IN THE CORONERS COURT
OF VICTORIA
AT BALLARAT

Court Reference: 2156/2009

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)

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

Inquest into the Death of Matthew Spalding

Delivered On: March 2012

Delivered At: Ballarat

Hearing Dates: 20 – 23 February 2012

Findings of: Michelle Hodgson

Representation:

Sergeant R. Anderson appeared to assist the Coroner.

Dr. P.B. Halley appeared on behalf of Ballarat Health Services.

Mr. R.H. Stanley appeared on behalf of Glenn Scott.

Mr. R.I. Gipp appeared on behalf of Nathan Butler.

I, MICHELLE THERESE HODGSON, Coroner,

Having investigated the death of MATTHEW GARNES SPALDING and having held an inquest in relation to this death on 20, 21, 22 and 23 February 2012, find that the identity of the deceased was MATTHEW GARNES SPALDING and that death occurred on 25 APRIL 2009 at BALLARAT HEALTH SERVICES, STURT STREET, BALLARAT.

FINDING INTO DEATH WITH INQUEST

The Coroners Court is different from other courts. It is an inquisitorial rather than an adversarial system. In other words, there is no trial, with a prosecutor and a defendant. Instead, there is an inquiry that seeks to find the truth about a person's death – to establish what happened, rather than who is to blame. The Coroner is more flexible in the evidence that they will accept, but they cannot punish.

When making a finding, coroners carefully consider all the submissions that come before them. Not every issue makes it way into the final report but everything has been weighed up and analysed.

A Coroner investigating a death must find:

- The identity of the person who has died;
- The cause of death;
- The circumstances in which the death occurred.

CONTENTS

BACKGROUND

1. Matthew was 28 years of age at the time of his death.
2. Matthew was the son of Linda and Bob Spalding and the partner of Michael Cartledge.

CIRCUMSTANCES

Finding of Matthew's body

3. Philippa Thomas[1], was a Registered Nurse, Division 1 and 3 who commenced work at the Ballarat Health Services, Adult Acute Unit on 24 April 2009 at about 9.15 pm.
4. At approximately 2.20 am, Ms Thomas commenced a round of patient observations.
5. Upon opening Room 7 which is where Matthew was staying as a voluntary patient, she discovered that the bed had been upended and that bed sheets and a jumper had been used to construct gallows and a noose upon which Matthew was hanging.
6. Ms Thomas stated that she thought upon seeing Matthew that he was deceased.
7. Ms Thomas then alerted Mr Glenn Scott, the night shift nursing supervisor who then also attended at Room 7.
8. Mr Scott stated to police that he saw Matthew hanging from the bed in the room.

   "The light was on and the bed had been turned on its end and was standing on its end. There appeared to be white twisted sheeting around Matthew's neck. The sheeting was tied to the top of the bed. The mattress was on the floor of the bedroom. There did not seem to be any signs of life from Matthew.

   I then went back to the office to get the resuscitation equipment and came back with it to Matthew's room. Matthew was still hanging and I thought I had to get

[1] Thomas IB98-133

him down and also to call a Code Blue. I then went to the office and rang 9444 (emergency medical number). I went back to Matthew's room."[2]

9. Ms Leanne Rankin, who was performing ECATT[3] duties within the ward that night overheard Ms Thomas advising Mr Scott of the situation in Room 7.

10. Ms Rankin then opened the door and observed Matthew's body in situ.

"...the bed was on it's bed – it's foot end on the floor and raised upright, so that the bed head was over against the wall...He was hanging from a sheet faced towards – facing the door and his legs were on the floor in a cross position, so his knees were what you saw and then his legs were behind him in a cross position....After I was gong to take a pulse but clearly he was deceased to me. Clearly he was very blue, cyanosed, very, very blue, finger tips were turning quite dark and he clearly was deceased...And I said ,"We have to – you've got to call a code.'...I was, like, "We've got to cut him down. We've got to cut him down."...And Phillippa was- and Glen I would say were very frozen still."[4]

11. A Code Blue was then called by nursing staff.

12. Resuscitation efforts by the medical team were stopped at 2.46 am.[5]

Post Mortem Examination

13. Matthew Lynch, a medical practitioner practising as a specialist in forensic medicine and pathology at the Victorian Institute of Forensic Medicine performed an autopsy on Matthew on 1 May 2009.

