IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 1406

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coronel's Act 2008***

I, AUDREY JAMIESON, Coroner having investigated the death of Mr CR[1] without holding

an inquest:

find that the identity of the deceased was Mr CR

born on 12 December 1966

and the death occurred on 15 April 2010

at Austin Hospital, 145 Studley Road, Heidelberg, Victoria 3084

from:

1a. HYPOXIC BRAIN INJURY
1b. ASPHYXIATION (BY LIGATURE)

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

1. Mr CR was 43 years of age at the time of his death. He was a financial planner with the Industry Super Fund but was on sick leave. In 2006, Mr CR had separated from his wife of 19 years, Mrs CR and had been living with his parents, Mr and Mrs EV, in Mill Park. The separation with his wife had been acrimonious and he did not sign the divorce papers until a week before his death. The couple had a daughter, Miss CR who was 14 years of age at the time of her father's death. In September 2009, Mr CR commenced a new relationship with Ms UD and they had plans for the future together.

2. In November 2009, Mr CR injured his back. Over the following three months his back pain became increasingly worse. On 3 February 2010, Mr CR consulted Mr Damian Tange, Neurosurgeon, and was advised that he required urgent spinal surgery. He subsequently underwent a microdiscectomy of the disc between the lumbar 3 and 4 vertebrae

[1] The name of the deceased and their family has been redacted to protect their identity.

and a laminectomy at Epworth Hospital. He remained in hospital for seven days and up until March he was generally showing signs of improvement. A re-injury resulted in a complicating haematoma, which required his return to Epworth Hospital and further surgery. He was diagnosed with Cauda Equina Syndrome. Mr CR was discharged home to his parents but was failing to improve.

3. On 5 April 2010, Mr CR was admitted to North Eastern Rehabilitation Centre, due to residual pain and right leg paraesthesia. On 6 April 2010, Mr CR had a loss of balance and near fall. He was examined by Dr Terence Lim, Consultant in Rehabilitation and Pain Medicine, who arranged for Mr CR to undergo further investigations.

4. On 6 April 2010, Mr CR was also seen by Dr Steven Hill, Consultant in Rehabilitation and Pain Medicine, he subsequently referred Mr CR for psychiatric consultation.

5. On 8 April 2010, Dr Naomi Elliot, Consultant Psychiatrist, reviewed Mr CR and formed the view that he was not depressed but had an appropriate level of anxiety related to the uncertain outcome of further surgery. Dr Elliot discussed with Mr CR the option of taken sedation at night to improve poor sleep pattern. He denied suicidal intent of plans.

6. On 8 April 2010, Mr CR underwent an MRI of the cervico-thoracic spine. The report of the MRI indicated that Mr CR had thoracic canal stenosis at the T2/3 and T3/4 and myelopathy. On 8 April 2010, Mr Tange informed Mr CR that he would require further surgery.

7. On 10 April 2010, another patient at the Rehabilitation Centre informed, Registered Nurse (RN) Marilyn De La Rue (Division 2), that Mr CR had told him that he was contemplating taking his own life. Nurse De La Rue rep1ied this to her supervisor as well as to other staff members but made no notation in the medical records. Nurse De La Rue approached Mr CR about his suicidal ideation, but he denied any intent, stating that this co-patient had exaggerated the representation that he had made him. Nurse De La Rue offered the assistance of a counsellor, but Mr CR stated that he was simply feeling angry at his current medical condition and rejected the need for a counsellor. Nurse De La Rue discussed Mr CR and this issue with the Senior Nurse, Joanne Le Nepveu about possible courses of action, but a decision was made that there was no apparent need to warrant the inclusion of psychiatric personnel. During the course of the remainder of the day RN De La Rue and RN Roasalie Elliott, separately saw Mr CR in his room. Both nurses engaged in amicable conversation with him about his medical condition, treatment and personal circumstances. Both nurses found Mr CR to be in good spirits. There was no immediate concern

by the nurses regarding his psychiatric welfare.

8. On 11 April 2010, Mr CR had a shower, dressed, attended his physiotherapy session, returned to his room and was later found by a cleaner sitting upright with the bell-cord wrapped tightly around his neck. Nursing staff attended immediately and rendered medical assistance. Paramedics were also contacted and when they arrived, they continued with resuscitative attempts. Cardiac output was restored and Mr CR was transferred to the Emergency Department at the Austin Hospital. He was cared for in the Intensive Care Unit however, on 15 April 2010, after consultation with family members, medical support was withdrawn as it was apparent that Mr CR would not recover. He passed away later that day.

Investigation

9. Dr Shelley Robertson, Senior Pathologist with the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Mr CR and reported to the Coroner that it was reasonable to attribute the cause of death to hypoxic brain injury due to asphyxiation from a ligature.

