IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 001503

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the ***Coroners Act 2008***

I, ROSEMARY CARLIN, Coroner having investigated the death of WJ

without holding an inquest:
find that the identity of the deceased was WJ
born on 23 November 1972
and the death occurred on 27 April 2012
at Northern Hospital, 185 Cooper Street, Epping, 3076

from:

1 (a) HYPOXIC BRAIN INJURY

1 (b) HANGING

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. On 20 April 2012, WJ , a voluntary psychiatric patient at Northern Hospital in Epping, used her dressing gown cord to hang herself in her ensuite bathroom. She sustained a severe hypoxic brain injury and died seven days later in the Intensive Care Unit of the hospital.

2. A brief prepared by Victoria Police for the Coroner included statements from Ms WJ sister, her treating medical and mental health practitioners and investigating officers. The Northern hospital medical records were also obtained. I took over the conduct of the investigation in January 2014 and obtained further material from North Western Mental Health (**NWMH**) as to its policies and procedures. I also obtained an expert report from Dr John Newton, the Medical Director of Mental Health at Austin Health and submissions from

NWMH in response.[1] I have drawn on all this material as to the factual matters in this finding.

Background circumstances

3. Ms WJ was born in Sydney on 23 November 1972. Shortly after her birth her family moved t Coolaroo, north of Melbourne, where she grew up with her brother and sister.

4. In 1994 Ms WJ moved to Perth and in 1997 she commenced a relationship with [redacted] with whom she had three children. In around 2001 Ms WJ and Mr [redacted] separated and in 2003 Ms WJ moved back to Melbourne with her children.

5. Ms WJ became depressed after her separation with Mr [redacted] and began to use illicit substances, particularly cannabis, on a more regular basis. She also used methamphetamine.

6. In 2009, Ms WJ gave birth to her fourth child.

7. Ms WJ was diagnosed with depression after her return to Melbourne. Her General Practitioner treated her with a variety of antidepressants, most recently Duloxetine. She also received some counselling form a psychologist. She did not have a history of past suicide attempts, nor any previous contact with public psychiatric services.

8. From the end f 2011 Ms WJ lived with her brother J[redacted], on and off. J[redacted] often observed his sister to be upset and crying, particularly over her appearance. Ms WJ teeth had been removed, apparently because of her medication and drug use.

9. At the end of March 2012 Ms WJ stayed with her father and told him she needed to admit herself into 'rehab'.

Circumstances proximate to death

10. On 12 April 2012 Ms WJ presented to Northern Hospital Emergency Department (ED) with a history of increasing anxiety, depression and suicidal ideation, although no plan. She indicated a willingness to accept treatment, especially because of her children.

11. On 14 April 2012 Ms WJ was admitted as a psychiatric inpatient to the Northern Hospital. Upon her admission, a doctor took a history and completed an initial risk assessment of Ms WJ. She was noted to exhibit paranoia and have suicidal ideas, although also expressing a desire to stay alive for her children. It was also noted that she

[1] Dr Peralta was afforded the opportunity to file a response, but indicated he was content to relay on the response of NWMH

had been smoking cannabis daily and had used Ice more than a week ago. The initial provisional diagnosis was recorded as deterioration in depressive illness and more recent onset of anxiety/panic symptoms in association with cannabis dependence. The doctor rated her as a moderate risk of suicide, but assigned an overall level of risk of 'low' on the Clinical Risk Assessment and Management (**CRAAM**) form.

12. As a result of the low risk assessment, Ms WJ was admitted to the Low Dependency Unit (**LDU**) and nursed on low risk observations. Hospital policy required a different frequency of observations depending on the patient's risk assessment. At the time, the policy required overnight observations of low risk patients at 12 am and 6 am. Further, hospital policy did not require routine removal of potential ligatures (such as shoelaces and dressing gown cords) from patients admitted to the LDU.