14. Dr Lynch concluded that

    1. *The cause of death in Mr Matthew Spalding is neck compression subsequent upon hanging. The mechanism of death in cases of hanging involves one or a combination of airway obstruction, vascular (arterial or venous) obstruction or cardiac arrhythmia induction in the setting of carotid sinus stimulation.*

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[2] Scott IB 96
[3] Ms Rankin was not involved in patient supervision on this evening.
[4] Rankin IB 12-13
[5] SEE Tandon IB210 Hospital File

2. *There was evidence at autopsy of a ligature mark about the neck and fractures of the larynx consistent with compressive force. No other injuries of note were identified.*

3. *No significant natural disease was noted at autopsy.*

4. *Toxicological analysis detected cannabinoids in urine.*[6]

Matthew's Mental Health History

15. Mrs Spalding gave a statement to police in which she outlined the history of her son's mental health.

16. Mrs Spalding states that Matthew's mental health problems extended back many years commencing with self harming in his late teens.

17. Matthew had a history of cannabis use and had been diagnosed with borderline personality disorder, anxiety and depression.

18. Approximately two years ago he had suffered a psychotic episode which resulted in the appointment of Matthew's case worker, Hollie Laver.

19. Dr Rajul Tandon, Matthew's treating psychiatrist summarised Matthew's mental heath history up to 23 April 2009, *inter alia*, at the inquest:

> *"..Mr Matthew Spalding was a 28 year old male in a supportive gay relationship, resident of Ballarat East…Matthew was regularly followed up by Ballarat Health Services Psychiatric Services since June 2007. He was referred on 10 June 2007 by the emergency Department as he presented following self inflicted lacerations on the forearms. This was in the context of an acute psychotic episode with a differential schizophreniform disorder and/ or drug induced psychosis along with significant anxiety.*
>
> *At the time of his referral, Matthew also had problems of cannabis and alcohol abuse. He was also using amphetamines recreationally. Matthew was treated by using and anti-psychotic Aripiprazole 15 milligrams per orally..*[7]

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[6] IB216-224

[7] DR Tandon stated at inquest that this maybe 10 milligrams not 15 milligrams as he checked this recently.

Matthew was taken for active case management since then. His mental state improved quickly, since the commencement of the medication. Matthew also engaged in psycho-social treatment initially provided to him by his treating clinician Anthony Harrington. This included illness education on anxiety and psychosis, relaxation training and CBD for anxiety…

Matthew decided to come off his anti psychotic medication in January 2008 as he felt that his ability to experience emotions was better without the medication. Subsequently, it was noted that Matthew used to experience on and off symptoms of lowered mood and anxiety and self harm thoughts, in the context of stress, that is relationship problems with partner, financial issues etc…

Matthew was also linked with a drug and alcohol counsellor.

Prior to the year 2007, Matthew had a history of several self harm episodes by self-cutting or overdose in the context of poor coping, substance abuse and symptoms of anxiety and depression. His initial contact with Ballarat Psychiatric Services was in the Year 2000 and subsequently in 2002. He was prescribed anti-depressant medication by his GP since October 1999.

Due to long term issues with poor stress tolerance, relationship problems, fear of abandonment, emotional dys-regulation, substance abuse and repeated self harm behaviour , a diagnosis of borderline personality disorder was considered on Axis 2, and this was discussed with Matthew and his partner Michael. Matthew was gradually introduced to distress tolerance; that is part of dialectical behaviour, therapy by his new treating clinician Hollie Laver in November 2008.

Matthew accepted this form of psycho-social psychological treatment.

In a review… on 26 March 2009, Matthew reported on felling anxiety in social settings. He reported that he ceased using cannabis. Use of psychological strategies discussed. Matthew requested for a p.r.n. use of – that is as and when required – use of Benzoodiazepine Alprazolam[8] which was prescribed to

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[8] Xanax

him and he was cautioned about its addiction potential, in view of his history of substance abuse."[9]

ISSUES RELATING TO PUBLIC HEALTH AND SAFETY

20. Section 67 (3) of the *Coroners Act* 2008 states that

> *A coroner may comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice.*

21. Issues that relate to public health and safety have been raised by the death of Matthew.

22. Mrs Spalding stated

> *"As parents, we almost forced him into doing what he didn't want to do, go into the psych ward. We wanted him to get help and we thought it was the best and safest place. How wrong we were."*

23. In closing submissions for Ballarat Health Services, Dr Halley, stated

> *"...we (Ballarat Health Services) whose Matthew's family and partner put trust in to care for Matthew and we do accept that Matthew was in our care, in Ballarat Health Service's care, when this tragic event happened and we take responsibility for the fact that he was in our care."*

24. Three issues have been raised by Matthew's death in April 2009:

    a. The adequacy of risk assessments for patients at the Adult Acute Unit;

    b. The presence of ligature points in the Adult Acute Unit;

    c. The adequacy of monitoring of patients during admission to the Adult Acute Unit;

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[9] Tandon IB 210-212

ADEQUACY OF RISK ASSESSMENTS

Matthew's Mental Health in the Days Preceding Admission to the Adult Acute Unit

25. Matthew's mental health had begun to deteriorate markedly from Wednesday 22 April 2009.

26. Both Mrs Spalding and Michael Cartledge, give harrowing accounts of the disturbed behaviour of Matthew in the days preceding his admission.

