IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2014 0918

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)
Section 67 of the Coroners Act 2008 [1]

Findings of:	Judge John Cain, State Coroner
Deceased:	Stuart Brant Garten
Delivered on:	2 May 2022
Delivered at:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank

[1] This finding is the result of an application to set aside a finding and re-open an investigation following an inquest held on 24 November 2014 and inquest finding made on 16 March 2017.

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INTRODUCTION

1. Stuart Brant Garten was a 34-year-old man who lived in Traralgon at the time of his death. Mr Garten was detained as an involuntary mental health inpatient at Latrobe Regional Hospital when he took his own life on 17 February 2014.

2. As Mr Garten was 'in care' at the time of his death, a mandatory inquest was held into his death on 24 November 2014 and a finding was made on 16 March 2017. On 23 March 2019 Mr Garten's aunt, Michelle Grocock, applied to set aside the finding and re-open the coronial investigation, and her application was granted.

3. This finding is the result of the original and re-opened coronial investigation.

BACKGROUND

4. Mr Garten grew up with his younger brother and sister and they were raised by their mother, Karen Garten. In 1988 and whilst living in Longwarry North, Mr Garten's younger brother passed away. Mr Garten was said to have struggled to come to terms with his brother's death and thereafter became protective of his mother and sister. In his adult years, Mr Garten was the victim of at least two assaults, which appear to have triggered post-traumatic stress disorder.

5. In later years, Mr Garten was employed in labour-type work, including fruit-picking. At the time of his death, he was in receipt of the Disability Support Pension.

6. Mr Garten's mother described him as caring, and family was important to him. It is evident from her statement that he was very much loved, and she provided ongoing and unwavering support to him during his life when he experienced mental ill health.

7. On 16 February 2014, Mr Garten was found hanging in the courtyard of the Secure Extended Care Unit at Latrobe Regional Hospital. At the time of his death, he was subject to an involuntary inpatient treatment order under the now repealed *Mental Health Act 1986* (Vic). Mr Garten was resuscitated and died the following day in the intensive care unit of Latrobe Regional Hospital.

THE CORONIAL INVESTIGATION

8. Mr Garten's death was reported to the Coroner as it was unexpected and unnatural, and so fell within the definition of a reportable death pursuant to section 4 of the *Coroners Act 2008* (**the**

Act). Reportable deaths include deaths that are unexpected, unnatural or violent, or result from accident or injury.

9. The death of a person in care or custody is a mandatory report to the Coroner. As Mr Garten was an involuntary inpatient detained at a mental health service pursuant to the *Mental Health Act 1986* (Vic) (repealed), he was deemed to be a person placed in custody or care at the time of his death. As Mr Garten was 'in care' at the time of his death, an inquest was mandatory.

10. The jurisdiction of the Coroners Court of Victoria is inquisitorial.[2] The Act provides for a system whereby reportable deaths are independently investigated to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[3]

11. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[4] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation,[5] or to determine disciplinary matters.

12. The expression "*cause of death*" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

13. For coronial purposes, the phrase "*circumstances in which death occurred*,"[6] refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

14. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, by coronial findings, comments and recommendations.

15. The previous coronial investigation in this case was undertaken on behalf of the coroner by a member of Victoria Police who was appointed as the coroner's investigator, Detective Senior Constable Ashley Bell. A coronial brief was prepared with witness statements taken from

[2] Section 89(4) *Coroners Act 2008* (Vic).
[3] Preamble and section 67 *Coroners Act 2008* (Vic).
[4] *Keown v Khan* (1999) 1 VR 69.
[5] Section 69(1) *Coroners Act 2008* (Vic).
[6] Section 67(1)(c) *Coroners Act 2008* (Vic).

Mr Garten's family, persons who witnessed the circumstances leading to Mr Garten's death, and the forensic pathologist's report.

THE RE-OPENED CORONIAL INVESTIGATION

The previous inquest and finding

16. Deputy State Coroner Iain West conducted an investigation into Mr Garten's death. His Honour held a summary inquest on 24 November 2014 at which time he was assisted by Inspector Paul Hayes from the Police Coronial Support Unit. Ms Lucy Hunter appeared on behalf of Latrobe Regional Hospital.

17. During the proceedings, Mr Garten's mother, Karen Garten, raised concerns regarding Latrobe Regional Hospital's lack of care and lack of observation of her son prior to his death. She also requested a copy of the inquest brief, which was provided to her. Deputy State Coroner West subsequently adjourned the matter to a date to be fixed for the Garten family to consider their concerns and to make them known to the Court. Over the following months, the Court contacted the Garten family on multiple occasions but no written submission outlining the concerns held by the family was received.

18. On 16 March 2017, His Honour finalised his investigation and made the following findings:

    (a) the identity of the deceased was Stuart Brant Garten, born 17 August 1979,

    (b) the death occurred on 17 February 2014 at Latrobe Regional Hospital, 10 Village Avenue, Traralgon, Victoria;

    (c) the cause of Mr Garten's death was *"1(a) Hypoxic/ ischaemic brain injury following resuscitated cardiac arrest"* and *"1(b) Hanging"*; and

    (d) the circumstances leading to his death were as follows:[7]

    On 8 January 2001, whilst living in Drouin, Mr Garten reported to police that he had been assaulted by an unknown person whilst retrieving clothing from his clothesline. As

[7] As they appear at paragraphs 2 to 18 of Deputy State Coroner West's finding, dated 16 March 2017.

a result of the attack, he was left with minor swelling to his lip and cheek area but was unable to assist police to identify his attacker.

On 28 February 2005, Mr Garten was again the subject of an assault which occurred outside a residential property in Drouin. He alleged that he was punched to the head a number of times which caused a laceration above his right eye as well as sore ribs. Following a police investigation, Mr Garten withdrew his complaint. He later stated to friends, family and medical professionals that he believed the injuries sustained during these incidents, in conjunction with his alcohol and drug use, were the root cause of his post-traumatic stress disorder and other mental health issues.

In late 2008, Mr Garten met Ms Gabby Merino through a mutual friend and their friendship blossomed into a relationship. In April 2013, Mr Garten's mental health began to deteriorate and was characterised by self-harm and threats of suicide. He was admitted as an involuntary patient in the Flynn Ward of Latrobe Regional Hospital's Mental Health Unit.