13. On 16 April 2012 Ms WJ was reviewed by consultant psychiatrist Dr Peralto. An intern documented this review in the progress notes and noted symptoms of depression, anxiety and paranoia. The intern also noted that Ms WJ had a *"passing thought" of harming herlself – but states she would never do that to her kids.'* No diagnosis or differential diagnosis ws recorded. Dr Peralto commenced Ms WJ on Quetiapine twice a day.

14. At 11.05 am on 18 April 2012 a social worker recorded '. WJ *appeared anxious and rated her mood as 2/10.* WJ *stated she had [suicidal ideation] yesterday & was "thinking of a plan" however stated she couldn't do it because of her children.* WJ *denied current [suicidal ideation].'* At 4 pm on the same day Ms WJ was reviewed by a psychiatric registrar who noted that WJ reported her mood and anxiety had worsened since her medication was changed by her General Practitioner 6 to 8 months ago. The notes record *"Currently feels down, depressed mood, has panic attacks, but not so frequently as she did before admission. Feels "paranoid" in open spaces and tries to avoid crowds. Appetite is better. Sleep has improved with medication. No suicidal thoughts."*

15. It appears from the progress notes that neither the social worker, nor the Registrar explored the nature of the suicidal plan formed by Ms WJ on 17 April 2012.

16. Nursing Notes for the remainder of 18 April 2012 and the next day record Ms WJ as having lowered mood, flat effect, self isolating behaviour and spending time on her bed, but no self harming thoughts. A single note at 7.20 pm on 18 April 2012 records Ms WJ as being nursed on medium risk observations, but otherwise all notes record that she is being nursed on low risk observations. It is not clear upon whose authority the observations were

increased to medium risk, nor upon whose authority they were downgraded. Nor is the reason for each change recorded. However, a note at 5.20 am on 20 April 2012 states *'nursed on LDU on low risk observations as per risk assessment on 14/4/12'*, as if the level of observations had never changed.

17. At 10.25 pm on 20 April 2012 Ms WJ requested and was given 20 mg of Temazepam to help her sleep. The progress notes (written retrospectively) then record that ' WJ *retired to bed after 24 hours and has appeared to sleep through to time of report'.*

18. At 6 am the next morning a nurse found Ms WJ hanging in her ensuite bathroom. She had jammed her dressing gown cord between the dor and door frame and wrapped the other end around her neck. She was unresponsive, not breathing and had no pulse. The nurse immediately commenced cardio pulmonary resuscitation. The emergency medical team arrived promptly and managed to establish a pulse. Ms WJ was then transferred to the Intensive Care Unit where she remained intubated and sedated.

19. When it became obvious that Ms WJ condition would not improve, discussions were had with her family and a decision was made to extubate her and cease treatment. At 7.23 pm on 27 April 2012 Ms WJ stopped breathing and was certified deceased.

20. An autopsy of Ms WJ body was undertaken by Dr Michael Burke, Forensic Pathologist with the Victorian Institute of Forensic Medicine. Dr Burke reported a medical cause of death as

    1 (a) Hypoxic Brain Injury

    1 (b) Hanging.

Access to potential ligatures

21. As stated, at the time of Ms WJ death items with potential ligature capacity were not automatically removed from LDU inpatients. They were only removed if it was indicated in the risk assessment. The reverse was true for high risk patients in the Intensive Care Area (**ICA**), where such items were prohibited unless otherwise indicated.

22. Ms WJ was not the first patient in a psychiatric hospital to commit suicide by hanging from an ensuite bathroom door. Indeed, Ms WJ was not the first patient to do precisely

this in the LDU of Northern Hospital.[2] She was also not the first patient to use a dressing gown cord to hang herself.[3]

23. Treatment of the mentally ill is predicated upon the principle that there should be minimum interference with the patient's human rights and dignity. So far as possible, there should be promotion of autonomy and empowerment within a culture of recovery. These principles are now enshrined in the *Mental Health Act* 2014 and a re consistent with the *Charter of Human Rights and Responsibilities Act* 2006.

24. The number of deaths of inpatients within psychiatric hospitals demonstrates the obvious tension between the therapeutic benefits of maintaining a minimally restrictive environment and the need to protect patients from self-harm. I accept that assessment and treatment of the mentally ill is a difficult task. I also accept that removal of apparent risks can have unintended consequences, including the possible creation of other risks.