27. Michael stated that:

> *"...In that last week he was extremely paranoid...I think he was just worried that someone was out to get him or out to get the people that he loved."*[10]

28. Mrs Spalding states that her son stated that he had recently finished taking Xanax.

29. Mrs Spalding felt so concern about Matthew's presentation on that Wednesday that she took him to the Eureka Medical Centre to see his General Practitioner, Dr Eggleston who prescribed 5 Temazepam to alleviate the symptoms that Matthew was experiencing.

30. On Thursday 23 April, Matthew barricaded himself within his home suffering what appeared to be paranoid delusions resulting in police attendance.

31. Matthew was taken to the Ballarat Hospital and begged to be taken home.

Risk Assessment by Hollie Laver[11]

32. Hollie Laver saw Matthew on 23 April 2009 and noted that Matthew was

    a. *Exhibiting some emerging psychotic and paranoid symptoms;*

    b. *was not feelings safe;*

    c. *was concerned about being tortured;*

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[10] Cartledge IB 71
[11] Laver T51-58

d. *was concerned that his medication was being interfered with;*

e. *believed he had seen a face in the window causing him to smash the window;*

f. *had ceased using prescribed Xanax three days prior;*

g. *had smoked marijuana that morning.*

33. Ms Laver completed a risk assessment and formulated that Matthew had a moderate risk of accidental self harm because of his paranoid thoughts and because his judgement and insight was impaired.

34. Ms Laver formulated that he had a low risk of self harm as he denied thoughts, plans or intent to harm himself.

35. Ms Laver formulated a management plan, having discussed the plan with Matthew, his parents and his partner.

36. Ms Laver liaised with Dr Praveen Thottappilil[12] who was agreeable to Matthew returning home with his parents provided that adequate supervision could be provided.

37. A clinical risk management plan was put into place that included;

a. *Matthew to take medications as prescribed (he was prescribed Imovane for sleeping);*

b. *Matthew to undertake relaxation techniques;*

c. *Matthew to avoid alcohol, marijuana and stimulants;*

d. *Matthew to seek reassurance from his parents and partner;*

e. *Matthew to contact Ballarat Psychiatric Services as needed;*

f. *Matthew to tell his parents and partner if he experienced thoughts of self harm;*

g. *Matthew's parents and/or partner to supervise Matthew at home.*

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[12] On Duty Psychiatrist

38. Matthew agreed with the clinical risk management plan, and further agreed to allow his parents and/or partner to contact Ballarat Psychiatric Services if he suffered from any worsening of his symptoms.

39. Ms Laver arranged for Kate Adams, mental health clinician to phone Matthew at 7.30 pm that evening to review his progress and also arranged for Matthew to attend a follow up appointment with Dr Rajul Tandon, psychiatrist on 24 April 2009.

40. That night Michael described Matthew:

"...He was absolutely shocking. He did not sleep at all. He was constantly going around to all the doors and windows and making sure they were locked...he didn't sleep at all."[13]

Risk Assessment by Dr Tandon on 24 April 2009

41. An urgent appointment was booked to see Dr Tandon on 24 April 2009.

"...I reviewed Matthew with Emily Smith....at 900 hours. Matthew came to the review with his mother.

He presented as restless, paranoid and as initially irritable. Matthew's mother informed me that Matthew did not sleep well.

Matthew's mother informed me that Matthew did not sleep well previous night and she was anxious about his management at home. I suggested hospitalisation to Matthew in view of his presentation and past history.

Matthew was reluctant with this initially.

Matthew agreed when he was reassured about its purpose and was explained to him; these included rest, management of insomnia, longtitudinal monitoring of mental state and commencement of medication.

(Dr Tandon) spoke with the shift manager, Chris Boyce, on phone and informed him about the outcome of review and decision to admit Matthew. Matthew was shifted to Adult Acute Unit where admission procedure was followed by the medical officer and inpatient nurse."

