IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 004587

FINDING INTO DEATH WITHOUT INQUEST

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

I, PARESA ANTONIADIS SPANOS, Coroner,

having investigated the death of CB
without holding an inquest:
find that the identity of the deceased was CB
born on 15 May 1985
and that the death occurred on 27 October 2012
at Broadmeadows Inpatient Unit, 35 Johnstone Street, Jacana, Victoria 3047
from:

I (a) HANGING

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances**:

1. CB was a 27-year-old woman, originally from New Zealand, who immigrated to Australia in August 2011. CB had previously worked as an actress and a hairdresser.[1]

2. In December 2011, CB commenced a relationship with Dale Ward and they soon moved in together. Individuals who observed the pair described their relationship as 'volatile' and, at times, abusive.[2]

3. In May of 2012, CB was admitted to St Vincent's Hospital following an intentional overdose and self-inflicted injury to her arm precipitated by Mr Ward threatening to end their relationship and the financial stress of losing her job.[3] CB was diagnosed with depression but failed to engage in psychological counselling recommended as part of her discharge plan.

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[1] Coronial Brief of Evidence pages 9-12 (Statement of Susan Parsons).

[2] Coronial Brief of Evidence pages 10-11 (Statement of Susan Parsons) and pages 18-19 (Statement of Silvia Hope).

[3] Coronial Brief of Evidence page 14 (Statement of Dale Ward).

4. Between May and October 2012, CB secured employment as a hairdresser and pursued her relationship with Mr Ward. Mr Ward reported that CB's mood improved initially and she became quite career-driven. However, she soon began to drink alcohol to excess periodically and this became a source of discord between them. Mr Ward wanted to end the relationship but was concerned that CB may harm herself if he did.[4]

5. On or about 24 October 2012, Mr Ward ended his relationship with CB. That evening, CB presented at the emergency department of the Royal Melbourne Hospital [RMHED] complaining of abdominal pain and nausea. No physical illness was detected by medical staff, but a history of depression and a probable diagnosis of anxiety were noted, before her discharge three hours later.

6. On 25 October 2012, CB was told that her employment had been terminated. She attempted suicide by hanging but called mental health triage when her attempt failed. CB was subsequently transported by police to RMHED pursuant to their powers under section 10 of the *Mental Health Act* 1986.[5]

7. At RMHED, an Emergency Crisis Assessment and Treatment Team clinician assessed CB. The clinician took a thorough history of recent events and past substance and alcohol use. CB disclosed that she had intentionally overdosed on antidepressant medication the day before, was regretful that her recent suicide attempts had failed, and that she continued to have thoughts of suicide. The clinician noted that CB cooperated with the assessment and that she agreed to be admitted to Broadmeadows Inpatient Unit [BIPU] as a voluntary patient.[6]

8. CB was admitted to BIPU on the afternoon of 25 October 2012. An initial risk assessment was conducted by Dr Niroshaui, a psychiatric registrar. Dr Niroshaui completed the North Western Mental Health's [NWMH] Clinical Risk Assessment and Management [CRAAM] Form by ticking a series of boxes to indicate the presence, absence and/or degree of specified static and dynamic risk factors.[7] No annotations or additional comments were made on the form, which was completed at 8.15pm.[8] At the time of assessment, CB was rated as a low overall risk of harm to herself or others. Based on that assessment, it was determined that she

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[4] Ibid.

[5] North Western Mental Health Service Medical Records relating to CB.

[6] Ibid.

[7] North Western Mental Health Service Medical Records relating to CB, page 22

[8] Ibid.

required a low level of staff supervision and would be nursed in the Low Dependency Unit [LDU].[9]

9. Nurse Hong was the admitting nurse, and described CB as 'pleasant and polite … cooperative'[10] and clothed in warm winter clothing including a purple knitted scarf.[11] In accordance with LDU policy, CB's belongings were not searched upon admission and none of her personal effects – including her mobile telephone[12] – were confiscated.[13] CB expressed no suicidal ideation, plan or intent when reviewed by Nurse Hong and stated that she 'feels safe in hospital'.[14]

10. Nursing notes made on 25 October 2012 indicate that CB spent most of the time in her room, was 'isolative and withdrawn' but smoked in the courtyard with other patients. She approached staff requesting valium 'a few times' but none was administered. CB continued to deny suicidal ideation, plan and intent. Overnight, CB 'appeared reasonably settled' and slept after she requested, and was given, a sedative.[15]

