Rule 63(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2017 4582

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: CATHERINE ANN WILLIAMSON

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	22 June 2023
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank 3006
Hearing Dates:	31 August 2021
Appearances:	Mr Paul Halley of Counsel (Minter Ellison) on behalf of Healthscope Operations Pty Ltd
Counsel Assisting the Coroner:	Senior Sergeant Jenette Brumby Police Coronial Support Unit

TABLE OF CONTENTS

I, AUDREY JAMIESON, Coroner having investigated the death of CATHERINE ANN WILLIAMSON

AND having held an Inquest in relation to this death on 31 August 2021

at the Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006

find that the identity of the deceased was CATHERINE ANN WILLIAMSON

born on 9 February 1958

died at the Victoria Clinic, 324 Malvern Road, Prahran, Victoria 3181

at an unknown time between 10 September 2017 and 11 September 2017

from:

1 (a) PLASTIC BAG ASPHYXIA

In the following summary of circumstances:

CATHERINE ANN WILLIAMSON was a voluntary patient at the private psychiatric hospital, the Victoria Clinic in Malvern when she was located deceased by nursing staff with a shower cap over her face and a plastic bag over her head. A number of "suicide notes" were located in her room.

BACKGROUND CIRCUMSTANCES

1. Catherine Ann Williamson[1] was 58 years of age at the time of her death. She had been married but had separated from her husband approximately two years prior to her death. The couple had two daughters.

2. Catherine had lived in Prahran with her husband and family and remained there initially after the separation. Her husband had moved to Lorne to set up a business and although it was not Catherine's intention to relocate, she subsequently had been forced to due to

[1] Catherine Ann Williamson was referred to as "Catherine" during the Inquest proceedings. For consistency, I have predominately referred to her "Catherine" during this Finding save for where formality has necessitated the use of her full name.

financial reasons. She moved to Lorne where she resided with one of her daughters. She found this move difficult and missed her friends in Prahran and although she explored ways to purchase her own home, she was unable to do so, causing her much distress. The death of her dog also caused her much unhappiness.

3. Catherine had a long history of mental ill health, initially diagnosed with depression she was subsequently diagnosed with schizo-affective disorder[2] after experiencing psychotic symptoms. Her first admission to the Victoria Clinic was in 2013. Catherine was known to have made four attempts on her life with medication overdoses. The most recent attempt was in late September 2016. Most of her attempts at her life had necessitated Catherine's admission to hospital for treatment.

4. Catherine had been treated by private Consultant Psychiatrist, Dr Keryn Fitzpatrick (**Dr Fitzpatrick**) since 1998.

SURROUNDING CIRCUMSTANCES

5. On 18 August 2017, Catherine was admitted to Victoria Clinic, a Healthscope[3] facility. She was feeling extremely unhappy and confused about where her life was heading. From admission, her medication remained unchanged, and she was linked with a social worker and psychologist and Dr Fitzpatrick saw Catherine for daily therapy. Catherine appeared settled and was participating in the unit program.

6. On Friday 8 September 2017, Catherine requested leave to go to a hairdresser and sought an employment agency referral to attend Centrelink. Seen by Dr Fitzpatrick, Catherine guaranteed her safety and denied any plans to self-harm.

7. The progress notes record Catherine's mood as low with ongoing anxiety regarding her future accommodation. She denied any thoughts of suicide, visited Centrelink on unescorted leave and on return attended the therapy program. Catherine was still

[2] Schizo-affective disorder is a combination of two mental illness, schizophrenia and a mood disorder.

[3] Healthscope Operations Pty Ltd (**Healthscope**) is a private healthcare provider which owns and manages the Victoria Clinic.

expressing disappointment at not being able to secure financial support to purchase her own property but was future focussed and had a plan to move to Broken Hill.

8. On Sunday 10 September 2017 Catherine self-reported her mood as low. Nevertheless, she had coffee with some friends whilst on unescorted leave and continued to discuss her move to a new life in Broken Hill. Pre-leave and post-leave risk assessments were performed by registered nurses. No "pat-down" or physical search was undertaken on Catherine's return from leave.