*Mr Garten underwent a mental health assessment and had multiple diagnoses of Post-Traumatic Stress Disorder, depression, schizophrenia, Borderline Personality Disorder and an acquired brain injury. He was transferred to the Latrobe Hospital's Secure Extensive Care Unit (**SECU**) between 17 November 2013 and 16 February 2014. His behaviours during this period included repetitive self-injury by cutting and strangling. His mental state was further characterised by paranoid ideation, auditory hallucinations, depression and impulsive behaviour.*

Over the 3 month admission to SECU, Mr Garten's mental state improved according to Dr Paul Lee, Clinical Director of Mental Health. Mr Garten was coping better with his symptoms and he also formed a working relationship with his case manager and was well supported by his mother and girlfriend. According to Dr Lee, his self-harming behaviours had reduced both in term of frequency and severity.

On 11 February 2014, Dr Lee assessed Mr Garten with the SECU multidisciplinary team. His mental state remained stable with no evidence of relapse. He was anxious about the possibility of discharge and advised that his preference would be to live in supported accommodation. He had also voiced his concerns about being discharged to both his

mother and girlfriend. He was also referred to a neuropsychologist to reassess his cognitive ability and did not disclose any plans to self-harm.

On 14 February 2014, Ms Merino spoke to Mr Garten and noted that his mood was down and he didn't want to talk. During their conversation, he again asked her to move out of home and reside with him. Ms Merino informed him that she still could not afford to move out as she was studying. Mr Garten became annoyed with her and hung up the phone as he had done so on other occasions.

On the morning of 16 February 2014, Nurse Karen McPherson attended Mr Garten's room and asked him to attend the medication room. Mr Garten refused and continued writing on a piece of paper on the floor. He denied any intentions of self-harm and refused to discuss his feelings or further mental state. He proceeded to the courtyard for a cigarette.

Nurse McPherson seized the note that Mr Garten had been writing and observed it was a suicide note addressed to his mother. At 9am, Nurse McPherson again spoke with Mr Garten and asked him again if he had plans to self-harm which he denied. He again refused to take his medications and Nurse McPherson asked him to empty his pockets to ensure he had nothing on him with which he could harm himself. She confiscated his cigarette lighter as he had used them previously to cut himself. She informed him she was concerned for him but he again denied any intentions to self-harm.

As a result of this behaviour, a request was made that Mr Garten undergo an assessment. The Hospital Medical Officer, Dr Joo Chuah was contacted. She indicated she would attend but had to attend to an emergency patient first. Mr Garten's hourly observations were increased to 2-3 times per hour. A short time later, he approached Nurse McPherson and asked if he could call his mother. According to Nurse McPherson, he did not show any signs of being distressed during the call. Ms Karen Garten stated that he asked her to visit him and she indicated she would try to that day but if not, would see him the following day.

At midday, Dr Chuah arrived on the ward. Mr Garten had refused lunch although was observed to be drinking fluids. Dr Chuah assessed him over approximately 30 minutes. She noted that he appeared slightly anxious with poor eye contact and low speech.

Mr Garten described his mood as 'bad' and made statements that he had had enough and admitted to ongoing suicidal thoughts although with no intent. He also reported paranoid thoughts that people were trying to harm him and reported auditory hallucinations which involved hearing medical staff make accusations that he was a paedophile.

Upon being informed of Mr Garten's suicide note, Dr Chuah attended to see Duty Psychiatrist Dr Rajiv Siotia to discuss her findings and management plan although did not mention the suicide note to him. Dr Siotia advised that nursing staff should continue to check Mr Garten's vital signs and ordered some blood tests to check his electrolyte levels. He also advised that Mr Garten was to be closely monitored given his suicidal thoughts. This was conveyed to the nursing staff by Dr Chuah. Mr Garten was advised he could not have his bedroom door closed and his observations were increased to 4 times per hour.

At approximately 1.30 pm, Nurse Jessica Cross commenced duty and received an unofficial handover in relation to Mr Garten. At 1.50pm she decided to assist the morning staff and checked his room. When she could not locate him, she checked the lounge and courtyard. Upon checking the courtyard closely for a second time, Nurse Cross located Mr Garten hanging at the foot of a tree. He had used a shoelace as a ligature and was lying in a prone position. His face was discoloured and it is believed he had been unconscious for approximately 20 minutes. Nurse Cross immediately retrieved the rescue tool to cut the ligature and called out to other staff for assistance. A code blue was declared and cardiopulmonary resuscitation was commenced which lasted for 45 minutes. A cardiac rhythm was regained and Mr Garten was admitted to the intensive care unit in an unresponsive and unconscious state.

On 17 February 2014 at 7.08pm, Mr Garten had still failed to regain consciousness or improved in his condition. A scan determined that he was brain dead and he was formally declared deceased.

Forensic Pathologist Dr Jacqueline Lee from the Victorian Institute of Forensic Medicine performed an external examination of Mr Garten and provided a written report of her findings. She identified a thin ligature furrow around the neck, consistent with a shoelace. A healing wound on the anterior aspect of the left wrist and healed vertical scars were

noted on the anterior aspect of the right wrist. Toxicological analysis revealed the presence of acetone, diazepam, nordiazepam, risperidone, hydroxyrisperidone, chlorpromazine, fluvoxamine and haloperidol, lignocaine and paracetamol.

On 24 November 2014, a summary inquest was held in relation to this matter. During the proceedings, Ms Karen Garten raised concerns regarding a lack of care and lack of observation of her son at the time prior to his death. She also requested a copy of the inquest brief which was provided to her. As a result, I adjourned the matter to a date to be fixed for the Garten family to consider their concerns and to make them known to the Court. In the preceding 13 months, the Court has heard nothing further from the Garten family despite multiple phone calls from our Registrars and Family Liaison Officers as well as numerous letters being sent to them. The last correspondence from the Court was sent on 1 February 2017 with nothing having been heard to date.

I therefore find that that cause of death of Stuart Garten was hypoxic ischaemic brain injury following resuscitated cardiac arrest in the context of hanging. I find that he intended the tragic consequences of his actions.

19. His Honour's findings were provided to Mrs Garten.

Application to set aside Deputy State Coroner West's findings

20. On 1 April 2019, the Court received a *Form 43 Application to Set Aside Finding* from Michelle Grocock (Mr Garten's aunt), dated 23 March 2019.

21. In her application, Ms Grocock requested all of Deputy State Coroner West's findings to be set aside and that the investigation be re-opened pursuant to section 77 of the *Coroners Act 2008*. In summary, the basis of her application was the family's concerns regarding the care Mr Garten received at Latrobe Regional Hospital. In summary, they were:

    (a) the adequacy of proposed discharge planning for Mr Garten;

    (b) that Mr Garten had access to a potential ligature (shoelaces) in his possession; and

    (c) communication issues (regarding his suicide note) between his medical practitioners.

