IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 4610

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: PAUL ALLAN SKINNER

Delivered On:	18 June 2013
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	4 and 5 September 2012
Findings of:	JOHN OLLE, CORONER
Representation:	Mr R. Stanley appeared on behalf of relatives of Mrs Skinner Dr P. Halley appeared on behalf of L. Salter, S. Marella and Y. Maringa Mr C. Winneke appeared on behalf of Goulburn Valley Health Senior Constable K. Talbot assisting the Coroner

I, JOHN OLLE, Coroner having investigated the death of PAUL ALLAN SKINNER

AND having held an inquest in relation to this death on 4 and 5 September 2012
at SHEPPARTON MAGISTRATES' COURT
find that the identity of the deceased was PAUL ALLAN SKINNER
born on 11 June 1981
and the death occurred on 3 December 2010
at Goulburn Valley Area Mental Health Psychiatric Unit – Wanyarra Unit, Monash Street, Shepparton 3630
from:

1 (a) HANGING

in the following circumstances:

PURPOSES OF A CORONIAL INVESTIGATION

1. The primary purpose of the coronial investigation of a reportable death[1] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstance in which the death occurred.[2] The practice is to refer to the medical cause of death incorporating where appropriate the mode or mechanism of death, and to limit investigation to circumstances sufficiently proximate and causally relevant to the death.

2. Coroners are also empowered to report to the Attorney-General on a death they have investigated; the power to comment on any matter connected with the death, including matters relating to public health and safety or the administration of justice; and the power to make recommendations to any Minister, public statutory or entity on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[3]

3. The focus of the coronial investigation is to determine what happened, not to ascribe guilt, attribute blame or apportion liability and, by ascertaining the circumstances of a death, a

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[1] Section 4 of the *Coroners Act 2008* requires certain deaths to be reported to the coroner for investigation. Apart from the Jurisdiction nexus with the State of Victoria, the definition of a reportable death includes all deaths that appear "to be unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury".

[2] Section 67 of the Act.

[3] Sections 72(1), 72(2) and 67(3) of the Act regarding reports, recommendations and comments respectively.

coroner can identify opportunities to help reduce the likelihood of similar occurrences in future.

Background

4. Paul Skinner was aged 29 years at the time of his death. On the 27 November 2010, Paul was admitted as an involuntary patient at the Wanyarra Unit, Goulburn Valley Health ('GVH').

5. Paul's admission followed an attempted suicide, having developed depressive symptoms following marital separation approximately a month prior to his admission.

FOCUS OF THE INVESTIGATION

6. I have focused my investigation on the clinical management of Paul throughout his Wanyarra admission.

Mrs Skinner's letter

7. A letter received from Pauls's mother setting out her concerns was distributed to the parties. I note the contents of the letter were measured and reasonable. Mrs Skinner was eloquent in her desire not to blame individuals, but to identify shortcomings, to learn lessons and implement improvements. I note throughout the inquest Mrs Skinner and her family exhibited great dignity. Despite the identification of serious shortcomings, on behalf of her family, Mrs Skinner steadfastly maintained the desire not to blame individuals.

8. Despite systemic shortcomings and practice deficiencies, I am satisfied at all times, Paul's best interests were the primary concern of all members of the clinical team.

Circumstances of Death

9. After midnight on 3 December 2010, Paul was observed asleep in his bed. At approximately 1.00am, he was found hanging in his room. Paul had used a bed sheet to fashion a noose. Resuscitation attempts were commenced but sadly, Paul was unable to be revived.

10. There were no suspicious circumstances.

Post Mortem Medical Investigation

11. On 7 December 2010 Dr Yeliena Baber, Forensic Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy.

12. Dr Baber found the cause of death to be hanging.

Uncontentious Matters

13. At the completion of the police investigation and prior to commencement of the inquest, it was apparent that a number of the facts about Paul's death were known and uncontentious. These include his identity, the medical cause of his death and aspects of the circumstances, including the place and date of death.