9. Registered Nurse, Sharon Zapantis (**Nurse Zapantis**) performed an assessment of Catherine's mental state and risk on her return from unescorted leave at approximately 1.32pm on 10 September 2017. Nurse Zapantis also searched Catherine's bags and wallet for any items of risk in accordance with Healthscope's policy *Harmful Objects – Items of Risk in a Mental Health Environment* and located a white plastic bag containing a candle holder, an object like a piece of stone with sharp edges, wrapped in tissue paper and a wooden stand attached, and a jar of relish. Nurse Zapantis confiscated these items and placed them at the Nurses Station in a place inaccessible to patients.[4]

10. Overall, on Sunday 10 September 2017, Catherine presented as settled with an improvement in her mood. She remained future focused, saying she had plans to do a barista course. The progress notes reflect her as low risk, she denied self-harm, suicidal ideation and guaranteed her safety. On that same day, an *Items of Risk/Prohibited Items Check Form*[5] was completed in Catherine's room at Victoria Clinic. No prohibited items or items of risk were found or required removal from Catherine's room.

11. Overnight observations of Catherine, performed by the night shift staff, commenced at 10.24pm and the visual observations record reflect Catherine as being asleep. CCTV footage of the corridor outside Catherine's room (Room N7) depicts a staff member entering the doorway of Catherine's room approximate to the hour from 10.24pm to 7.37am on 11 September 2017.

[4] Statement of Sharon Zapantis dated 11 January 2018 – Coronial Brief (CB) at pages 160 – 162.

[5] Victoria Clinic *Items of Risk/Prohibited Items Check Form* dated 10 September 2017 - CB at page 66.

12. On Monday 11 September 2017 at approximately 8.20am, an agency nurse performing the medication round, entered Catherine's room after she did not respond to a knock on the door. Catherine was lying on her side with her back to the door and a blanket partially covering her head. When she did not respond to her name or by being gently shook by the nurse, the blanket was pulled away from her head revealing that Catherine had a grey plastic shopping bag over her head, tied around her neck and under her chin.

13. The agency nurse pushed the 'assistance' button before alerting other nearby staff. A second nurse responded to the call for assistance and removed the plastic bag from Catherine's head, to discover a shower cap over her face. Catherine was unresponsive and cold to the touch – the two nurses commenced cardio-pulmonary resuscitation (**CPR**). Around the same time the second nurse realised that the 'assistance' button rather than the 'emergency' button (to activate a 'Code Blue') had been pressed by the agency nurse, so rectified the situation. Additional assistance arrived and an emergency kit and portable AED/defibrillator utilised. Resuscitation efforts continued pending the arrival of Ambulance paramedics.

14. At approximately 8.41am, Ambulance paramedics arrived at Room N7 and found that Catherine had no signs of life, that rigor mortis was present in her extremities and lividity was also noted down the right side of her body. At approximately 8.47am Catherine Ann Williamson was declared deceased.

15. Attending Police located several "suicide notes" addressed to friends and family on a desk within Catherine's room.

JURISDICTION

16. CATHERINE ANN WILLIAMSON'S death was a reportable death under section 4 of the Coroners Act 2008 ('the Act'), because it occurred in Victoria, and was considered unexpected, unnatural or to have resulted, directly or indirectly, from an accident or injury. In addition, Catherine's death was reportable under section 4(d) because immediately before her death she was a patient within the meaning of the *Mental Health Act 2014*.

PURPOSE OF THE CORONIAL INVESTIGATION

17. The Coroners Court of Victoria is an inquisitorial jurisdiction.[6] The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[7] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death. [8]

18. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by Coroners, generally referred to as the 'prevention' role.[9] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[10] These are effectively the vehicles by which the prevention role may be advanced.[11]

19. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.

---

[6] Section 89(4) Coroners Act 2008.

