannot conclude that the information was not handed over.

9. I acknowledge there was a dispute between who was the appropriate next of kin or primary carer while Ms Nigro was an involuntary patient. This dispute continued after Ms Nigro's death and I was required to make a determination on 18 February 2009. WMH failed to contact Ms Pace following Ms Nigro's death; they contacted family members. While I am not critical of WMH contacting family, the failure to contact Ms Pace is difficult to reconcile with Dr Tawde's phone call to Ms Pace, as primary carer, on the afternoon of 9 February 2009. For Ms Pace to find out about Ms Nigro's death some time later is understandably upsetting. This was regrettable, however it was not causative to Ms Nigro's death and I make no further comment.

10. Ms Nigro presented to WMH as an involuntary patient with a contemporaneous history of self harm. Access to items capable of being used to self harm should have been removed based on her presentation. It was standard in the LDU that such items were not removed. This approach does not allow for consideration of patients' individual risk. It is a principle of the Mental Health Act that patients are to be cared for in a least restrictive environment. However, this principle does not divest WMH of its responsibility to ensure patient safety which requires effective monitoring of a patient and the access they have to personal belongings.

11. I find there were a number of shortfalls in the care provided to Ms Nigro which did not equate to the appropriate delivery of care required for involuntary patients.

12. I acknowledge that since Ms Nigro's death Mercy Health have implemented a number of changes in relation to hanging points and observations.

13. I find the manner of Ms Nigro's death was preventable. However, I cannot make a finding that her death could have been prevented beyond the opportunity and the means accessible and available to her on that night.

14. I accept and adopt the medical cause of death as identified by Dr Noel Woodford and find that Maria (Mary) Teresa Nigro died from hanging in circumstances where I am satisfied

that she intended to take her own life. The evidence of family conflict lends weight to a reasonable proposition that Ms Nigro's domestic and family relationships may have influenced her decision making on that night. However, in the absence of an expression of intent or "suicide note," I am unable to make a definitive finding on whether it did amount to a precipitating event or reason that led Ms Nigro to take her own life.

CONCLUDING COMMENTS:

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

Ms Nigro's overnight nursing observations reduced to hourly observations from half hourly. All witnesses gave evidence that it was standard practice that patients in the LDU were on half hourly observations during the day and hourly observations at night. This generalised approach does not give any consideration to management strategies based on risk assessment for individual patients and in evidence it appeared that nursing staff were unaware of individual management strategies. This reflects poorly on the training staff received at WMH.

The Chief Psychiatrist conducted a review of inpatient deaths between 1 January 2008 and 31 December 2010. The report states that the frequency of observations over the night shift should be congruent with daytime observations unless otherwise decided and documented.[115] WMH's management strategies in place at the time of Ms Nigro's death do not state that observations reduce overnight.

While I make this comment, I can not definitively find that more frequent observations would have prevented Ms Nigro's death.

RECOMMENDATIONS

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

With the aim of minimising risk and preventing like deaths, I recommend Mercy Health develop and implement policies and procedures for the LDU whereby access to items that may be used to

[115] Chief Psychiatrist's investigation of inpatient deaths 2008-2010 (2012) Office of the Chief Psychiatrist, Victorian Government, Department of Health, p 31.

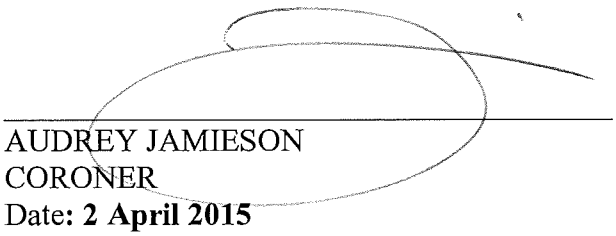
self harm are removed or reduced. Such policies and procedures should include checking patients and the unit for potentially harmful belongings and belongings that could be used for self harming purposes, monitoring items brought into the unit by visitors and educating visitors on the potential risks associated with such items.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the findings be published on the internet.

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

- Ms Lesley Pace
- Ms Silvana Girardello
- Ms Sofie Portelli
- Dr Mark Oakley Browne, Chief Psychiatrist, Office of the Chief Psychiatrist
- Mr Michael Regos, on behalf of Mercy Health
- Ms Eleanor Coates, on behalf of Ms Pace
- Constable Noel Reilly

Signature:



AUDREY JAMIESON
CORONER
Date: **2 April 2015**