22. Mr Garten's family had not raised these concerns in any detail previously and they were not referred to in the previous findings. Therefore, there had been no assessment of the appropriateness of Mr Garten's care while he was an involuntary patient. Deputy State Coroner Caitlin English decided that Ms Grocock's application constituted new facts and circumstances and that it was appropriate to re-open the investigation (which are the criteria under section 77).

23. On 13 June 2019, Deputy State Coroner English made a decision to set aside Deputy State Coroner West's findings and re-open the coronial investigation.

24. On 5 April 2022, Deputy State Coroner English was appointed to the County Court and I took over carriage of this matter for the purposes of finalising this finding.

The scope of the re-opened investigation

25. I have had regard to the statement of identification completed by Mr Garten's uncle, Tony Biekens, dated 17 February 2014, and the post-mortem report completed by Dr Jacqueline Lee, Forensic Pathologist at the Victorian Institute of Forensic Medicine, dated 7 May 2014.

26. No controversy has been raised regarding the findings made as to Mr Garten's identity and cause of death pursuant so subsections 67(1)(a) and (b). I therefore adopt those particular findings as made by Deputy State Coroner West.

27. Ms Grocock's application raises concerns about the care and treatment Mr Garten received at Latrobe Regional Hospital. I will therefore confine my finding to the circumstances leading to his admission and the care he received there (the findings made pursuant to subsection 67(1)(c)).

28. As part of the re-opened investigation, Deputy State Coroner English obtained information from Latrobe Regional Hospital regarding relevant policies and guidelines in place at the hospital at the time of Mr Garten's death and the changes made at the hospital since his death.

29. Her Honour also obtained advice from the Coroners Prevention Unit (**CPU**) regarding the appropriateness and reasonable of the mental health treatment received. The CPU is staffed by healthcare professionals, including practising physicians and nurses. Importantly, these healthcare professionals are independent of the health professionals and institutions under consideration. They draw on their medical, nursing, and research experience to evaluate the

clinical management and care provided in particular cases by reviewing the medical records, and any particular concerns which have been raised.

30. I have set out the information from Latrobe Regional Hospital and the CPU's advice below.

31. Given the effluxion of time since Mr Garten's death, I do not believe that a further inquest would elicit any further or more specific evidence regarding the circumstances leading to his death. I have had regard to the coronial brief, Mr Garten's medical records, and the further information from Latrobe Regional Hospital and the advice from CPU. I am satisfied that I can make findings pursuant to section 67(1)(c).

Standard of proof

32. All coronial findings must be made based on proof of relevant facts on the balance of probabilities.[8] In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[9]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED PURSUANT TO SECTION 67(1)(c) OF THE ACT

33. Mr Garten had a documented psychiatric history, including involuntary treatment orders from about 2001 and had multiple diagnoses current at the time of his death including post-traumatic stress disorder, depression, borderline personality disorder (**BPD**), and paranoid schizophrenia.

34. Mr Garten reported substance use since he was a teenager, and traumatic incidents when substance affected including a sexual assault and at age 26 years and several significant physical assaults with a probable acquired brain injury. Mr Garten ceased his use of substances after that time; however, he had commenced self-harming the year prior to his death, and this continued with cutting and hanging/strangulation. Mr Garten's brother died when he was nine years old, and he also experienced intergenerational trauma.

35. Mr Garten had experienced periods of relative wellness and functioning usually when in a stable relationship. Mr Garten had been living in the Latrobe Regional Hospital Community Residential Care Unit, Traralgon. He regularly consulted a private psychologist and was case managed by

[8] *Re State Coroner; ex parte Minister for Health* (2009) 261 ALR 152.
[9] (1938) 60 CLR 336.

Latrobe Valley Community Mental Health Service (**LVCMHS**) on a community treatment order under *Mental Health Act 1986* (Vic). Mr Garten had a neuropsychology assessment and occupational therapy functional assessment completed, which were used to inform his care.

Mr Garten's admission to the Flynn Ward

36. By April 2013, Mr Garten's mental health had deteriorated following a reduction in clozapine (an antipsychotic) because of adverse physical effects (weight gain, gynaecomastia, oedema, and cardiac palpitations) and was characterised by poor sleep, an escalation in impulsive self-harming acts and suicidal ideation, auditory and visual hallucinations, increased anxiety and fearfulness and he could no longer cope at the Community Residential Care Unit. His medication was changed to risperidone (also and antipsychotic), but it was not effective in halting his mental state deterioration and he was admitted as an involuntary patient in the acute psychiatric Flynn Ward of Latrobe Regional Hospital.

37. The treatment plan was appropriately amended during Mr Garten's eight-month admission to meet his needs. There was evidence of the treating team engaging with Mr Garten, of engagement with his mother (Karen Garten), and support for carer burden associated with her son's illness and that of her mother, frequent multidisciplinary reviews, and contemporary specialist review and advice sought from neuropsychology and occupational therapy.

38. In July 2013, the Flynn Ward sought a specialist clinical assessment from the state-wide specialist BPD service, SPECTRUM,[10] because of the treating team's ongoing concerns for Mr Garten's safety given his continued moderate to high risk of suicide, that he had required a high dependency environment for over 100 days, completed a course of electroconvulsive therapy without sustained clinical change, had a change of antipsychotic to haloperidol depot injection/oral and the antidepressant fluvoxamine, and his self-harming behaviours (which included making nooses) in the unit continued.

39. The SPECTRUM short-term plan was for a consistent response to Mr Garten's self-harming behaviours, treatment with an antipsychotic (antidepressant or mood stabiliser) to stabilise his agitation, persecutory and paranoid ideations, build rapport and a working relationship with a mental health professional who would support him over the longer term, provide reassurance,

[10] Spectrum is a state-wide specialist mental health service for people with a borderline personality disorder.

community case management, and a step-down and graduated approach to his return to the community. The moderate term management plan that was provided focused on Mr Garten's first few months after his discharge to the community, and suggestions for a long-term plan were included.

Mr Garten's transfer to the Secure Extended Care Unit

40. Mr Garten was transferred to the Latrobe Regional Hospital's Secure Extended Care Unit (**SECU**),[11] which was a six-bed ward in the Flynn Unit complex, on 17 November 2013 after he was assessed as not ready for return to the Community Residential Care Unit, had chronic suicidal, and some defensive homicidal thinking.

41. Psychiatric and medical assessments were completed at SECU, and Mr Garten was rated as overall high risk. A Comprehensive Assessment and Service Plan was developed and noted the category of observation frequency was dependent on Mr Garten's presentation and encouraged frequent communication and engagement. Mr Garten was a cigarette smoker and throughout the admission he was frequently in the SECU courtyard smoking. At times he gardened in the courtyard because he wanted to and as part of the ward program.