14. Given this, I formally find that the deceased was Paul Allan Skinner, born on 11 June 1981, late of 25 Kennedy Street, Euroa; that he died on 3 December 2010 at Wanyarra, Goulburn Valley Health, located at Monash Street, Shepparton, and that the medical cause of death is hanging.

15. I am satisfied Paul died as a result of suicide

Introduction

16. The inquest brief is comprehensive.

17. All interested parties have fully co-operated with my investigation. Witnesses provided frank and forthright evidence. Individual shortcomings were acknowledged. The witnesses displayed a collective determination to ensure deficiencies were identified.

18. GVH has acknowledged serious systemic deficiencies. To the credit of GVH, wide-ranging system improvements have been implemented.[4] The medical and nursing professionals involved in Paul's care could not have reasonably foreseen his imminent risk of death. Having considered all the evidence, I am unable to conclude that any individual failing contributed to Paul's death. Further, I am not satisfied that the absence of the identified systemic failings would have necessarily averted the tragic outcome. A conclusion such as

[4] Communication of Minter Ellison, Solicitors for Goulburn Valley Health, dated 21 November 2012, attached documented hospital policies, psychiatric environmental risk assessments and updated digital observation chart to reflect the enhancements made subsequent to the investigation and circumstances of death of Mr Skinner.

this would be based on speculation only. I am, however, able to say that the systemic deficiencies identified were serious and did not serve Paul well.

19. The manner in which GVH and members of the clinical staff have co-operated with my investigation provides comfort to myself, and family members, that the tragic circumstances of Paul's death will be a catalyst for change.

Major Issues

20. Counsel for the respective parties offered the inquest great assistance throughout.

21. Inpatient psychiatric facilities are a vital community resource. Clinical staff face significant challenges in meeting their professional obligations. All clinical staff require support but none more so than nursing staff members. It is essential that staff members receive full support in the performance of their onerous duties. Policy and guidelines must be clear, consistently implemented and designed to ensure best practice.

22. Informal practices, inconsistent with hospital policy, must not be tolerated.

- Nurses unilaterally reducing clinical observations.
- Nurses signing observations on behalf of other nursing staff.
- Nurses making entries in observation charts for observations, which were not performed.

23. Evidence has disclosed a long standing informal practice was implemented by night nursing staff at Wanyarra. Namely, irrespective of the observation regime set by the treating doctor, between 10.00pm and 7.00am one hourly observations only, were performed.[5] Long term night staff could not recall a time when the informal practice was otherwise. Medical staff were unaware their stipulated visual observation directions, were not being followed. It appears the rationale was visual observations overnight, more regular than hourly, were considered unsettling for patients.

[5] 6.1 Hospital Policy entitled Charge Nurse to reduce the alteration level following a documented risk assessment.

The regularity of nursing observations formed an integral component of medical clinical judgement

24. Dr Bialylew explained:

> "I knew Paul – well, I approved Paul remaining in the Low Dependency Unit. I didn't think he was without risk, indeed, I think he was a serious risk. And I required him to be under 15 minute observation."

25. According to Dr Bialylew, her task was to indicate the level of observation required, and identify the appropriate ward to ensure Paul was housed in the least restrictive setting. In her view, the Low Dependency Unit ('LDU') was appropriate, on the basis of round the clock 15 minute observations. Dr Bialylew noted that Paul's cluster B condition could result in rapid, unforeseen shift from feeling absolutely fine to "suicidal".

26. Dr Bialylew read nursing entries, which confirmed that Paul was being observed at 15 minute intervals throughout the night. Had she known the entries were incorrect, she may have reassessed her decision to house Paul in LDU.

27. She understood nursing visual observations could only be reduced by a doctor.

28. She was unaware nurses only performed one hourly observations between 10pm and 7am, despite entries in observation charts portraying 15 minute observations overnight.