[7] Section 67(1) of the *Coroners Act 2008*.

[8] See for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).

[9] The "prevention" role is explicitly articulated in the Preamble and Purposes of the Act.

[10] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[11] See also sections 73(1) and 72(5) of the Act which requires publication of Coronial Findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a Coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.

20. Section 52(2) of the Act provides that it is mandatory for a Coroner to hold an Inquest into a death if the death or cause of death occurred in Victoria and a Coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown. The death of Catherine Ann Williamson did not strictly fall within the purview of s52(2) as she was a voluntary patient immediately before her death and thus not within the definition of "a person placed in care" as it is defined in sections 3 and 4 of the Act.

21. Nevertheless, section 52(1) of the Act further provides that a coroner may hold an inquest into any death that the coroner is investigating. Coroners have absolute discretion as to whether to hold an Inquest. However, a Coroner must exercise the discretion in a manner consistent with the preamble and purposes of the Act. In deciding whether to conduct an Inquest, a Coroner should consider factors such as (although not limited to), whether there is such uncertainty or conflict of evidence as to justify the use of the judicial forensic process; whether there is a likelihood that an Inquest will uncover important systemic defects or risks not already known about and, the likelihood that an Inquest will assist to maintain public confidence in the administration of justice, health services or public agencies.

22. Having regard to the known circumstances including that Catherine, a person with mental ill health being cared for in an inpatient setting, albeit as a voluntary patient, appeared to have utilised a personal item to end her life, it was appropriate for an Inquest to be held.

23. This finding draws on the totality of the material; the product of the Coronial Investigation into the death of Catherine. That is, the court records maintained during the Coronial Investigation, the Coronial Brief and further material sought and obtained by the Court, including additional information/submissions received from the Interested Party, Healthscope Operations Pty Ltd and from Counsel Assisting, Senior Sergeant Jenette Brumby.

24. In writing this finding, I do not purport to summarise all of the evidence but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity. The absence of reference to any particular aspect of the evidence does

not infer that it has not been considered.

STANDARD OF PROOF

25. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining whether a matter is proven to that standard, I should give effect to the principles enunciated in Briginshaw v Briginshaw. [12] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:

    - the nature and consequence of the facts to be proved;
    - the seriousness of any allegations made;
    - the inherent unlikelihood of the occurrence alleged;
    - the gravity of the consequences flowing from an adverse finding; and
    - if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.

26. 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.

INVESTIGATIONS PRECEDING THE INQUEST

Identity

27. On 11 September 2017, CATHERINE ANN WILLIAMSON was visually identified by her treating psychiatrist, Dr Keryn Fitzpatrick who completed a Statement of Identification.

28. Identity was not in dispute and required no further investigation.

[12] (1938) 60 CLR 336.

Medical Cause of Death

29. On 12 September 2017 Dr Michael Burke, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine (**VIFM**) performed an external examination of the body of Catherine Ann Williamson and provided a report of his findings dated 2 October 2017. At the time of his examination Dr Burke had available to him the Victoria Police Report of Death for the Coroner, Form 83.

Post mortem examination

30. Dr Burke reported that his examination found no evidence of any injuries commenting that the post mortem computed tomography (CT) scan was unremarkable as was the external examination.

Toxicology

31. Toxicological analysis identified a number of drugs prescribed to Catherine Ann Williamson at levels not commented on by Dr Burke but appear to be within therapeutic ranges. No additional drugs or poisons were identified.

Forensic pathology opinion

32. Dr Burke ascribed the cause of death to plastic bag asphyxia.

Healthscope Internal Review

33. An internal review into the death of Catherine Ann Williamson was undertaken by Healthscope. The findings of the review were not provided to the Court save that the lawyers acting on behalf of Healthscope at the time[13] informed the Court that the review did not identify any deficits in the care it provided to Catherine. They declined to provide a copy of the review to the Court but did provide details of actions completed or were underway as a result of the review. These actions included:

    - Harmful Objects Items of Risk in Mental Health Environment – policy was reviewed without change.