11. On the morning of 26 October 2012, Consultant Psychiatrist Dr Rudolph and his junior colleagues reviewed CB. She presented as alert and cooperative, 'ambivalent' about her mood but 'not obviously depressed'.[16] CB provided a history that included some family history of mental illness, traumatic experiences during her own childhood, alcohol use from 12 years of age with illicit drug use in early adulthood, ceasing after drug rehabilitation, long-standing anger management, trust and abandonment issues and chronically unstable mood.[17] CB reported three previous psychiatric admissions since the age of 14 years, five suicide attempts

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[9] Ibid.

[10] North Western Mental Health Service Medical Records relating to CB, page 23.

[11] Coronial Brief of Evidence, page 56 (Statement of Nurse Quinnie Hong).

[12] CB appears to have used her mobile telephone to communicate with, or attempt to communicate with, Mr Ward on 25 and 26 October 2012. Mr Ward's last text message to CB was received on 25 October 2012 at 3.39pm. CB sent six text messages to Mr Ward on 25 October 2012 after his last message, and sent him a final message on 26 October 2012 at 11.34am. It is unlikely that NWMH staff were aware of these messages or their content, which document CB's attempts to remonstrate/open a dialogue with Mr Ward following the breakdown of their relationship; the messages appear in the Coronial Brief of Evidence, pages 58-93.

[13] Ibid.

[14] North Western Mental Health Service Medical Records relating to CB, page 24.

[15] Ibid.

[16] Coronial Brief of Evidence page 36 (Statement of Dr D. Rudolph).

[17] Coronial Brief of Evidence pages 34-38 (Statement of Dr D. Rudolph) and Western Mental Health Service Medical Records relating to CB, pages 25-31.

and the infrequent resort to self-harm by cutting when in crisis.[18] She reported her recent relationship breakdown and job loss and some current significant symptoms of anxiety but denied current suicidality.[19]

12. Dr Rudolph diagnosed CB with Borderline Personality Disorder [BPD] and an Adjustment Disorder [AD]. He stated that his impression of CB was of a woman with 'chronically unstable mood' experiencing 'situational crisis' for which she was ill-equipped to cope, and that given her apparent and current lack of social supports, her 'maladaptive coping strategies would often be used to her detriment'.[20] Dr Rudolph noted that there were 'chronic risks' for CB, particularly if faced with on-going relationship stressors.[21] Dr Rudolph considered that long-term psychological intervention, rather than psychotropic or antidepressant medication, was likely to be the optimal treatment regime for CB.[22] However, Dr Rudolph did authorise CB to receive antidepressants and medication to reduce agitation in the LDU.[23]

13. Although Dr Rudolph's clinical notes of his assessment appear in CB's NWMH Medical Records they do not include a formal risk assessment. Dr Rudolph's stated recollection is that a risk assessment was discussed and that CB's risk level was once again assessed as low.[24] No "Consultant Revised" CRAAM was completed until 1pm on 27 October 2012.[25]

14. Nursing notes made on 26 October 2012 indicate that CB 'kept a low profile', spending the majority of her time in her own bedroom.[26] She was 'pleasant but revealed little'. She refused all meals except lunch, sought and was given diazepam that evening and appeared to sleep overnight.[27]

15. On 27 October 2012, CB presented to nursing staff as 'anxious and upset' and so seroquel was administered along with her morning medications.[28] Again, CB spent most of the day in her

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[18] Ibid.

[19] North Western Mental Health Service Medical Records relating to CB, pages 25-31.

[20] Coronial Brief of Evidence page 36 (Statement of Dr D. Rudolph).

[21] Ibid.

[22] Ibid.

[23] Coronial Brief of Evidence pages 36-7 (Statement of Dr D. Rudolph).

[24] Ibid.

[25] North Western Mental Health Service Medical Records relating to CB , page 21.

[26] North Western Mental Health Service Medical Records relating to CB, page 32.

[27] Ibid.