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[13] CartledgeIB75

42. Matthew was extremely unwell, and the clinical assessment and decision to admit Matthew was an appropriate one.

Risk Assessment on Admission to the Adult Acute Unit

43. Dr Tandon states that *"admission procedure was followed by the medical officer and inpatient nurse. Matthew was given PRN medication, that is, as and when required medication, Olanzepine 5 milligrams and diazepam 10 milligrams at 1230 hours…Urine drug screen conducted was positive for benzodiazepine, cannabis and opiates. He was put on a marijuana withdrawal scale and a 30 minute visual observation in general ward."*[14]

44. The medical file documents Matthew's admission to the unit that afternoon and includes observations that he was *"calm, cooperative and polite"* referring to the intake assessment document completed by Ms Emily Smith earlier that day.

45. This document clearly outlines that Matthew was commenced on 30 minute observations with a plan to monitor his risks and behaviour, to start review the next morning and to provide support and reassurance.

46. Risk assessment is a core component of clinical practice.

47. Ballarat Health Services had in place documented risk assessment procedures at the time of Matthew's admission to the inpatient unit.

48. The risks of accidental self harm were recorded as moderate on the basis that he had impaired judgment and insight whilst he was considered a low risk of deliberate self harm due to his denial of such thoughts.

49. In answer to a question by myself at Inquest as to whether Matthew presented as high risk of suicide, Dr Tandon stated:

> *"…I wouldn't say that he presented as a high risk of suicide to me, Your Honour. Being aware of his past history and presentations, I was worried that he was – the risk – indeterminable. That's why I decided for him to be hospitalised, because he needed to be supervised more closely in terms of*

[14] Tandon IB210-212

treatment and its response, as well as to be mindful that if the situation changes, an appropriate necessary actions could have been taken regarding his management."[15]

50. In the "Chief Psychiatrist's Investigation of Inpatient Deaths 2008-2010" Report dated January 2012 it was noted that "admission is only contemplated when treatment in the community can not be safely provided."[16]

51. It was noted that "predicting and preventing inpatient suicides is extremely difficult."[17]

"Several researchers have tried to predict inpatient suicides on the basis of identified risk factors. However, the evidence suggests that these factors are not specific or sensitive enough to have significant clinical utility."[18]

52. The policy of the Ballarat Health Services of ensuring that new admittees were to be on 30 minute observations recognised that patients were particularly vulnerable on their first night as inpatients.

53. Professor Abdul Khalid, the Director of Clinical Services at Ballarat Health Services Psychiatric Services stated that the *"placing Matthew on a 30 minute observation regime was reasonable and appropriate in the circumstances."* [19]

54. A protocol titled "Admission to the Adult Acute Unit Mental Health Services"[20] details the current practice with respect to the admission of psychiatric patients.

55. Prior to April 2009 (at the time of Matthew's death) nursing, assessment and treating plans were recorded in the patient's progress notes.

56. Following Matthew's death the Hospital reviewed its procedure for admitting patients to the Adult Acute Unit.

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[15] TandonT29
[16] P.29 "Chief Psychiatrist's Investigation of Inpatient Deaths 2008-2010"
[17] P.11 "Chief Psychiatrist's Investigation of Inpatient Deaths 2008-2010"
[18] P.11"Chief Psychiatrist's Investigation of Inpatient Deaths 2008-2010"
[19] Khalid Statement dated 14 February 2012
[20] See Exhibit A

57. The policy change is an improvement in the communication of admission documents and nurse and treatment plan documents.

58. The document sets out much more clearly than the pre April 2009 documents the issues that should be looked at and documented in relation to harm when a patient has been admitted to the Unit.

59. It sets out clearly the levels of observation that are required.

60. Dr Tandon states that compared to the documentation in use pre April 2009 it is *"...much more evidence based, based on all the research which supports the decision making in terms of risk assessments as well as the – the planning of risk management in an acute setting like the acute units. So it's definitely much more evidence-based, more objective and that is an improvement from April 2009."*

61. I note that the current Ballarat Health Services "Risk Assessment and Risk Management Guidelines" emphasises that **"great weight should be given to information and opinion from those who know the individual well, whether they are family, friends or staff."**[21]

62. Dr Tandon's evidence was that the current Ballarat Health Services Risk Assessment and Risk Management Guidelines is distinguishable from the traditional use of freehand notes which do not provide prompts for all areas of assessments.