[13] DLA Piper Australia.

- The Agency Orientation checklist was updated.
- Establishment of a database to monitor agency staff compliance with orientation.
- Staff compliance rate was 71% in November 2017.
- Escalation of care brochure was updated.
- Code Blue drills held on 8 February and 24 April 2018.
- Education to clinical staff about recording information and conducting visual observations.
- Memorandum to staff on 18 October 2017 concerning the recording of observations.
- A mandatory training compliance monitoring system was established, and reports are now provided monthly.

34. In the absence of the review *per se* or a Summary of the Review it is not possible to be confident that the actions listed were appropriate or addressed any identified gaps.

Coroners Prevention Unit[14]

35. At my request, the Coroners Prevention Unit (CPU) completed a review of the mental health management of Catherine Ann Williamson at the Victoria Clinic between 18 August 2017 and 11 September 2017 when she was located deceased. On information available to them at the time of the completion of their review[15], CPU identified and

[14] The Coroners Prevention Unit was established in 2008 to strengthen the prevention role of a coroner, the CPU assists coroners with research in matters related to public health and safety. The Unit also reviews the medical care and treatment administered to patients in matters referred to it by a coroner where concerns have been identified. The CPU is comprised of health professionals with training and skill in a range of areas including medicine, nursing, public health and mental health. Any review undertaken by the CPU on behalf of the Coroner is intended to provide clarity to matters that are in dispute and assist the Coroner to determine whether further investigation is warranted, including by way of expert report, or whether there is sufficient material on which to finalise the investigation.

[15] 30 April 2019.

discussed with me the August 2017 Healthscope Corporate Policy and Procedure which included the following Observation Practice Standard in regard to visual observation rounds at night, or when a patient is sleeping applicable at the time of Catherine's death:

The patient is to be seen (no checking through a closed door) and the patient observed to ensure that they are alive (evidence of breathing) safe and any action that is required to be taken is promptly taken.[16]

36. The previous policy dated February 2016 had no detailed definition regarding observations and the requirement of ensuring the person conducting the check to confirm signs of life. The only specific reference about the method and thoroughness of the observation is explained in terms that it should be the least intrusive method of observation as is appropriate to the situation. Due sensitivity to the patient's dignity and privacy are determining factors when performing the observation.

37. CCTV was present at the Victoria Clinic and on review of the footage for the night 10 – 11 September 2017 staff are depicted attending Room N7 door area for a short period on each of the nightly checks. The footage does not depict staff fully entering Catherine's room. At approximately 8.20am, when located, Catherine showed signs of rigor mortis and lividity indicating that she may have been deceased for some time explicably leaving the overall impression that staff did not comply with the standard depicted in the above stated Policy and Procedure.

38. CPU informed me that their review of the information available to them enabled a conclusion that the night shift staff at Victoria Clinic did not follow the Healthscope Mental Health Risk Assessment and Observation Patient policy as they did not establish that Catherine was alive at the time of each check. Had the policy and procedure been adhered to, Catherine's actions may have been identified earlier which in turn would have enabled appropriate and immediate intervention to be taken.

[16] Corporate Policy and Procedure Mental Health Risk Assessment and Observation levels – Patient – August 2017, pages 3 of 8.

Additional CPU research

39. At my request CPU also provided a summary of deaths involving ligatures among Victorian mental health inpatients between 2000 – 2017.[17] In this review[18] the CPU identified 58 ligature-involved suicides in Victorian inpatient psychiatric units between 2000 - 2017.[19] Of the 58 ligature-involved suicides, 37 of them used personal items, and 11 of those were with belts. Among these suicides, as of 29 January 2018, Victorian Coroners had delivered Findings in 53 deaths; 16 Findings included recommendations, 20 regarding ligature points, and nine Findings included recommendations regarding access to ligatures.

