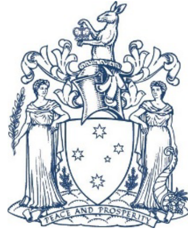


IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 003256

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

Section 67 of the ***Coroners Act 2008***

Findings of:	AUDREY JAMIESON, Coroner
Deceased:	Judith Mary Pollard
Date of birth:	27 December 1949
Date of death:	18 June 2023
Cause of death:	1a: Complications of lipoid pneumonia following the ingestion of shampoo, conditioner, toothpaste and inhalation of hairspray
Place of death:	Goulburn Valley Health, 2/2-48 Graham Street, Shepparton, Victoria, 3630
Keywords:	Voluntary inpatient suicide, personal item suicide

INTRODUCTION

1. On 18 June 2023, Judith Mary Pollard was 73 years old when she died 18 days after consuming a large volume of toiletry products. At the time of her death, Judith lived in Katunga with her husband, Ian Pollard (**Mr Pollard**).

Mental Ill Health

2. Judith had an extended history of mental ill health, dating back to her thirties. At 34 years of age, she was admitted to the Numurkah Hospital. While an inpatient, Judith attempted suicide by hanging using the waistband of a dressing gown. She was transferred to the Ambermere Hospital in Shepparton, where she remained for approximately six weeks and received electroconvulsive therapy (**ECT**).

3. On 18 April 2023, Judith visited her general medical practitioner (**GP**) and complained of feeling *'depressed and anxious'*. Judith's medication regime was updated including to increase the dose of her antidepressant, amitriptyline. Throughout May 2023, Judith had three re-visits with her GP and on each occasion presented with persistent mental ill health.

4. By the end of May 2023, Judith's *'paranoia kicked in and she was saying strange things again how she could kill people and how she would do it'*.

THE CORONIAL INVESTIGATION

5. Judith's death was reported to the coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned an officer to be the Coronial Investigator for the investigation of Judith's death. The Coronial Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

9. This finding draws on the totality of the coronial investigation into the death of Judith Mary Pollard including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

10. On or around 30 May 2023, Judith attempted to climb through the bedroom window during the night, believing that the house was on fire. On 31 May 2023, Judith's daughter, Nicole Koopman (**Ms Koopman**), contacted Dr Spencer and he referred Judith to a psychiatrist of the Shepparton Private Hospital.

11. On 1 June 2023, during the afternoon, Judith was voluntarily admitted to the mental health ward of Shepparton Private Hospital. Mr Pollard and Ms Koopman spoke with clinicians, according to Mr Pollard:

> *'[Ms Koopman] took the dressing gown cord and mirrors out of Judith's bag so that she couldn't use any of it to harm herself due to knowing what happened last time she was in hospital.*
>
> *Both [Ms Koopman] and [he] spoke to the staff making it clear that she had a history of attempting suicide whilst in hospital and we were concerned she would make those attempts. [They] told staff she would need to be watched'.*

[1] Subject to the principles enunciated in Briginshaw v Briginshaw (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

12. Upon Judith's admission, clinicians conducted a risk assessment and determined she was at *'moderate'* risk of suicide and/or self-harm. Judith was categorised to receive nursing observations every 30 minutes.

13. On 2 June 2023, at 3:30 am, a nurse located Judith next to her bed, vomiting. Judith told the nurse she drank shampoo, conditioner, consumed a tube of toothpaste and inhaled a container of breath mints, in an attempt to suicide.[2] The nurse contacted emergency services and Judith's treating psychiatrist who ordered she be transferred to the emergency department (**ED**). The nurse observed *'signs of aspiration'* and performed physical assessments every 15 minutes until the ambulance arrived.

14. Shepparton Private Hospital staff contacted and informed Judith's family of her actions, and she was transferred to the Goulburn Valley Hospital ED. She was diagnosed with hypotension (low blood pressure), an acute kidney injury and dysphagia (difficulty swallowing). She was transferred to the Intensive Care Unit (**ICU**), then to the mental health unit once she stabilised.

15. On 6 June 2023, Judith experienced a seizure, and a Medical Emergency Team (**MET**) call was made. She was transferred to the medical ward and received treatment for aspiration pneumonia. On 13 June 2023, she became unconscious, and another MET call was made. Clinicians concluded this was due to anti-psychotic induced respiratory depression.

16. Clinicians diagnosed Judith with lipoid pneumonia – a rare lung disease due to the aspiration of lipid-containing products. On 14 June 2023, clinicians consulted with Mr Pollard and decided to commence steroids as the *'only possible effective treatment'* for lipoid pneumonia. However, Judith's condition continued to deteriorate, and she was transitioned to palliative care.

17. On 18 June 2023, at 12:07 am, clinicians declared Judith deceased.

Identity of the deceased

18. On 18 June 2023, Judith Mary Pollard, born 27 December 1949, was visually identified by her spouse, Ian Pollard, who completed a formal Statement of Identification.

19. Identity is not in dispute and requires no further investigation.

[2] Medical records of this visit indicate that Judith told staff she consumed a container of breath mints. She later told her family that she inhaled a canister of hairspray.

Medical cause of death

20. Forensic Pathologist Dr Joanne Chi Yik Ho (**Dr Ho**) of the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on the body of Judith Pollard. Dr Ho considered materials including the Victoria Police Report of Death for the Coroner (**Form 83**), e-Medical Deposition Form completed by Goulburn Valley Health, medical records of Goulburn Valley Health and post-mortem computed tomography (**CT**) and provided a written report of her findings dated 24 July 2023.