"...it removes the error of individual error and it adds more objectivity to the assessment."[22]

LIGATURE POINTS IN THE ADULT ACUTE UNIT

63. The design and layout of an inpatient unit is critical in delivering safe inpatient care.

64. In the "Chief Psychiatrist's Investigation of Inpatient Deaths 2008-2010" it was noted that the;

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[21] P6 "Risk Assessment and Risk Management Guidelines"
[22] TandonT35

"It is appropriate that mental health services are of an equal standard to those in other areas of health. However, this has presented an added risk given the difficulties of providing accessible observation and the degree of ingenuity sometimes shown by person's intent on suicide. There will always be a balance between the physical environment and amenity, and potential for self harm."[23]

65. In her statement Tamara Irish, the Executive Director of Mental Health at Ballarat Health Services stated

"...each of the rooms in the Unit now contain a bed which can not be repositioned or elevated, magnetic hooks in the bathroom and a cupboard for patients' belongings. There are no longer any ligature points in any of the rooms in the Unit. Each of the rooms looks out on to a courtyard space and has a large, unbreakable window to ensure adequate natural sunlight. Ensuite bathing facilities are especially designed to ensure ligature points have been eliminated. With the same intention, bathroom doors have concealed hinges."[24]

66. These changes were effected as the result of a $5.5 million funding for the upgrade of the Adult Acute Unit.

67. The re-development of the unit was completed in 2010.

68. I had the opportunity to observe the refurbished Adult Acute Unit on 21 February 2012.

69. I note that the Chief Psychiatrist cautions against *"progressively limiting the amenity of bedrooms in response to single events."*[25]

70. On my observation, the amenity and comfort of the acute unit was not at all compromised by the elimination of ligature points and provided an unobtrusive and humane setting for the health treatment of inpatients

71. I was advised by Counsel for the Hospital[26] in closing submissions that the bed which Matthew had used had never been an identified risk factor

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[23] "Chief Psychiatrist's Investigation of Inpatient Deaths 2008-2010" Pp33-34
[24] Irish Statement 21 February 2012
[25] "Chief Psychiatrist's Investigation of Inpatient Deaths 2008-2010" P34
[26] Dr Halley

under previous risk assessments and that he had been unable to advise of any previous deaths whereby the bed was used in this manner.

72. It seems tragically obvious now that the bed could have been used in this way and that fixing the bed to the floor is a simple and effective way to ensure that a bed is not used again to enable the death of an inpatient.

MONITORING OF PATIENTS OVERNIGHT IN THE ADULT ACUTE UNIT

Nursing Observations

73. A category of observation is common across all mental health units.

74. In essence, a category of observation is a process for checking on the wellness and whereabouts of each patient in a Unit.

75. All of the Nurses on duty on the night of Matthew's admission knew what an observation required.

76. Ms Rankin stated that an observation consisted of *"go around with a torch and check for respirations and where they were laying and if they were awake, but I wouldn't "Are you awake" you'd say – just check".*[27]

77. Ms Thomas stated that when she did an observation round, her practice was *"You have a torch and you check each room and you look to see if the person's breathing....Sometimes it only takes a few seconds...you look to see that the patient's clean, comfortable, dry , asleep, breathing."* [28]

78. Mr Butler gave evidence as to his understanding of a visual observation:

"So you enter the room and if it's dark you utilise torch to see if there's a clear rise and fall of the patient's chest, ensuring – and what's happening in the surrounding environment. If there's no – if there's lights on you don't need the torch and try to be as minimally invasive as possible to the patient so you don't disturb their rest period."[29]

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[27] T74
[28] T87
[29] T140-141

79. Ms Scott stated that he understood observing a patient to be *"..during the night you'd open the door and shine the torch and um, make sure there was, um, they were breathing, there was good colour, they were – weren't restless, um, they looked comfortable, um, there was nothing dangerous around the, the bed. Um, that, um I don't know, the room wasn't too hot or yeah, um...."*[30]

80. The very clear purpose of the observations is to ensure the well being of a patient.

Nursing Arrangements at the Adult Acute Unit on 24 and 25 April 2009

81. In a statement dated 20 February 2012, Ms Tamara Irish[31] set out the nursing arrangements that were in place in April 2009.

82. She states that the model for nursing overnight included the following:

    a. *all new admissions were observed every 30 minutes for the first 24 hours of admission;*

    b. *the shift manager was responsible for allocating the tasks for each of the nursing staff on during the shift, including two who would perform observations. The shift manager was also responsible for the supervision of all nurses, including their activities and documentation.*

    c. *the allocation of tasks by the shift manager would depend on the number and status of the patients in the unit and the number of staff rostered for each shift; and*

    d. *staff includes 3 nursing staff and one ECATT staff member who was a triage worker.*

What were the observations of Matthew?