42. On 12 November 2013, Mr Garten requested his haloperidol (antipsychotic medication) be changed because he believed it was ineffective. Dr Paul Lee, consultant psychiatrist, subsequently ceased it and commenced risperidone depot and PRN (as needed) medication was also reviewed. Dr Lee also assessed Mr Garten with the SECU multidisciplinary team and approved escorted leave with staff on hospital grounds.

43. Staff worked with Mr Garten on positive strategies for dealing with negative thoughts including encouragement and support to engage in prevention and distraction techniques (television, music, mindfulness, relaxation, thought diary, word puzzles), which he intermittently used throughout the admission, but he continued to seek PRN (as needed) medications often. Mr Garten did not leave the unit until 19 December 2014 to walk to the onsite café with staff, which he enjoyed.

44. By January 2014, Mr Garten was more settled, engaged with recovery activities including cooking, washing his clothes, and walking outside of the unit with some flashbacks but no suicidal

[11] Secure extended care units provide medium to long-term inpatient treatment and rehabilitation for people who have unremitting and severe symptoms of mental illness or disorder.

ideation or acts. His mental state was more stable, he utilised less PRN medications and was working with his LVCMHS case manager, Patrick Horgan. Mr Garten expressed concerns about discharge, was clear he did not want to live alone, that his preference was to live in supported accommodation and that he wanted to return to live at Community Residential Care Unit. He started to make plans that included improving his relationship with his girlfriend, a course, and a job and was noted to be appropriately anxious. He was referred to a neuropsychologist to reassess his cognitive ability and did not disclose any plans to self-harm.

45. In mid-January 2014 and after a changed appointment with his case manager, he expressed concerns to Dr Lee about his case manager, about journal keeping, people from Flynn Ward (in what context is unclear), and he demanded to be allowed to go for unescorted walks. His paranoia and concerns about his and his mother's safety increased over coming weeks.

46. Mr Garten became aware he was not going to return to the Community Residential Care Unit when he received a letter asking him to collect all his belongings and that there was refunded monies at Latrobe Regional Hospital finance department. He was distressed about not returning to Community Residential Care Unit as he had made clear he wanted to. It was explained that he would have to reapply if he wanted to return to Community Residential Care Unit. Mr Garten was also finding it difficult to comprehend information about refunded rent from Community Residential Care Unit and the SECU staff also found it difficult to clarify this on his behalf.

47. Mr Garten settled overnight, however during the following morning he refused to go to Community Residential Care Unit with his case manager to collect his belongings as arranged. Mr Garten was later found scratching his left wrist, which was cleaned and dressed. When the nurse returned to check if Mr Garten would attend the pre-booked neuropsychology appointment, he was verbally abusive, but he attended the appointment and was then reviewed by a doctor.

48. On 10 February 2014, Mr Garten became withdrawn and would not engage with co-patients, engaged with staff only when questioned directly, and laid in the courtyard for two hours. However, he engaged with his mother and with another visitor.

49. The following day he was reviewed by the treating team, including Dr Lee. Mr Garten reported he was not sure of the discharge plan although he had met with Quantum Housing, did not want to live alone, and that he needed supported accommodation close to his girlfriend, Gabriella Merino. Mr Garten's concerns about living alone were supported by Ms Merino and his mother

who stated he was frightened and anxious about the prospect of having to live on his own especially after meeting with the housing agency.

50. On 13 February 2014, Mr Garten's mental state had changed, with a decrease in mood and following a visit from his mother he reported he was upset and requested PRN medication. He requested to go to the high dependency unit (**HDU**) in Flynn Ward, but this was refused after assessment. He settled for the remainder of the day and overnight.

51. On 14 February 2014, Ms Merino spoke to Mr Garten and noted that his mood was down, he did not want to talk, was unsettled, and unsure about where he would end up. During their conversation, he asked her to move out of her home and live with him, but she refused because she was at university and could not afford it. This caused conflict between them and Mr Garten's last interaction with Ms Merino was to tell her she was no help before he ended the phone call.

52. On 15 February 2014, Mr Garten told staff his girlfriend did not understand him, and his mother never listened to him.

Events leading to Mr Garten's death

53. On the morning of 16 February 2014, enrolled nurse Karen McPherson went to Mr Garten's room and asked him to attend the medication room. Mr Garten refused and continued writing on a piece of paper on the floor. He denied any intentions of self-harm and refused to discuss his feelings or his mental state. He proceeded to the courtyard for a cigarette. Nurse McPherson obtained the note that Mr Garten had been writing and saw it was a suicide note addressed to his mother.

54. At 9.00am, Nurse McPherson tried to escalate the situation in the first instance to a Flynn Ward/SECU registered nurse, Associate Nurse Unit Manager Anita Wilson, but she was on a break. Nurse McPherson subsequently spoke with another Flynn Ward registered nurse, Francine Riley, who supported the decision to increase the SECU observations of Mr Garten.

55. Nurse McPherson and Psychiatric Services Officer Gayle Watson, the only other staff member on shift in SECU, went together to Mr Garten who was in the courtyard and asked him again if he had plans to self-harm which he denied and said he would not harm himself. They offered him his routine and a PRN medication dose, which he refused. Nurse McPherson asked him to empty his pockets and confiscated his cigarette lighter as he had used it previously to cut himself.

56. Nurse McPherson then escalated the situation to Associate Nurse Unit Manager Wilson, showed her the note Mr Garten had written, reported she had increased the frequency of observations, and that she believed he should be reviewed by a doctor. Associate Nurse Unit Manager Wilson agreed and left Nurse McPherson to organise the response.

57. Nurse McPherson went to the Duty Psychiatrist office however the on-duty psychiatrist, Dr Rajiv Siotia, was not there. She returned to SECU and telephoned him about her concerns, including the suicide note, and was told to contact Dr Joo Chuah, registrar, which she did.

58. Between 9.30am and 10.00am, Psychiatric Services Officer Watson went to the Flynn Ward for an unknown reason, but she saw and spoke to Dr Chuah about reviewing Mr Garten. However, she did not say why, believing this was outside of her scope of practice.

59. Nurse McPherson later stated that she told Dr Siotia about the suicide note, however Dr Siotia stated he was not informed by anyone prior to the incident in SECU.

60. Nurse McPherson increased Mr Garten's hourly observations to between 15 and 30 minutes. According to Nurse McPherson, she offered Mr Garten his medications six times over the morning, which he refused. He telephoned his mother and asked her to visit him, and she indicated she would try that day but if not, would see him the following day. Nurse McPherson stated that Mr Garten did not show any signs of being distressed during the call, which was later supported by his mother.