25. NWMH has advised that since the death of Ms WJ a number of changes have been implemented to reduce the chance of another patient hanging himself or herself. These changes relate to identifying and removing ligature points within facilities, in particular ensuite bathrooms, and a new policy in relation to the removal of potential ligatures and other hazardous items.

26. The new policy, called *Removal of Hazardous Items in Inpatient Units* was introduced in September 2014. This policy mandates the removal of *'neck scarves'* from inpatients regardless of their legal status, risk assessment or placement in either the LDU or ICA. *Scarves* is explained to include *'pashminas, shawls, wraps or other long pieces of fabric that can potentially be fashioned into a noose or ligature'*. The policy provides a process by which such items can be identified and removed upon patient admission in a fashion that ensures dignity and least offence. The policy also requires observance of the 2014 *Chief Psychiatrists Guideline – Criteria for Searches to Maintain Safety in an Inpatient Unit for Patients, Visitors and Staff.*

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[2] The Chief Psychiatrist's investigation inpatient deaths 2008 – 2010 found that four of the deaths examined occurred in this way, with one occurring in the LDU of Northern Hospital.

[3] As one instance, refer to the Finding Into Death with Inquest of Maria Nigro COR 2009 0829. At the time of writing I am investigating another suicide within a psychiatric hospital by use of a dressing gown cord and ensuite bathroom door.

27. Save for the comments I make below as to the wording of the document, I am satisfied that the new policy is appropriate and has addressed my concerns in relation to patients' access to potential ligatures. I accept that since 2012 NWMH has been proactive in identifying and removing potential ligature risks across its facilities. I recognise this is a costly exercise. To the extent there remain any potential ligature risks I stress the importance of removing them as soon as possible.

Adequacy of risk assessment

28. After the initial risk assessment upon her admission to the LDU, all explorations of Ms WJ suicide risk were simply noted in the progress notes, rather than documented on the hospital risk assessment forms. I recognise that mental health assessments should not simply be an exercise in form filling and the lack of completed forms does not necessarily mean the assessments were inadequate. However, the forms contain assessment tools designed to assist with accurate assessments. Further, the rigour of completing the form may serve to ensure a comprehensive assessment.

29. The independent expert, Dr Newton, made a number of observations about Ms WJ clinical management whilst at Northern Hospital and the adequacy of documentation. I accept and adopt his opinions.

30. Dr Newton considered that all patients admitted to a psychiatric unit should have formal risk assessments on a daily basis for at least the first few days. At this early stage little is known about the patient and their risks are likely to fluctuate. This was particularly so for Ms WJ as it was her first presentation to a public mental health facility.

31. Dr Newton also considered there was a danger in reducing the complexity of a patient assessment to a single overall score, as occurred with Ms WJ initial risk assessment. He stated *'requiring a single overall rating of global risk levels when somebody can be very high on one axis of risk, such as non-compliance or aggression and very low on other axes of risk such as self-harm or suicide can be problematic and may lead to managing a patient as low risk when some risks require more specific management.'*

32. Dr Newton noted that Ms WJ repeated assertion that she would not act on her suicidal ideas because of her children may have prevented further exploration of her risk. He commented that exploration of the plan she claimed to have on 17 April 2012 may have elicited useful information and helped staff to understand the real level of her suicide risk.

33. Dr Newton noted there was a clear gap in documentation of any diagnosis by senior medical or nursing staff of Ms WJ during her admission. Following her death a Registered Nurse completed a hospital document titled *Separation* noting as the principal diagnosis *'situational crisis'*. Dr Newton noted there was little evidence to support this diagnosis and it did not reflect the clinical reality. Further, this diagnosis is inconsistent with the diagnosis of *'major depression'* recorded by Dr Peralta on the *Notice of Death'*.[4]

34. In the *Notice of Death* Dr Peralta also stated *'over the following days her symptoms appeared to improve with pharmacological treatment and support received. She had regular reviews including two consecutive days prior to her death, where her mental state was noted to be improved...'*. This was reiterated in the statement Dr Peralta provided for the purposes of the coronial investigation. The assertion that Ms WJ was continually improving is inconsistent with family observations that Ms WJ deteriorated in the days before her death. Further, as Dr Newton stated, it is not obvious from the progress notes that Ms WJ did improve during her stay.