29. Mr Stanley, for the family, accurately identified the systemic deficiencies:

    a. The failures resulted in real consequences, though acknowledging speculation to find the tragic outcome could have been averted. Certainly, the failures represented lost opportunities.

    b. In respect to observation's deficiencies, failure to perform 15 minute observation as directed by Dr Bialylew and recording observations which did not occur resulted in:

        - an inability to identify a deterioration in Paul's mental state;

        - Dr Bialylew unable to reassess her initial decision that Paul could be safely housed in LDU;

- note-keeping portrayed an incorrect picture to staff who read the file, in particular medical staff, namely, that Paul was receiving 15 minute observations overnight when, in fact, he was not;

- the failure to update the Riskman computer to ensure that a critical incident observed early in Paul's admission was not entered on the computer;

- and, further,[6] that the knowledge of the cord obtained from Paul which raised concerns with the nursing staff was not conveyed to Dr Bialylew; and

- The document failed to record whether Paul was provided sedative medication as required at 8.00pm on the night prior to his death.

29. I note the following submission of Mr Winneke on behalf of GVH:

> "It's all very well to have guidelines, but they've got to be put in practice, and yes, the hospital has guidelines and the nurses were aware of the guidelines, but obviously there's got to be a degree of communication which ensures that one knows what the other is doing and one knows that the guidelines are being followed.
>
> Your Honour, so to that extent, as Mr Brown accepted, it's accepted on behalf of the hospital that there was this practice that had developed. And it is unfortunate that it developed and it has, as Your Honour pointed out, it may well have led to missed opportunities."[7]

Ligature Audit

30. GVH acknowledged the hanging point used by Paul had been identified some years earlier although the solution to the problem was not identified. Following recommendations made by the Chief Psychiatrist subsequent to the death of Paul, the hanging point has been removed.

GVH has made significant improvements

31. GVH has provided detailed documentation to the inquest setting out the changes to policy following internal review.

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[6] It is acknowledged that Dr Bialylew was made aware of the incident.

[7] Page 265 Transcript.

No Occupational Therapist (OT) funding

32. Due to funding difficulties there was no OT engaged at Wanyarra. Without exception, witnesses agreed, that the role of an OT in an inpatient facility such as Wanyarra is essential.

33. The benefits of an OT at a psychiatric inpatient facility are compelling.

Medium Dependency Unit ('MDU')

34. When Paul was deemed suitable for transfer from HDU, the sole option was LDU. I consider the circumstances of this investigation, once again warrant consideration of the development of an MDU.

35. In my view, the unique nature of an inpatient psychiatric facility, combined with the complexity of psychiatric inpatient clinical decisions, would be greatly assisted by an option of a MDU.

COMMENTS

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

1. The issues identified in my investigation and inquest into Paul's death, are not unique to GVH. The practice shortcomings and failure to remove ligature points are not unique to GVH. Sadly, coronial investigations into deaths at other facilities in Victoria have identified similar problems.[8]

2. Lessons apply across the board. Management and ward staff must have open lines of communication to ensure that policy assures best practice and practice is performed in compliance with policy.

3. It is trite to say that inpatient psychiatric medical and nursing staff work in a most challenging environment. They need and deserve every resource and support to assist them carry out their onerous duties.

[8] Eg - Matthew Spalding 2156/09; James Falzon 3547/10.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendations[9] connected with the death, directed at the Department of Health:

1. That every authorised psychiatric inpatient facility endeavour to employ an occupational therapist.

2. That consideration be given to creation of MDU at authorised psychiatric inpatient facilities.

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

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

    i. "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."

5. 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.

6. 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.

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

[9] Recommendations 3 – 7 are adopted from Spalding recommendations

i. "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."

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

Sergeant Terence Whitehead, Investigating Member
The Family of Paul Skinner
Goulburn Valley Health
Registered Psychiatrist Nurses Salter, Marella and Maringa

Signature:

JOHN OLLE
CORONER
Date: 18 June 2013