61. Dr Chuah assessed Mr Garten at midday for about 30 minutes. Mr Garten had refused lunch although he did drink fluids. She noted that he appeared slightly anxious with poor eye contact and low speech. Mr Garten described his mood as bad and made statements that he had had enough of life, had ongoing suicidal thoughts with intent (but no plan), thoughts that people were trying to harm him, and reported auditory hallucinations which involved hearing SECU staff make accusations that he was a paedophile.

62. Dr Chuah spoke with Dr Siotia to discuss her findings and management plan although did not mention the suicide note to him. The management plan included checking Mr Garten's vital signs, pathology, and increase the frequency of monitoring by SECU staff (however there was no specific frequency documented), to commence a fluid balance chart, increase frequency of mental state examinations and risk assessments, and that Dr Siotia would review Mr Garten later that

day. Nurse McPherson also stated Dr Chuah noted if SECU's concerns increased, Mr Garten was to go to the HDU in Flynn Ward and that he was not to be allowed in his room with the door closed.

63. Mr Garten was advised he could not have his bedroom door closed and according to Nurse McPherson his observations increased to about every 15 minutes, however the statements and medical records suggest this was not adhered to.

64. At approximately 1.20pm, Enrolled Nurse Jessica Cross commenced duty and received an unofficial handover in relation to Mr Garten in the SECU office in the presence of Nurse McPherson, Dr Chuah, and Psychiatric Services Officer Watson. Dr Chuah stated she left for lunch and on her return, she heard the code blue. According to Registered Nurse Appu Joseph (who had worked the morning shift in Flynn Ward), Nurse McPherson told him to give his handover in the Flynn Ward while SECU got ready for handover. Nurse McPherson saw Mr Garten at 1.40pm on his way to the courtyard and Psychiatric Services Officer Watson stated she saw Mr Garten coming out of one of the bathrooms next to his bedroom between 1.45pm and 1.50pm.

65. At 1.50pm, Nurse Cross decided to assist the morning staff by completing the observations, checked Mr Garten's room, unit lounge, and part of the courtyard and could not find him. She alerted other staff and together they re-entered the courtyard and found Mr Garten hanging from a tree having used his shoelace as a ligature. He was described as lying on his side with his upper body off the ground by the initial staff at the scene and as prone by those who arrived in response to the code blue.

66. Nurse Cross immediately retrieved the rescue tool to cut the ligature and a code blue resuscitation response lasted for 45 minutes. A cardiac rhythm was regained, and Mr Garten was admitted to the intensive care unit in an unresponsive and unconscious state.

67. Mr Garten failed to regain consciousness and his condition did not improve. On 17 February 2014 at 7.08pm, and he was formally declared deceased.

FAMILY CONCERNS

68. As part of her application, Ms Grocock provided a submission which included comprehensive background information about Mr Garten and eight specific questions she requested be answered. The CPU reviewed these concerns and provided the following commentary.

Suicide note, who was aware of it, and the failure to make timely contact with Mrs Garten

69. Ms Grocock asked why Mrs Garten was not notified of her son's suicide note. The family were unaware of Mr Garten previously writing any suicide note and were of the opinion that this event was demonstrative of the start of an escalation in his behaviour, of which Mrs Garten should have been informed. Ms Grocock also asked why the consultant psychiatrist was not informed of the suicide note.

70. The evidence in the coronial brief is conflicted on who knew about the suicide note.

71. Dr Siotia claimed he was not informed by anyone of its existence, however Nurse McPherson stated that when she telephoned Dr Siotia (after she had gone to the Duty Psychiatrist's Office and he was not there), that she expressed her concerns and told him about the suicide note.

72. Dr Chuah did not tell Dr Siotia about the suicide note.

73. According to the Latrobe Regional Hospital root cause analysis report, Mr Garten had previously written letters/notes which included suicidal thinking but no intent/plan.[12] However this information was not evident in the medical record progress notes for the duration of Mr Garten's admission(s) nor included in any crisis management/safety plan or risk assessment.

74. This suggests that up until Nurse McPherson's actions on the day of Mr Garten's incident, staff did not apply clinical weight to Mr Garten's suicide notes.

75. It is reasonable that Mrs Garten was contacted in relation to Mr Garten's change in clinical presentation and not in response to the suicide note alone. It was also reasonable to await the review by the medical staff to notify her on what had occurred and the outcome.

[12] Statement of Executive Director of Mental Health Cayte Hoppner, dated 30 October 2019.

76. I also note that Mr Garten did speak to his mother that morning, after he had composed the suicide note and did not present as distressed.

Access to the Hight Dependency Unit

77. Ms Grocock asked why Mr Garten was not taken to the HDU when he was highly agitated. He had asked to be transferred several times but had been refused.

78. Mr Garten had been previously moved to the HDU, especially during his many months in Flynn Ward. However, after his move to SECU he was moved to HDU only on 3 December 2013 for observation after he had cut his wrist with a razor blade and was awaiting transport to Dandenong Hospital for a plastics consultation of the wound. He asked to be moved to HDU on 13 February 2014 when upset after a visit by his mother. After assessment, he was not transferred to HDU and remained in SECU and was settled for the remainder of the day and slept overnight.

79. According to Nurse McPherson, on the 16 February 2014 and as part of Dr Chuah's instruction to her about the plan for Mr Garten, she told her that if the staff concerns increased for Mr Garten, he could be moved to HDU. However, Dr Chuah did not document this or any discussion about such a move with Dr Siotia or with Associate Nurse Unit Manager Wilson, who was the senior clinical nurse.

Searching Mr Garten's room after suicide note found

80. Ms Grocock asked why Mr Garten's room was not searched after the suicide note was found.

81. Searching a patient's room and belongings for ligatures/self-harm items is not a routine activity unless a specific part of a patient's care plan or it would need approval by a senior staff member. If the risk is high, a patient can be moved from the unit to an environment considered more safe.

82. Nurse McPherson and Psychiatric Services Officer Watson removed the items Mr Garten gave them when asked but there does not appear to have been an awareness of other items he could have used for self-harming, instead focusing on the use of the lighter which he had most recently used to scratch at the wound he had made on 3 December 2013.

Mr Garten's access to shoelaces

83. Ms Grocock asked why Mr Garten had shoelaces in his shoes.

84. After Mr Garten's admission to SECU he was found by nursing staff with his shoelaces around his neck on 13 and 16 November 2013 and 26 January 2014. On 29 December 2013 Mr Garten asked that his shoes be removed because he did not feel safe with them. Some staff were aware of the risk of his using ligatures and on 14 December 2013 he was asked to only use his iPod earphones in front of staff because of the risk.