21. The post-mortem examination revealed multiple bruises, predominantly on the arms.

22. Toxicological analysis of ante-mortem samples collected by Goulburn Valley Hospital on 9 June 2023 identified the presence of the following compounds:

Amitriptyline	~ 0.2 mg/L
Nortriptyline	~ 0.5 mg/L
Sertraline	~ 0.1 mg/L
Risperidone	~ 21 ng/mL
Hydroxyrisperidone	~ 24 ng/mL
Olanzapine	~ 0.03 mg/L
Quetiapine	~ 0.3 mg/L
Levetiracetam	~ 23 mg/L

23. Dr Ho provided an opinion that the medical cause of death was 1(a) COMPLICATIONS OF LIPOID PNEUMONIA FOLLOWING THE INGESTION OF SHAMPOO, CONDITIONER, TOOTHPASTE AND INHALATION OF HAIRSPRAY.

FAMILY CONCERNS

24. During the course of my investigation, Mr Pollard and Ms Koopman expressed their concerns regarding the medical treatment provided by Shepparton Private Hospital.

25. Mr Pollard wrote, *'I feel like this could have been avoided if the staff at Shepparton Private [Hospital] had watched [Judith] the first night when she was admitted'*.

THE FREQUENCY OF STAFF OBSERVATIONS FROM 1 TO 2 JUNE 2023

26. To better understand the circumstances of Judith's death, I sought the assistance of the Coroners Prevention Unit to assess the medical management provided by Shepparton Private Hospital.[3] I note that Shepparton Private Hospital is operated by Ramsay Health.

27. In a statement to the Court, the Nursing Unit Manager spoke to the frequency of observations implemented regarding Judith. They stated, *'all new admissions are placed onto 30 minute observations for at least the first 24 hours on the ward'.* The relevant policy, *Risk Assessment & Category Observation* states:

> *'It is highly recommended that staff undertake additional rounds between prescribed times so that patients cannot discern a pattern or set time or fixed staff routine'.*

28. The CPU considered Judith's medical records and identified that there were no additional observations recorded in line with the policy recommendation. On this point, the Nursing Unit Manager stated that it *'can be difficult to balance providing a quiet environment which promotes sleep, whilst completing more frequent rounds'.* While the CPU agreed with this statement, they opined it does not account for the total absence of additional rounds overnight from 1 to 2 June 2023. The Nursing Unit Manager did not provide a reason regarding the absence of additional observations.

29. In medical records, nursing observations are documented as occurring on the hour and half past the hour for the duration of Judith's admission. The CPU hypothesised that this enabled Judith to predict when nursing observations would occur and consume the large volume of toiletries within the 30-minute window unnoticed. Had additional, staggered or random observations been conducted, it is less likely that Judith would have been able to predict nurses' arrivals.

30. The CPU stated however, even if staff had conducted random observations, Judith may have nonetheless been able to consume the toiletries relatively quickly or in stages.

[3] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

ACTIONS TAKEN BY SHEPPARTON PRIVATE HOSPITAL SINCE JUDITH'S DEATH

31. I sought a statement from Shepparton Private Hospital's Director of Clinical Services to understand what actions they had taken in the time since Judith's death. They informed me that the hospital completed a Serious Adverse Patient Safety Event (**SAPSE**) review regarding the circumstances of Judith's admission.

32. As a result of the SAPSE review, Shepparton Private Hospital updated its procedures regarding patients' personal items. These include decanting patients' products into 100 mL containers, storing the remainder out of their access, and prohibiting patients from owning hairspray.

33. I commend Shepparton Private Hospital for the preventative measures they have adopted and consider that they are a positive initiative in preventing inpatient suicides and/or self-harm through the deliberate ingestion of personal care items.

RECOMMENDATIONS

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

1. In the interests of promoting public health and safety and with the aim of preventing like deaths, I recommend that **Ramsay Health** update its *'Risk assessment & Category Observation'* policy by mandating that staff complete additional observations and provide guidance regarding staggering observations with the view to prevent patients discerning their frequency.

FINDINGS AND CONCLUSION

1. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

   a) the identity of the deceased was Judith Mary Pollard, born 27 December 1949;

   b) the death occurred on 18 June 2023 at Goulburn Valley Health 2/2-48 Graham Street, Shepparton, Victoria, 3630; and,

   c) I accept and adopt the medical cause of death ascribed by Dr Ho and I find that Judith Mary Pollard died due to complications of lipoid pneumonia following the ingestion of shampoo, conditioner, toothpaste and inhalation of hairspray.

2. AND I find that Judith Mary Pollard consumed the products with the intention to end her own life, and that she did so in the context of an extended history of mental ill health and a prior suicide attempt.

3. AND having commented on the frequency of nursing observations completed by Shepparton Private Hospital staff, I find that Judith Mary Pollard had the opportunity to learn the routine of nursing observations and accordingly, was able to surreptitiously ingest the products.

4. AND the weight of the evidence before me does not enable me to make a finding that even if staff had observed Judith Mary Pollard at random intervals, whether her actions and subsequent death could have been prevented.

5. AND FURTHER I commend the actions taken by Shepparton Private Hospital since Judith Mary Pollard's death to restrict future patients' access to potentially hazardous products and am hopeful this will assist to prevent deaths associated with inpatient personal item suicides.

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

Pursuant to section 73(1A) 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:

Ian Pollard, Senior Next of Kin

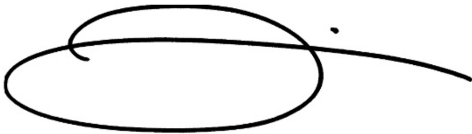
Nicole Koopman

Ramsay Health

Goulburn Valley Health

Constable Amy Williams, Coronial Investigator

Signature:



AUDREY JAMIESON

CORONER

Date: 27 February 2025

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 investigation. 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.