10. The Police investigation was conducted by Constable V Guilbert, who obtained a number of statements from relevant medical and· nursing persom1el. The investigation identified indications that Mr CR had been planning his suicide for at least two days prior to his strangulation attempt on 11 April 2010. Test messages and voice messages provide some indication as well as a detailed draft text message to family and friends created on 9 April 2010. Mr CR had also cancelled his Foxtel and let the insurance and registration on his car lapse prior to his admission to the rehabilitation centre. There is also evidence of deteriorating mental health reported in statements from Mr CR's mother, Mrs EV and his best friend Mr AG, depicted by negative comments that Mr CR was making.

11. The investigation also identified that Mr CR's medical team had not been made aware of the discussion that Mr CR was believed to have had with a co-patient, nor had they been made aware of the conversations that took place after that with RN De La Rue and her discussion with RN Joanne Le Nepveu, the nurse in charge at the time. At no time did the nursing staff notify any of the medical practitioners or record discussions or activities surrounding these discussions with Mr CR. In addition, there was no indication that nursing staff had increased their monitoring of Mr CR given the events of that day. In addition, a review of the medical notes also reveals that Dr Naomi Elliot did not record that Mr CR had denied suicide intent or plan as depicted in her statement obtained in the course of the investigation.

12. On 3 November 2011, a Mention hearing was held in the Coroner's Court. Legal representation for North Eastern Rehabilitation Centre Hospital, a Healthscope Ltd facility, appeared. The purpose of the Mention hearing was to inform Healthscope Ltd that my investigation thus far indicated that some adverse comments may be warranted and giving them an opportunity to provide submissions in respect of this possibility, without the need for the matter to proceed to a formal public hearing/inquest.

13. On 15 November 2011, I received a lengthy submission under cover letter dated 14 November 2011, from Mr Michael Regos from DLA Piper Australia, on behalf of their client Healthscope Ltd. In summary, it was submitted:

"The Centre acknowledges that the alleged conversation between the deceased and co-patient regarding the deceased contemplation of suicide was not recorded in the medical record and ought to have been recorded. Nevertheless, it says that upon becoming aware of the conversation it acted promptly and appropriately and that all nursing staff caring for the deceased after that alleged conversation until the time of his death were aware of the alleged conversation and that recording it would have made no difference to the management by staff."

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

1. The nursing staff on the day/evening shift of 10 April 2010, should have contacted a medical practitioner when they became aware of Mr CR's suicide ideation. In addition, despite their discussion between themselves and their discussion with Mr CR, there is no further evidence that they recognised any change in risk by for example, increasing their observations of him. The evidence indicates that the nursing staff felt reassured and alleviated of the responsibility to provide more proactive follow up in part, because Mr CR had been assessed by a qualified psychiatrist three days prior.

2. I accept the submission that improved communication may not have changed the outcome for Mr CR, but nursing staff should not underestimate the evidence[1] of the increased safety from best practice handover, recording and reporting practices, irrespective of what speciality they work in.

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

1. Healthscope North Eastern Rehabilitation Centre Review the Restorative Rehabilitation Pathway and include greater emphasis on the screening for high prevalence disorders such as anxiety and depression, to increase the early intervention and treatment of psychiatric illness in patients.

2. Healthscope North Eastern Rehabilitation Centre undertakes to develop a delegation procedure specifying the criteria for notifying responsible medical practitioner out-of-hours, over patient's clinical deterioration including mental state, thereby increasing patient safety.

3. Healthscope North Eastern Rehabilitation Centre undertake a review of the quality of the clinical handover process, including written clinical documentation and variable handover formats to improve the communication about, and safety of its patients.

Finding

I find that Mr CR died from hypoxic brain injury seconda1y to asphyxiation by a ligature, whilst an in-patient of the North Eastern Rehabilitation Centre.

AND

I further find that Mr CR intended to take his own life and that there is evidence to support a conclusion that he had been planning to do so for some time. In the circumstances I am unable to find that any actions or omissions by the centre would have prevented his death.

[1] Wong MC, Yee KC, Turner P. 2008 Clinical handover literature review. *eHealth* Services Research Group, University ofTasmania, Australia. For Australian Government Austra lian Commission on *Safety and Quality in Healthcare.*

Pursuant to rule 64(3) of the Coroners Court Rules 2009, I order that these findings be published on the internet.

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

Mr JN, Senior Next of Kin;

Mr Michael Regos, DLA Piper Australia (MIRO1:0490727);

Mr Robin Shae, Austin Hospital;

Healthscope Ltd (Trading as North Eastern Rehabilitation Hospital);

Constable Veronique Guilbert.

Signature:

AUDREY JAMIESON
CORONER
20 JUNE 2012