85. On 13 November 2013, Mr Garten was assessed as low risk, was given back his sneakers and shoelaces and was to tell staff if the urge to use them was overwhelming. An appropriate and documented plan in the progress notes was for Mr Garten to look at lace-free footwear to minimise temptation and reduce risk. However, there is no evidence to suggest this was followed up.

86. The blanket removal of such items in a SECU environment is not appropriate. Nonetheless, the Chief Psychiatrist's Guidelines promotes a case-by-case assessment.[13] Individual case-by-case assessment does not rule out accessing other ligatures from other patients in the unit, but Mr Garten did not have a history of accessing other ligatures from other patients or places.

87. Nonetheless, Mr Garten had stated, and it was documented, that he was tempted by his shoelaces, and he had felt unsafe. In such circumstances and in line with the case-by-case approach in the Chief Psychiatrist's Guidelines and in a patient centred care approach, it was reasonable for Mr Garten's crisis management/safety plan, early warning signs, specific advice to staff etc, to include removal of his shoelaces (and lighter, access to means) when his risk was high and/or follow through on the plan for him to get lace-free shoes.

88. A review of the medical records does not support a risk mitigation approach such as a crisis management or safety plan was available to Mr Garten or to Nurse McPherson. The development of a crisis management/safety plan with a person with frequent self-harming and BPD is fundamental and supported in the national guidelines. This approach is not specific to the treatment environment (inpatient, community etc), but to the identified and individual needs of the patient and is developed and negotiated with the individual.[14]

[13] Department of Health, Chief Psychiatrist's Guidelines: Criteria for searches to maintain safety in an inpatient unit – for patients, visitors and staff, 3 July 2014.
[14] Australian Government, National Health and Medical Research Council, Clinical Practice Guideline for the Management of Borderline Personality Disorder, 2012, sections 8.5, 10.2.

The last sighting of Mr Garten

89. Ms Grocock asked for details about when Mr Garten was last sighted given he was supposed to be on close monitoring.

90. There is conflicting information about the last sighting of Mr Garten and based on the information it is likely he was not sighted within the informally increased 15 minutely timeframe.

Impact of the delay in handover in Secure Extended Care Unit

91. Ms Grocock asked whether the morning shift not being ready for handover to the afternoon shift affected Mr Garten's monitoring.

92. The CPU advised that the delay in clinical handover in SECU is unlikely to have contributed to Mr Garten's death. The CPU noted that handover is not and should not be linear in wards of low staffing levels and as Nurse Appu had commenced the shift in SECU, his first priority should have been to SECU. The medical records were available and as oncoming Nurse Cross did in completing the observations that were due, the option to support Nurse McPherson who was preparing for handover did not take precedence over the needs of Flynn Ward.

Skills of the staff on duty on the day of Mr Garten's death

93. Ms Grocock asked about the staff on duty at the time of Mr Garten's death and whether they have relevant experience to deal with the situation.

94. Nurse McPherson was an enrolled nurse and was on shift with a non-clinical Psychiatric Services Officer in the six-bed SECU. The CPU advised that this was unreasonable.

95. A Psychiatric Services Officer is a non-clinical role which left Nurse McPherson the only clinical staff member in SECU. However, Nurse McPherson as an enrolled nurse was not a senior nurse and should not have as a matter of routine been the senior on shift in the SECU.

96. However, in saying that, Nurse McPherson did quickly and repeatedly escalate her concerns for Mr Garten to senior nursing and medical staff and the response, especially of the registered nurses in Flynn Ward was suboptimal.

97. It appears that Drs Chuah and Siotia and the Flynn Ward nursing clinical leads on the shift and on the on-coming shift to SECU left the clinical decision making and safety of Mr Garten and other patients and visitors to Nurse McPherson. This included frequency of observations and any need for a more secure environment. This was inadequate and reflected a suboptimal response to Nurse McPherson's appropriate attempts to escalate her concerns and lack of senior support for the SECU staff and safety of the patients.

98. Executive Director of Mental Health, Cayte Hoppner, referred to the root cause analysis completed after the death of Mr Garten and noted the following:[15]

> *... as a result of Mr Garten's death and following the RCA [root cause analysis], LRH [Latrobe Regional Hospital] removed the PSO (Psychiatric Services Officer) position and replaced this with a nursing position. The SECU roster now has an Associate Nurse Unit Manager (Grade 3 Registered Nurse) and either a Registered Nurse Grade 2 or an Enrolled Nurse per shift. The Enrolled Nurse reports to the Registered Nurse/ANUM [Associate Nurse Unit Manager] who reports to the SECU Nurse Unit Manager (Registered Nurse Grade 5). This has strengthened the minimum skills/qualifications in SECU and provides a clearer operational and clinical reporting structure.*

99. The CPU considered that this was an appropriate response to the inadequate SECU staffing profile at the time of Mr Garten's death.

Escalation of Mr Garten's care immediately before his death

100. In addition to the advice provided in responses to Ms Grocock's questions above, the CPU provided advice as to whether Mr Garten's care immediately before his death was appropriately escalated.

101. The CPU advised that the response to Nurse McPherson's attempts to escalate her concerns to senior nursing staff and in part to medical staff was inadequate.

[15] Email from Executive Director Mental Health Latrobe Regional Hospital Cayte Hoppner, dated 2 March 2020.

102. Nurse McPherson escalated the situation to Dr Siotia, who required Nurse McPherson to arrange for Dr Chuah to see Mr Garten. She then escalated to Nurse Riley and Associate Nurse Unit Manager Wilson (who were her clinical seniors on 16 February 2014.)

103. It is not clear if Dr Siotia knew, or if he had that it would have changed the outcome, however the suicide note and Nurse McPherson's concerns should have resulted in a more proactive response from Associate Nurse Unit Manager Wilson including but not limited to direct support to Nurse McPherson and/or a direct review of Mr Garten and his mental state.

104. Oncoming Nurse Appu chose to leave the SECU in circumstances where Nurse McPherson was occupied in the office implementing the plan Dr Chuah had recorded and preparing for handover, which left non-clinical Psychiatric Services Officer Watson on the unit and looking after the five patients and Mr Garten.

105. Nurse Appu stated Nurse McPherson told him to give his handover in Flynn Ward. However, as the registered nurse who had commenced his shift in SECU and the senior clinical nurse, it was reasonable to expect he would undertake some exploration of what was happening and how his now being on shift could have been of assistance.