[28] North Western Mental Health Service Medical Records relating to CB, page 32.

bedroom. She reported visual and auditory hallucinations but denied suicidal ideation.[29] During "one-on-one time" with Nurse Mathew at 3pm, CB engaged only 'superficially' but reported feeling 'anxious and crazy'.[30] She requested, and was given, seroquel and diazepam.[31] CB refused all meals that day but continued to take fluids. At 6.45pm, CB reported symptoms of anxiety and requested, and was given, seroquel again.[32]

16. At approximately 9pm on 27 October 2012, Nurse Harawa-Freeman was performing pre-handover checks of all patients. The nurse knocked and called twice at CB's door but received no response. The nurse opened the door and, although the lights were off, saw CB hanging by a scarf from the door of a wardrobe.[33]

17. Nurse Harawa-Freeman alerted other staff and emergency services. Shift manager Nurse Bester, and another nurse, performed cardio-pulmonary resuscitation [CPR] until paramedics arrived.[34] Paramedics attempted to resuscitate CB but she could not be revived.

18. Forensic Pathologist, Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (VIFM) performed an external examination of CB's body. Dr Baber reviewed the circumstances of CB's death as reported by the police to the coroner, post-mortem CT scans of the whole body and toxicological results when preparing a written report of her findings. Dr Baber attributed CB's death to hanging.

19. Post-mortem toxicological analysis revealed the presence of quetiapine (an antipsychotic marketed as "Seroquel"), desmethylvenlafaxine (an antidepressant), citalopram (antidepressant) and diazepam (a benzodiazepine sedative/hypnotic) at levels consistent with normal therapeutic administration.

20. At my request, a Mental Health Investigator [MHI] from the Coroners Prevention Unit's[35] reviewed the adequacy of the clinical management and care provided to CB while she was a inpatient at BIPU. The MHI advised that:

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[29] Ibid.

[30] Coronial Brief of Evidence page 54 (Statement of Gijo Mathew).

[31] North Western Mental Health Service Medical Records relating to CB, page 33.

[32] Ibid.

[33] Coronial Brief of Evidence page 39 (Statement of Simba Harawa-Freeman).

[34] Coronial Brief of Evidence page 52 (Statement of Mark D. Bester).

[35] The Coroners Prevention Unit [CPU] was established in 2008 to assist coronial investigations and the formulation of coronial recommendations and comments aimed at "prevention". The CPU is staffed by independent highly skilled and experienced clinical medical, mental and allied health care professionals.

a. Environmental factors likely to pose risks to patients were not minimised by the policies and procedures at BIPU during CB's admission. It is inappropriate for a patient in an acute mental health unit to have access to a ligature, such as the scarf CB used to hang herself. Given the level of acuity of patients and the accompanying risk of self-harm, belongings should be searched and anything capable of being used as a ligature removed. Even if the patient who owns the item is assessed as a low risk of self-harm, his/her property could be accessed by other patients. The Chief Psychiatrist has issued a Guideline in relation to mental health units' duty of care that encompasses the maintenance of a safe environment; the Guideline specifies items – plastic bags, scarves, belts, shoe laces and headphone cords – that could endanger patients and which should be confiscated.[36]

b. BIPU staff inadequately employed and documented risk and mental state assessments throughout CB's admission. Risk assessments are used in the psychiatric setting as the basis on which care and treatment is planned. Mental State Examinations [MSEs] are an important part of the risk assessment process. The CRAAM policy requires that a consultant psychiatrist complete a "Consultant Review" CRAAM Form within 24 hours of an initial CRAAM assessment. This did not occur in CB's case. Moreover, the CRAAM requires that all risk assessments be accompanied by clinical notes addressing the rationale for the risk level set, and any changes, so that clinical decisions about treatment(s) and the frequency of staff supervision are clear and evidence-based. No entries of this type were made in CB's clinical file, risk assessments were solely ticked boxes, and so the clinical rationale for her care remains unclear.

c. The last MSE recorded in CB's file was that conducted by Dr Rudolph on 26 October 2012. Minimum standards of care in psychiatric units require that MSEs be conducted at least once each day of an admission. The best practice standard, and that applicable to the CRAAM, stipulates that MSEs are performed once each shift during an admission. In relation to the systematic and regular conduct of MSEs, CB's care at BIPU did not meet the minimum standards expected in psychiatric units.

