IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 / 5565

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: NAOMI HALL

Delivered On:	12 June 2013
Delivered At:	Coroners Court Melbourne
Hearing Dates:	19 December 2012
Findings of:	JOHN OLLE, CORONER
Representation:	Ms S. Allen on behalf of Eastern Health
Police Coronial Support Unit	Leading Senior Constable T. Cristiano

I, JOHN OLLE, Coroner having investigated the death of NAOMI HALL

AND having held an inquest in relation to this death on 19 December 2012
at MELBOURNE
find that the identity of the deceased was NAOMI EVA-MAY HALL
born on 16 January 1972, aged 37
and the death occurred on 27 November 2009
at Royal Melbourne Hospital, Grattan Street Parkville 3050

from:

1 (a) HEAD INJURY SUSTAINED IN MOTOR VEHICLE COLLISON (PEDESTRIAN)

in the following circumstances:

1. At inquest the following summary was received into evidence:

> "Naomi Hall was an involuntary patient at the Mental Health Unit of Maroondah Hospital, Ringwood East. She had been placed in the unit the weekend prior to the incident. She resided at Mentone and was 37 years old.
>
> On Tuesday morning, 24 November 2009, Naomi had left the unit and made her way to Maroondah Highway, Ringwood. She left a note in her room with her final thoughts and requests.
>
> Shortly after 11am, Naomi arrived within the vicinity of 290 Maroondah Highway in Ringwood, which is a childcare and kindergarten centre. She was seen at this time by an employee of the centre. It is believed that Naomi was waiting near the front of the centre for up to 15 minutes.
>
> At approximately 11.19am, Naomi observed a tip truck travelling southwest along the inside lane of the inbound lanes towards her location. At this time, she stepped out from behind a power pole and speed restriction sign, on to the roadway, into the direct path of the truck. She then turned around to face the truck.

Upon sighting Naomi, the truck driver swerved to the right in an attempt to go round her, however, she moved to her left in order to ensure that the collision could not be avoided.

The truck collided with Naomi and dragged her along the road. She suffered severe head injuries and was conveyed to hospital and Naomi died three days later in intensive care at the Royal Melbourne Hospital.

The truck involved was inspected by police at the scene. No mechanical fault was observed and the truck appeared to be in a roadworthy condition. The skid marks left at the scene were even in appearance, which suggested that all the brakes were operating correctly.

The truck was carrying brown fill and even though the truck was not weighed, there was nothing to suggest that the truck was carrying an excessive load. The driver was given a PBT and this was negative.

Naomi had a history of depressive illness. She had been seeing a private psychiatrist for some time and had been on and off medication for her illness. Several days leading up to this incident, she was admitted to Maroondah Hospital in a psychotic state.

A friend who visited Naomi in the unit described her as being in a state never previously seen before. Her friend, herself a clinical psychologist as well, believed that Naomi was paranoid and was of the belief that everyone, including her psychologist was conspiring against her.

Even though her state of mind had not changed over the following days, there was nothing to indicate that Naomi would be a risk to herself."[1]

Clinical management

2. The family were concerned with the decision to transfer Naomi from the high dependency unit (HDU) to the low dependency unit (LDU) on 21 November 2009.

3. Statements from clinicians were obtained. Dr Kennedy, Consultant Psychiatrist provided a detailed report. On admission, Naomi was reviewed the on-call psychiatrist. Her involuntary

[1] Summary of written evidence by Leading Senior Constable Cristiano

status confirmed. Naomi was found to have prominent paranoia with compromised insight and judgement. Her assessment for inpatient review was conducted in the HDU, where Naomi's level of distress:

> "had deemed to settle to a degree that permitted transfer to the less restrictive, Low Dependancy Unit. The transfer occurred without incident."[2]

Naomi commenced to develop a rapport with nursing staff.

4. I am satisfied the transfer from HDU to LDU was in compliance with hospital protocols and clinically based. In the LDU:

> "Overall, nursing reports indicated that Ms Hall was settling into the ward environment well, however, with limited interaction with ward peers. She attended to her own needs adequately and was always well groomed. She was pleasant in superficial interactions with a restricted range of emotion, accepting the hospital assessment in general, and demonstrated no acute risks of self harm or harm to others."[3]

5. At the multidisciplinary meeting on 24 November 2009, Dr Fiona Wood, senior registrar noted no acute concerns from staff regarding Naomi's safety. Further, Dr Wood held no concerns regarding Naomi's management and felt confident in the team approach[4].