83. All of the Nurses on duty that night knew that Matthew was on 30 minute observations.

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[30] T166

[31] Executive Director of Mental Health at Ballarat Health Services.

84. This was communicated in a number of ways including at handover, on Matthew's patient file and also awareness of the practice that patients on their first night of admission were on half hour observations.

85. The Nursing Observation Chart indicates that Matthew was observed at half hourly intervals until the discovery of his body at approximately 2.25 by Ms Thomas.

86. The Nursing Observation Chart records that at 1.30 am and 2.00 am Matthew was "in bed asleep"

87. Mr Scott provided a statement to police on 25 April 2009 stating that he had personally checked Mr Spalding at 1.55 am stating *"I observed Matthew lying in bed and presenting himself as though he was asleep. I didn't say anything to Matthew and shone my torch on his chest and face and he appeared to be asleep. I note his chest to be rising and falling and he appeared to be settled and sleeping."*[32]

88. Ms Leanne Rankin raised her concerns with Mr Scott based on her observations of Matthew's body in relation to the timing of the observations that he had told police he had conducted personally.[33]

89. In a recorded interview with Detective Senior Constable Jess on 29 April 2009 Mr Scott stated that he had conducted a "check" on Matthew at 1.00 am.

90. He then stated that a check occurred at 1.30 am. *"Nathan checked him at 1.30."*

91. He then stated that he had signed that entry in the Nurses Observation Chart.

92. Mr Scott stated that at 2.00 am

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[32] ScottIB96
[33] RankinT64 IB 183

"Nathan went past his room, and I admit he didn't open the door, but he said – I said "How is he?" And he said, "His light's still off and,"..."

93. When questioned as to how he knew that Mr Butler had not opened the door he stated that Mr Butler had told him.

94. When queried by Senior Detective Jess how he could then write up that discussion as "in bed asleep' he stated *"he had been asleep and he looked like he was sleeping soundly and ..."*[34]

95. He states that *"Nathan should have opened his – opened his door, we – it – it was a false assumption that ..."*[35] he goes on to state that Nathan had told him that the light in Matthew's room was off.

96. In a recorded interview with Detective Senior Constable Jess on 14 May 2009, Nathan Butler gave his account of events.[36]

97. He stated that he had conducted a visual round observing Matthew at around 1.20 am.

98. He stated that Glenn Scott had told him he had done the 1.00 am check of Matthew and he had initialled the observation by Glenn Scott.

99. Mr Butler stated that Mr Scott then asked Mr Butler if he could initial Mr Butler's observations at 1.20 am which he did because it was convenient for him to do so standing next to the observation sheets.

100. Between 1.20 and 1.35 Mr Butler had been on a break but returned to assist Mr Scott and Ms Thomas with another patient who had caused a disturbance in the high dependency unit requiring the cleaning of her room.

101. Mr Butler states that he was engaged in assisting with the cleaning up between about 1.40 am to 1.55 am.

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[34] Scott IB 214
[35] Scott IB263
[36] Butler IB134-170

102. The mop and bucket was located in an area near the room of Matthew.

103. Mr Butler states that he was asked at that time by Mr Scott if *"it was all quiet down there";*

> *"down that end. I said yeah, there were no sound out of the ordinary. I didn't actually do a visual check, but he did initial it."*[37]

104. In his evidence before this Court, Mr Butler stated that he did not do any observations of Matthew after 1.20 am.

105. Mr Butler stated that he returned the mop and bucket that he had been using to assist in the PICA at around 2.00 am. He states that he walked past Matthew's room at that time and that the door was closed.[38]

106. He did not make any visual observation of Matthew at that time.

107. When he was returning to the nurses station he was asked by Mr Scott whether it was "all quiet?"

108. Mr Butler stated that he assumed it was a question that was – *"if it was literally quiet down there, which I responded to "Yes" there was no noise as such, no"*

109. He stated that at that point in time he was unaware that that conversation was to form the basis of an entry in the observation chart.[39]

110. He stated he became aware that Mr Scott had advised that he used that conversation as the basis for an observation entry during the investigative phase into Matthew's death.

111. He stated that from 2.00 am to 2.15 am he was on a telephone call to his girlfriend.

112. It appears that Matthew was not asleep.

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[37] Butler IB148
[38] Butler T 134
[39] Butler T136

113. There have now been several different versions provided by Mr Scott in relation to the missed observation of Matthew that night.