[36] Victorian Department of Public Health, Criteria for searches to maintain safety in an inpatient unit – for patients, visitors and staff, Chief Psychiatrist Guideline 1301019 MOB, June 2014.

d. BIPU nursing staff failed to adequately engage with CB and failed to appreciate the deterioration in her mental state, especially on 27 October 2012. Nursing notes reflect that little or no interaction occurred, or was pursued, by nurses on shift during CB's admission. Nurses appeared content to allow CB to remain isolated in her room and nursing notes generally only recorded CB's location within the LDU. Notes of the "one on one time" Nurse Mathew had with CB on the day of her death suggest that little or no effort was made by the nurse to engage CB on more than a superficial level, even when she reported feeling 'anxious and crazy'. The implications of CB's diagnoses (BPD and AD) and the changes in her presentation, her increased level of anxiety, report of psychotic features and expressed need for additional medications, were not recognised by nurses as potentially reflective of a change in CB's mental state or risk level.

21. In light of the issues identified by the MHI, I invited NWMH to respond. Associate Professor Vine, Executive Director of NWMH, provided submissions to the Court on 26 August and 16 October 2014. Associate Professor Vine stated that:

    a. Safeguards were adopted in psychiatric units like BIPU, such as the removal of "hanging points", to reduce the likelihood that patients have the means to attempt suicide by hanging.[37]

    b. The Chief Psychiatrist Guideline in relation to inpatient searches and environmental safety, first published in 2013 after CB's death, provides guidance rather than directives for good clinical practice. Associate Professor Vine opined that the general application of 'extremely restrictive interventions' such as searches on every patient would be to 'impose a harsh regime on many to avert a rare and often unpredictable event,' like the suicide of an inpatient.[38]

    c. Although clinical files cannot record every interaction with or observation of a patient, CB's clinical file evidences a number of omissions from required and expected documentation.[39]

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[37] Submission to the Court by Associate Professor R. Vine dated 26 August 2014. See also the Statement made by NWMH Director of Operations, Peter F. Kelly on 28 July 2014 in which BIPU environmental hazard-reduction measures was canvassed. Environmental Safety Audits are conducted at BIPU annually. In 2013-2014, capital improvements were completed at NWMH facilities, among these was the removal of cupboard doors in BIPU patient rooms.

[38] Ibid.

[39] Submission to the Court by Associate Professor R. Vine dated 16 October 2014

d. That staff 'relied too heavily on [CB's] verbal reassurances and may not have given sufficient consideration to the fact that [she] had attempted self-harm on two successive days'. Given the recent occurrence of CB's self-harm attempts and that the stressors precipitating them were ongoing, 'it is arguable whether her risk was appropriately assessed as low'.[40]

e. Risk assessment is a 'difficult and imprecise process' and engagement with the patient is 'essential to making such assessments as valid as possible'. NWMH 'could perhaps have done more to engage and understand' CB. Staff 'respected CB's apparent desire to be on her own, and this may have limited any endeavour to engage with her ... or question her in greater depth'.[41]

f. The 'assessment, treatment and care provided to CB [at BIPU] ... was adequate, though not of an optimal standard'.[42]

22. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[43] The effect of the authorities is that Coroners should not make adverse findings against or comments about individuals, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

23. I find that given her presentation on 25 October 2012, it was appropriate for CB to have been admitted to BIPU as a voluntary psychiatric inpatient.

24. I accept that clinicians, particularly those working with voluntary patients in psychiatric units, face a difficult task when arriving at an appropriate balance between the imposition of undue restrictions on their patients' liberty and taking necessary precautions to secure their safety. Nonetheless, even without the benefit of hindsight, it is surprising that CB was permitted to retain a three-metre long woven scarf whilst a patient at BIPU, particularly as she was admitted to BIPU due to ongoing suicidality, in the context of two proximate suicide attempts,

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[40] Ibid.

[41] Ibid.

[42] Ibid.

[43] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences..."

most recently an attempted hanging. An appropriate balance between the patient's liberty and her safety (and that of others on the ward), was not struck in CB's case.

25. I find that the decision by BIPU staff to allow CB to retain her scarf whilst in the LDU, and the policy or practices that facilitated that decision, were flawed.