35. NWMH advised that following the death of MS WJ CRAAM refresher training was completed and a review of the CRAAM documentation was underway as at May 2015. Further, according to Dr Peralta current policy requires completion of a risk assessment form upon review, even if there is no change to a previous risk assessment. This was not the case at the time of Ms WJ death.

Overnight observations

36. Dr Newton considered that observations of a low risk patient at midnight and 6 am were in keeping with standard hospital practice. The current CRAAM policy requires an extra observation at 3 am.

37. The Chief Psychiatrist's investigation of inpatient deaths 2008 – 2010 recommends the frequency of observations over the night shift should be congruent with daytime observations unless otherwise decided and documented.

Conclusions

38. I am satisfied having considered the evidence that further investigation is not required.

[4] A *Notice of Death* was required to be provided to the Chief Psychiatrist given Ms Willis death as an inpatient in a psychiatric hospital

39. I find that WJ died on 27 April 2012 from hypoxic brain injury consequent upon hanging. I am satisfied she intended to end her life.

40. I acknowledge that assessment of suicide risk is extremely difficult. Nevertheless, I am satisfied that assessment of Ms WJ suicide risk would have been enhanced by daily formal documented risk assessments and exploration of the plan she formulated on 17 April 2012.

41. Hospital documentation serves the dual purpose of communication between staff and allowing subsequent scrutiny of events. It would have been preferable for the recording of a diagnosis after consultant review. Also, the progress notes should have explained the reason for the increase in risk observations on 18 April 2012 to medium and then its decrease back to low.

42. Whilst the risk assessment process was not optimal, I am not satisfied that Ms WJ risk assessment was necessarily wrong, nor that the suboptimal process contributed to her death.

43. Similarly, I am not satisfied that more frequent observations over the course of the night would necessarily have prevented Ms WJ death. The fact she was revived upon being discovered at 6 am suggests she hung herself at a time relatively close to 6 am.

44. I find that at the time of Ms WJ death Northern Hospital's policy in relation to potential ligatures was consistent with therapeutic treatment principles; however, it did provide her with the means to end her life. I am satisfied that subsequent to Ms WJ death NWMH has changed this policy and acted appropriately to reduce the risk of ligature deaths in the future.

COMMENTS

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

1. Whilst the intent of the policy *Removal of Hazardous Items in Inpatient Units* is clear, the wording is apt to confuse. The word '*scarf*' has a common and innocuous meaning. Rather than use the word *'scarves'* and then seek to define it to include potential ligatures that are not scarves, it would be preferable to use some other terminology, such as *'potential ligatures'* and then give examples. In any event, dressing gown cords, shoelaces, belts and headphone cords should be specifically mentioned. Presently they are not.

2. Further, the opening word *'Notwithstanding'* in paragraph 6 of the policy has a tendency to undermine the absolute prohibition contained in the earlier paragraphs. A reader of the document might reasonably enquire if paragraph 6 was intended to be a qualification of the earlier prohibition, or an additional power to search. Given paragraph 4 states the initial unpacking of items is not to be construed as a search, I am satisfied that paragraph 6 is not intended to detract from the force of the earlier paragraphs, however the document should be reworded to make this clear.

RECOMMENDATIONS

Pursuant to section 72(2) of the Coroners Act 2008, I make the following recommendation(s) connected with the death:

1. I recommend that NorthWestern Mental Health re draft their policy *Removal of Hazardous Items in Inpatient Units* in line with the comments set out above

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

The family of WJ ;
Dr Newton;
The Chief Psychiatrist;
Investigating Member, Victoria Police; and
Interested parties.

Signature:

ROSEMARY CARLIN
CORONER
Date: 6 August 2015