106. Ms Hoppner provided the January 2018 Mental Health – Escalation of Care Protocol and noted:[16]

> *In addition, LRH [Latrobe Regional Hospital] implemented a Clinical Escalation policy which clearly indicates when staff can escalate clinical concerns and who to, including senior Managers, Executive and Clinical Directors. This ensures that all staff are encouraged and supported to speak with any level of the organisation if they have concerns about any aspect of clinical care.*

107. The CPU advised that this protocol does encourage a stepped process for escalation of concerns in SECU and sets out responsibilities for using ISBAR[17] and those of the Nurse Unit Manager and consultant psychiatrist or delegates and that a clear plan is to be documented in the medical records.

[16] Email from Executive Director Mental Health Latrobe Regional Hospital Cayte Hoppner, dated 2 March 2020.
[17] ISBAR is a standardised format/tool for the transfer of information, particularly when there are time- constraints. ISBAR (Introduction, Situation, Background Assessment, Recommendation). ISBAR organises a conversation into the essential elements in the transfer of information from one source to another. Its effectiveness has been demonstrated in both clinical and non-clinical situations of communication transfer.

Planning Mr Garten's discharge

108. The national 2012 Clinical Practice Guideline for the Management of Borderline Personality Disorder was applicable at the time of Mr Garten's death and includes the following advice:[18]

> *People with BPD are sensitive to feeling rejected or abandoned. Health professionals who have developed a significant relationship with a person with BPD should anticipate that withdrawal and ending of treatments or services, and transition from one service to another, may evoke strong emotions and reactions in the person.*
>
> *… Planning for transfer to another service or discharge from treatment should begin well in advance, because transfer takes longer to achieve safely in people with BPD than for other people who use mental health services. At the beginning of treatment, it may be helpful for the clinician to explain that the treatment will eventually come to an end.*
>
> *The treating clinician can help the person cope by emphasizing any progress that the person has made towards recovery, clearly expressing confidence in the person's ability to manage their life now and after the end of treatment, encouraging the person to think about future goals and challenges and how they will approach these, and supporting the person to identify other sources of support. If appropriate, the treating clinician should also discuss plans for the end of treatment with the person's family, partner and carers.*

109. The CPU advised that based on the medical records, the approach to Mr Garten's discharge in part complied with this, however there was a lack of listening to him about his reluctance, distress, and expressed fear of living alone. However, there is nothing documented about an actual or even possible discharge date that had been discussed with Mr Garten or his family.

110. Case Manager Horgan was focused, as expected, on transitioning Mr Garten out of SECU and safely into the community. Medical records support the SECU staff across most shifts and Case Manager Horgan invested considerable time and in working with him about strategies to change his thinking that were supportive, reassuring and based on cognitive behavioural principles.

[18] Australian Government, National Health and Medical Research Council, Clinical Practice Guideline for the Management of Borderline Personality Disorder, 2012, section 8.3.

Mr Garten would become distressed about leaving the unit but discussion about facts and his choices were not always linked to self-harming.

111. Nonetheless the decision making about the planning and especially the discharge destination for Mr Garten was devolved by the SECU treating team to Case Manager Horgan. This occurred in circumstances of the SECU treating team having documented occasions in which Mr Garten expressed his concerns to them about independent living. When Mr Garten expressed concerns about the Case Manager Horgan plan for him to live independently, there was nothing to suggest the treating team, of which Case Manager Horgan was essentially a member, liaised or discussed the conflict and ongoing appropriateness of the plan in the light of Mr Garten's increasingly reported distress about living independently. It did not appear that Case Manager Horgan was invited to or attended the team meetings and clinical reviews for Mr Garten, however he did make regular entries in the progress notes.

112. The Recovery model used in mental health focuses on the goals of the patient. Mr Garten was clear he wanted to go Community Residential Care Unit or a Supported Residential Service and this was supported by his mother, who also communicated her concerns to the treating team.

113. The evidence-base for increased risk associated with prolonged hospitalisation for a person with a BPD is sound.[19] Mr Garten was treated for several psychiatric diagnoses during his near 10-month admission, however this does not reduce the likelihood of his experiencing abandonment anxiety at the prospect of a discharge, especially to independent living which he had been clear he did not believe he would achieve.

Safety Planning

114. The Safety Awareness Assessment and Planning protocols provided by Ms Hoppner include a 2016 community services version[20] and 2017 inpatient specific protocol which applies to SECU and which are contemporary.[21] It includes the development of a Consumer Safety Plan which is developed by a patient with the assistance of the medical officer and is an adjunct to the clinical risk assessment, application of a category of risk (low, medium, high), and is linked to safety checks and ongoing assessments. The low category requires a Consumer Safety Plan development

[19] Australian Government, National Health and Medical Research Council, Clinical Practice Guideline for the Management of Borderline Personality Disorder, 2012.
[20] Statement of Executive Director of Mental Health Cayte Hoppner, dated 30 October 2019, Appendix 2C.
[21] Statement of Executive Director of Mental Health Cayte Hoppner, dated 30 October 2019, Appendix 2D.

with nursing staff and in the HDU. The content of the Consumer Safety Plan was not provided, nor is there advice about how the Consumer Safety Plan is referred to by the patient and/or clinicians in decision-making, how and when it is reviewed for relevance and usefulness or updated.

115. It is reasonable to expect the content of a patient's safety plan would in the circumstances of Mr Garten's death (BPD, prolonged admission, previous self-harming, stated temptation to use shoelaces for self-strangulation) include a practicable and appropriate approach to access to potential or previously used items in self-harming when that patient's risks increase either through self-reporting or as assessed by clinicians and in what circumstances these items are returned.

FURTHER CHANGES MADE AT LATROBE REGIONAL HOSPITAL SINCE MR GARTEN'S DEATH

116. It has been over six years since Mr Garten's death and in that time mental health services have changed and Latrobe Regional Hospital was asked to provide a list of policies regarding SECU, risk assessment, escalation, access to items in the SECU, nursing observation policy, staff training, and an internal review of Mr Garten's death. Some of these have already been detailed above in reference to concerns raised by Ms Grocock and the CPU's review of care.

Internal and external reviews

117. According to Cayte Hoppner, Executive Director of Mental Health at Latrobe Regional Hospital, the root cause analysis made the following recommendations, all of which were implemented in 2014 and 2015:

(a) improve clinical handover through the use of ISBAR, and revision of the policy;

(b) review the observation policy and adherence;

(c) review the risk assessment and inpatient admission protocols;

(d) improve clinical communication; and

(e) rostering of staff.

118. In addition, Latrobe Regional Hospital sought an independent external review of the inpatient unit (Flynn Unit including SECU) in November and December 2014, which has resulted in improvements to medical and nursing handover, training for staff, implementation of the Safewards Program,[22] auditing of the risk assessment policy and escalation processes and establishment of an electronic medical record (due for completion in 2020).