114. Regardless, it beggars belief that an experienced psychiatric nurse of some 19 years standing could make the leap from what he observed Mr Butler doing, at the time of the recording of a purported observation by Mr Scott, to being an observation that Matthew was *"in bed asleep"*.

115. It was submitted by Mr Scott's Counsel that I should not make an adverse finding against Mr Scott with regards to the disparate versions of events that he has given the police and this inquiry.

116. He submits that any disparity is attributable to the shock and post traumatic stress that he has since suffered since the discovery of Matthew's body.

117. I prefer the evidence of the Nathan Butler, Phillippa Thomas and Nicole Rankin as to the events of that evening who have been consistent in their recount of events.

118. It was submitted by Mr Stanley on behalf of Mr Scott (who I find as the Nursing Shift Supervisor[40] was responsible for ensuring that the observations clinically indicated and required were conducted properly) that I could not find *"in any leap that a two o'clock observation would have saved Matthew."*[41]

119. Mr Gipp submitted that *"Had the observations been conducted at 2.00 am it is possible that Matthew would not have had the opportunity to commit suicide."*

120. Matthew was not checked on and did not have any contact with staff for at least one hour.

121. Mrs Spalding poignantly stated in her interview with police:

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[40] A position he had held innumerable times over the past 19 years.
[41] Stanley SubmissionsT244

"...the awful thing that stays with you is the fact he was in that room without anyone. What must have been going- it must have been horrendous for him to – to go to the lengths he obviously went to make sure he was successful." [42]

122. Sergeant Gale made the observation that *"It appeared Spalding made attempts to hang himself with other items before using parts of a bed sheet."*

123. In his room was located, his phone charger which was broken in two, a jumper whose sleeve had been unpicked and a torn up bed sheet used as a ligature. [43]

124. Matthew was fully dressed in jeans, belt, t-shirt and socks when he hanged himself.

125. He had a history of three days without sleep and the staff member on the previous shift had arranged for an order of the hypnotic Zopiclone.[44]

126. A properly conducted observation by an experienced psychiatric nurse at 2.00 am may have identified that Matthew was certainly not sleeping between 1.20 am and 2.25 am that morning.

127. On any account, the lack of observations for at the very least, one hour on Matthew afforded him a lengthy opportunity to ruminate and make preparations for his death.

The practice of initialling the observations of other nursing staff

128. The formal practice at the time of Matthew's death is that the staff member responsible for sighting a patient places their initial against each period on a form, which is considered evidence of formal sighting of a patient.

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[42] L Spalding IB 51
[43] IB213-214
[44] Marketed as Imovane that is a short acting hypnotic/sleeping medication. It works by reducing the time taken to fall asleep, increasing the duration of sleep and decreasing the number of awakenings.

129. It has become clear during the evidence of Ms Thomas, Mr Butler and Mr Scott that some nurses on these shifts would from time to time initial the observations of other nurses.

130. All nurses stated that they had observed this happening in the shifts they had worked.

131. It is difficult to estimate how frequently this was occurring from the evidence of these three witnesses.

132. It was referred to as substandard or not best practice.

133. There was some conjecture as to whether there was a "culture" of this occurring at the Ballarat Hospital.

134. It was clearly a practice adopted by individual nurses but I do not accept that this was a practice that all nurses shared and accepted or one that characterised the institution.

135. All of the nurses when questioned conceded that they knew this practice was wrong.

136. It went directly against what they knew was acceptable practice and hospital policy.

Nursing Observation Policy at Ballarat Health Psychiatric Services Adult Acute Unit post April 2009

137. In an email to all nursing staff dated 19 May 2009, staff were advised

> *"...every patient must have a clearly identified NOC and the documentation reflecting the allocation and recording of completed observations by the nurse undertaking the observation. This task of documentation cannot be delegated."*[45]

138. A further email dated 26 May 2009 advised of proposed changes to the Nursing Observation Chart

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[45] Exhibit 1A

"will be revised to be more relevant to psychiatric risk observations and assist the nurse to record information which is relevant to the behavioural activity of the patient. Until that is achieved, please record activity as : - settled and socialising. Unsettled in dining area. Asleep in chair. Irritable when conversing. Isolating self in room but awake. Lingering near exit and unsettled, etc. this is designed to contribute clinical information on the patient rather than just be a check list."

...Night Duty now has a primary nurse capacity. All staff must carry a case load, perform checks and record as described above. The primary role of night staff is the safety and care of inpatients. Inpatients must be prioritized above phone duties. It may be helpful to remember – Your patient=your check. Your check=your signature. Your signature=your responsibility."