6. A detailed statement was supplied by the Program Director of Mental Health at Eastern Health, Paul Leyden[5]. A copy provided to the family.

7. I am satisfied the initiatives referred to in Dr Leyden's report, following the Eastern Health 'major review of risk assessment and the clinical alignment with functional observations' and subsequent findings and initiatives are appropriate. In particular, I note:

> "There has been education of staff around the visual observation processes, highlighting that observation categories should not alter overnight, unless with the agreement of the relevant medical practitioner."[6]

---

[2] Statement Dr Kennedy

[3] Statement of Dr Kennedy

[4] Dr Wood had extensive contact with Naomi

[5] Dr Leyden "Based on the documentation available related to the clinical presentation, the risks and subsequent trial in LDU, I believe the management of Naomi in LDU following her admission was appropriate."

Improvements in the clinical risk tool

8. Ms Allen for Eastern Health detailed improvements in relation to the clinical risk tool:

> "It was a complete review of the risk assessment process, not just in relation to this particular matter, but it was a review done in relation to all the clinical risk assessments and the types of tools we were using and so there's just now it's been – it's much more facilitated to align risks with the management strategies for the patient, so it's a little bit easier to fill in the forms and then align it with management plans and recording"[7]

9. Naomi was placed on 30 minute nursing observations. It appears following a nursing decision, Naomi's observation levels were reduced to 60 minute.[8] On 24 September, Naomi's contact nurse was handed over 60 minute observations. Naomi was last observed by her contact nurse at 10 am on 24 September. Between 10am and 11.30am, Naomi's contact nurse had duties in HDU[9] Upon her return to LDU, it appeared Naomi had absconded from the ward.

10. Having reviewed the detailed clinical statements, I am satisfied the decision to transfer Naomi to LDU was not unreasonable and further, Naomi's decision to abscond could not have been reasonably foreseen.

11. Naomi's family have suffered a tragic loss. I offer the family my sincere condolences.

12. The driver of the vehicle, which struck Naomi, had no opportunity to avoid impact and bears no responsibility for the sad outcome.

13. I am satisfied Naomi deliberately stepped in front of the on coming vehicle.

---

[6] Statement Dr Leyden – a number of Inquests have identified this systemic issue across the State of Victoria.

[7] Submission of Ms Allen, Eastern Health

[8] A number of coronial investigations have identified this systemic flaw. I note Dr Leyden's assurance that Eastern Health has addressed this issue. Nursing observation levels cannot be reduced without agreement of the relevant medical practitioner.

[9] "During this period Naomi was being monitored by the shift leader." – RPN Green-Cassidy

Post Mortem Medical Examination

14. On 30 November 2009, Dr Matthew Lynch Forensic Pathologist at the Victorian Institute of Forensic Medicine inspected the body of Naomi Hall.

15. Dr Lynch found the cause of death to be head injury sustained in motor vehicle collision (pedestrian). Dr Lynch commented:

> "Naomi Hall is a 37 year old woman who was a psychiatric patient at Maroondah Hospital and absconded. She has walked into the path of an oncoming truck and sustained significant head injury. She was admitted to the Royal Melbourne Hospital on the 24th November 2009, and a CT scan of the brain revealed extensive head injury with subdural haematoma. She underwent decompressive craniectomy but the injury was considered non-survivable and she has died on the 27th November 2009.
>
> I have made an external examination on the body and the findings are consistent with the history. There is evidence of recent right craniectomy. I have reviewed the post mortem CT scan which reveals right craniectomy with cerebral oedema and subarachnoid haemorrhage. The family have expressed the preference for no internal examination".[10]

Finding

I find the cause of death of Naomi Hall to be head injury sustained in motor vehicle collision (pedestrian).

[10] Comments from Dr Matthew Lynch, Forensic Pathologist

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

The family of Naomi Hall

Leading Senior Constable David Depyle, Maroondah Traffic Management Unit

Eastern Health

Signature:

JOHN OLLE
CORONER
Date: 12 June 2013