26. I accept that the assessments made by clinicians about a psychiatric patient's risk of suicide and other harmful behaviours are challenging, and that the process may be imprecise. That said, the process is not mere guesswork. Rather, it requires a systematic and reasoned evaluation of all available clinical information, including a mental state examination, to assess a patient's level of risk, at a given point in time. The patient's historical and current clinical record, as well as observations of, and interactions with, him/her by treating staff are essential, along with good record keeping, to gathering the necessary information to exercise clinical judgements about risk.

27. Clinicians ought not be criticised for failing to predict adverse events, even ones as grave as the suicide of an inpatient. However, clinicians should be criticised when their failure to conscientiously perform risk assessments (and MSEs), and to do so at regular intervals, results in the sub-optimal management and care of their patients.

28. The available evidence supports a finding that CB's clinical management was compromised by the failure of BIPU staff to perform (and document) formal, systematic and regular risk assessments and MSEs, in breach of the applicable minimum standards of clinical practice and the requirements the CRAAM system used at BIPU.

29. The evidence also supports a finding that BIPU nursing staff failed to adequately engage with CB during her admission. As a result, CB did not receive reasonable and appropriate management or care whilst at BIPU, especially on 27 October 2012, when her mental state was deteriorating markedly. Nursing staff failed to appreciate the deterioration in CB's mental state and so took no action, either themselves or by communicating her changed condition to medical staff, to improve CB's clinical course or forestall her ultimate actions.

30. I find that CB intentionally took her own life on 27 October 2012 whilst she was a voluntary inpatient at BIPU, and that the cause of her death was hanging.

31. The available evidence supports a finding that inadequate engagement between BIPU nursing staff and CB, and their failure to recognise a deterioration in CB's mental state, in circumstances where NWMH admission procedures provided her with the means to act on a suicidal impulse, all contributed to her death.

RECOMMENDATIONS

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

1. I recommend that NWMH change its policy that presently allows patients of the LDU to retain items that are capable of being used as a ligature to ensure that it complies with the Chief Psychiatrist Guideline on Criteria for searches to maintain safety in an inpatient unit – for patients, visitors and staff.
2. I recommend that the cupboards in patient rooms of the BIPU be adapted to remove 'hanging points'.
3. I note that I was advised by NWMH that a memorandum entitled "Removal of Hazardous Items in Inpatient Units" and dated 3 September 2014, which specifies NWMH's search and seizure policy in relation to potentially dangerous articles (including scarves and other lengths of fabric) belonging to inpatients, was distributed to Nursing, Inpatient and Area Managers and Clinical Services Directors, among others. The Memorandum refers to the Chief Psychiatrist Guideline on the same topic and links search criteria to individual clinical and environmental risk assessments throughout the course of an admission.
4. I further note that I was advised by MWNH that cupboard doors in BIPU patient rooms were removed during ligature-point remedial works in 2013-2014.
5. I recommend that NWMH reassess the current CRAAM guideline or policy regarding the level of engagement required for patients rated 'low risk'. Clear instructions should be developed for staff to produce consistency in:
    a. the frequency of formal documented mental state examinations across each shift,
    b. the requirement for a formally documented and notarised rationale explaining determination of a patient's 'low risk' rating; and
    c. the frequency, timing and recording of visual observation of patients.
6. I recommend that NWMH provide focused and detailed training to the nursing and allied staff and medical staff of the BIPU concerning the static risk factors (including those specific to particular diagnosed conditions) and dynamic risk factors (including changes in perception and increased anxiety levels) of individuals with mental illness.

7. I note that in her submission dated 16 October 2014, Associate Professor Vine undertook to ensure that staff received further support and training on the importance of engagement and gaining a collateral history of patients.

8. I recommend that NWMH provide focused and detailed training to the nursing and allied staff and medical staff of the BIPU about the procedure for escalation/referral to more senior staff of changes in mental state, dynamic risk factors for suicide (including changes in perception and increased anxiety level) of people with mental illness.

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

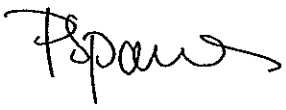
CB's family

Associate Professor Ruth Vine, NorthWestern Mental Health

Constable M. Schappacher, Broadmeadows Police Station

The Chief Psychiatrist

Signature:



PARESA ANTONIADIS SPANOS
CORONER
Date: **2 February 2015**

Cc: Manager, Coroners Prevention Unit