Secure Extended Care Unit annual ligature point audits

119. Ms Hoppner provided the most recent ligature point audits for 2014 and 2019 and noted it is an annual audit and the tool is industry standard. A review of the audit results shows the 2014 audit was site-wide and a broad audit with multiple actions mostly focused on the safety of current beds and changes in the SECU courtyard. The 2019 audit is SECU specific and noted three actions related to shortening on cords in the television and sensory rooms and repair of a broken bed locker. Monitoring of the results of these audits and completion of actions is the executive responsibility.

120. Ms Hoppner stated the Latrobe Regional Hospital Mental Health Ligature Risk Guidelines and Audit Tool was current at the time of Mr Garten's death is based on the Queensland Health 2012 Guideline for Managing Ligature Risks in Public Mental Health. The Latrobe Regional Hospital guideline also references the Worcestershire Health and Care (2014) Policy for assessing, addressing and managing ligature risks in mental health inpatient units. Both referencing documents provide guidance as to the makeup of the auditing "team" for a ligature audit. This information was not clearly articulated in the Latrobe Regional Hospital Mental Health Ligature Risk Guidelines and Audit Tool provided however the guidelines has been reviewed and as of 25 March 2020, reflects the correct process of a team and an external member completing the audits. The 2014 audit was completed by a team of five and the 2019 completed by the SECU Associate Nurse Unit Manage. At the time of Ms Hoppner's statement, the 2020 Audit was scheduled and due to be completed according to the reviewed guideline/tool.[23]

[22] Originating in the UK and implemented internationally, the Safewards model was developed from a broad body of evidence, including several large-scale research studies conducted over a number of years. In Victoria, Safewards was trialled across seven services (18 units) over one year. It was extensively evaluated by the Centre for Psychiatric Nursing, University of Melbourne with significant and positive results. The Safewards model and associated interventions have been highly effective in reducing conflict and containment and increasing a sense of safety and mutual support for staff and patients.
[23] Email from Executive Director Mental Health Latrobe Regional Hospital dated 17 March 2020.

Suicide prevention

121. Ms Hoppner outlined the Zero Suicide framework and program implemented in 2017 including a Nurse Practitioner – Suicide Prevention position who leads work across the service, and a Hospital Outreach Post Suicidal Engagement program for direct support for people at risk of suicide.

Staff training

122. Ms Hoppner provided records of training for staff that has been completed for 2014, 2015, 2016, 2017, and 2018. The records are extensive and cover aggression management training, behavioural interventions, risk management including nursing observations, suicide prevention, assessment, and management training, search procedures, Safewards program,[24] clinical handover and transition of care including the use of ISBAR, ASIST,[25] clinical deterioration and Safety Awareness Assessment and Planning, which includes risk assessment, safety planning and escalation of risk and nursing observation.

123. The training has been linked to and supports the policy/guideline changes made by Latrobe Regional Hospital and also includes contemporary training that have become part of practice and care delivery through the National Safety and Quality Health Service Standards,[26] and Department of Health Mental Health Branch and Chief Psychiatrist expectations of contemporary care standards for a public mental health inpatient service.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

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

124. Mr Garten died from brain injury sustained through self-strangulation in the courtyard of Latrobe Regional Hospital SECU after he had unusually and repeatedly refused all medications and composed a suicide note to his mother. This behaviour triggered the SECU staff to have safety

[24] Safewards - Originating in the UK and implemented internationally, the Safewards model was developed from a broad body of evidence, including several large-scale research studies conducted over a number of years. In Victoria, Safewards was trialled across 7 services (18 units) over one year. It was extensively evaluated by the Centre for Psychiatric Nursing, University of Melbourne with significant and positive results. The Safewards model and associated interventions have been highly effective in reducing conflict and containment and increasing a sense of safety and mutual support for staff and patients.
[25] ASIST – applied suicide intervention and skills training.
[26] Australian Commission on Safety and Quality in Health Care, 2012 and 2017 Editions.

concerns, which resulted in an informal increase in frequency of observations, removal of access to some means, and repeated escalation attempts by Nurse McPherson to her senior nursing and medical staff. I am satisfied the response by the senior nursing staff was suboptimal in both support for Nurse McPherson and for Mr Garten and his safety.

125. SECU and the treating team(s) for Mr Garten's admission(s) had sought expert advice for his care and in the main SECU and his case manager implemented a short-term management plan as outlined by SPECTRUM, but it was fragmented and significantly there is limited evidence that Mr Garten's own goals and wishes were central to the treating team's planning for his discharge.

126. The internal and external reviews undertaken by Latrobe Regional Hospital after Mr Garten's death, environmental improvements, and the adoption of contemporary practices was proactive, and it is evident that the service has learned from the circumstances of Mr Garten's death and undertaken changes to improve the quality of care and safety of patients in the SECU.

127. Nonetheless, there are issues that were not addressed through the hospital's actions and changes including:

    (a) the communication between SECU and community case managers specific to discharge planning that acknowledges and addresses the patient's goals and concerns; and

    (b) the inclusion of discussion with SECU patients about access to means in the Consumer Safety Plan.

128. I will therefore make recommendations that Latrobe Regional Hospital implement improvements in these areas with a view to preventing further similar deaths. These recommendations specifically target the family's concerns about the discharge process (which Mr Garten was clearly extremely concerned about) and his access to means (shoelaces).

FINDINGS AND CONCLUSION

129. Having investigated the death, and held an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Stuart Brant Garten, born 17 August 1979, died on 17 February 2014 at Latrobe Regional Hospital, 10 Village Avenue, Traralgon, Victoria, from hypoxic/ ischaemic brain injury following resuscitated cardiac arrest and hanging in the circumstances described above.

RECOMMENDATIONS PURSUANT TO SECTION 72(2) OF THE ACT

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

1. I recommend **Latrobe Regional Hospital** Secure Extended Care Unit review its discharge planning to include as fundamental, routine, and real-time discussion between SECU and community mental health staff that is representative of a patient's concerns and goals.

2. I recommend **Latrobe Regional Hospital** Secure Extended Care Unit review the content of the Consumer Safety Plan for opportunities to include practicable and agreed access to means controls.

I convey my sincere condolences to Mr Garten's family for their loss.

Pursuant to section 73(1) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Karen Garten, senior next of kin
Michelle Grocock
Sebastiano Romano, Executive Director of Mental Health, Latrobe Regional Hospital
Office of the Chief Psychiatrist
Sergeant Jaymie Carroll, Victoria Police, Coroner's Investigator.

Signature:

Judge John Cain
State Coroner
Date: 2 May 2022

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.