139. Ms Irish provided details of the current nursing arrangements at the Adult Acute Unit.

"The current model for nursing overnight in the Unit includes the following:

a. *the overall nursing responsibility on a shift by shift basis of the patients in the unit rests with the Shift Manager;*

b. *staff including 3 nursing staff and one ECATT staff member who is triage worker;*

c. *each nursing staff member is initially allocated 2 hours responsibility for nursing observations. Once each of the three staff members have completed 2 hours of observations, each staff member is then allocated an additional hour of observations. The observation rotations are planned at the commencement of the shift and recorded on the whiteboard so that each staff member knows who is responsible for observations at all times during the night;*

d. *the Unit Manager is responsible for monitoring the number of inpatients in the Unit and ensuring the appropriate level of staff are working;*

e. *additional staff may be rostered if there is a change of circumstances warranting same. Additional staff members are engaged at the discretion of the Shift Manager, via the unit Manager based on the needs of the Unit's client cohort;*

f. *if the Unit has patients in the intensive care area then additional staff members are rostered on to ensure safe practice. Staffing of the intensive care unit is allocated from staff on shift if extra staff required. They are arranged according to patient acuity and level of clinical activity.*

g. *In the event of clinical need, relating to in particular, the risk of deliberate self harm (DSH) harm (actual or potential) or harm to others (HTO) a patient may be shifted to a location close to the nursing office or into the psychiatric intensive care unit for close observation and treatment.*

h. *All new admissions are observed every 15 minutes for the first 24 hours of admission; and unless otherwise directed by the Consultant Psychiatrist;*

i. *Three monthly spot checks of patient observation sheets are conducted by the Nurse Unit Manager or delegated Associated Nurse Unit Manager to ensure hospital's current model for nursing overnight is efficient and effective."*[46]

140. The model for overnight nursing in the unit after Matthew's death provides clarity as to the responsibility of individuals for the making and documenting of nursing observations.

141. The model reinforces the role of personal professional responsibility for nursing staff and provides a layer supervision and accountability for these critical observations.

CONCLUSION

142. I find that Matthew died of hanging in the early morning of 25 April 2009 at the Adult Acute Unit, Ballarat Hospital.

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[46] Statement of Tamara Irish 21 February 2012

143. I find that Matthew's death in the Adult Acute Unit on 25 April 2009 was preventable.

144. Predicting intent of self harm is an inherently difficult task. I am satisfied in all the circumstances of this case that the risk assessments conducted by Ms Laver and Dr Tandon were conducted with the utmost professional care and were adequate.

145. Matthew should not have had the means (access to his bed as a ligature point) or the opportunity (infrequent observation) to hang himself that morning.

146. Though a matter of speculation whether the outcome would have been averted, it certainly would have been more difficult for Matthew to have constructed gallows from his bed and make ligatures if the Nursing observations were conducted properly.

RECOMMENDATIONS

1. To prevent suicide in the mental health adult acute inpatient setting, I recommend that the Department of Health:

A. Produce guidelines to assist health services to design inpatient units that maximise adequate patient observations and to mitigate risks associated with ligature points.

B. Implement Recommendation 7 made in the report titled *"Chief Psychiatrist's investigation of inpatient deaths 2008-2010"* that:

> "The Department of Health and health services ensure there is clear and consistent process and documentation for nursing observations, and that any change in required observation level is made after suitable discussion and consideration. The frequency of observations over the night shift should be congruent with daytime observations unless otherwise decided and documented."

C. In addition to Recommendation 1B above, the process and documentation of nursing observations should incorporate supervision and accountability to ensure that there is no doubt as to a Nurses responsibility to conduct observations as clinically indicated.

D. Develop Risk Assessment and Risk Management Guidelines specific to inpatient / bed-based Adult Acute

Units. The assessment and guidelines should reflect the evidence-base and be inclusive of the range of vulnerabilities and risk exposures present in the adult acute inpatient setting.

E. Implement Recommendation 15 made in the report titled *"Chief Psychiatrist's investigation of inpatient deaths 2008-2010"* that:

> "That the Chief Psychiatrist convene a panel every three years to inquire into inpatient deaths over that time to consider overall practice improvements and issues relevant to the mental health system."

Michelle Hodgson

Coroner

13 March 2012

I direct a copy of the finding to the following parties for their action:

1. Mr Lance Wallace, Acting Secretary Department of Health

2. Dr Ruth Vine, Chief Psychiatrist

I also direct that this finding be distributed to the following parties for their information only:

1. Mr Spalding's parents

2. Coroners Prevention Unit

Coroners Court of Victoria