40. Reference to this review is pertinent to the circumstances of Catherine in that it also included reference to investigations where the ligature used was a personal item of the deceased.

41. On 2023 I again sought assistance from the CPU to provide me with data on intentional deaths in mental health inpatient units in the period 2000 – 2022 where the deceased had utilised a personal item to end their life.

42. The CPU data report[20] addressed suicides of inpatients that occurred specifically in mental health inpatient units, either public or private. It did not address suicides of inpatients in other settings, such as those receiving mental health treatment in addition to other treatment in general hospital settings or where the deceased was a voluntary inpatient and suicided while on day leave or had absconded. The primary data source the CPU used for this report was the Victorian Suicide Register (VSR), which contains coded information on method and location for every suspected and coroner-determined suicide investigated by a Victorian coroner between 1 January 2009 and the present.

[17] Coroners Prevention Unit review of Ligature-involved suicide among the Victorian Mental health In-Patient Units for the period 1 January 2000 – 31 December 2017, dated 29 January 2018.

[18] In this review the case inclusion included hanging, ligature strangulation and plastic bag asphyxia in circumstances where the plastic bag was secured by a ligature such as a rope, belt or so on. Plastic bag asphyxia where a ligature was not used, were not included.

[19] Which includes reference to COR 2017 0953 and COR 2009 0829 which I refer to later in this Finding.

[20] Coroners Prevention Unit data report on suicides using personal items in mental health inpatient units for the period 1 January 2000 to 31 December 2022, dated 8 May 2023.

The VSR data was supplemented by a search of the National Coronial Information System (NCIS)[21] to identify ligature involved suicides between 2000 and 2008. The CPU included any suicide that occurred in a mental health inpatient unit where the deceased used a personal item(s) to suicide.

43. The CPU informed me that between 2000 and 2022, there were 63 suicides in Victorian inpatient psychiatric units involving personal items. Seven of these deaths involved the use of plastic bags,[22] including the death of Catherine Williamson, and the death of Veronika Kouros,[23] *a Finding into Death with Inquest* that I have just recently completed. Other methods included hanging (n=51, 88%), overdose (n=3, 5.2%) and the use of sharp objects (n=2, 3.4%). 12 of the deaths (19.1%) occurred within a private inpatient unit, and 51 deaths (80.9%) occurred in a public inpatient unit.

Conduct of my Investigation

44. The investigation and the preparation of the Coronial Brief was undertaken by Senior Constable Andrew Kruger on my behalf.

INQUEST

Direction Hearing/s

45. A Directions Hearing was held on 8 November 2019. Senior Sergeant Brumby from the Police Coronial Support Unit (**PCSU**) appeared to assist me. Mr Mark Sullivan from Minter Ellison Lawyers appeared on behalf of Healthscope (Victoria Clinic).

46. The issues identified at the Directions Hearing for which I sought additional statements included:

[21] The NCIS is an Internet-based data storage and retrieval system of all deaths reported to Coroners in Australia and New Zealand since 2000 and 2007, respectively. It comprises coded and free-text data and up to four full text documents generated for the coroners' investigation, namely the summary of text from the police report of death to the coroner, autopsy report, forensic toxicology report, and coroners' findings

[22] Though the data suggests that these plastic bags were sourced from different locations, for the purposes of this Finding I have taken a plastic bag to be a 'personal item'.

[23] COR 2018 1293.

- The adequacy of the observation checks conducted overnight on Catherine and reconciling this with the Healthscope policy which stipulates that the checks should be sufficient to confirm the patient is alive.

- How Catherine obtained access to the plastic bag and shower cap which she used to asphyxiate herself, considering the Healthscope "Items of Risk Policy" and how this is applied to patients.

- How Agency staff are familiarised with emergency procedures.

Materials obtained after the Directions Hearing

47. Statements were received from Lisa Stokes (**Ms Stokes**), Victoria Clinic Director of Nursing (at the time of Catherine's death) and Dr Keryn Fitzpatrick, Catherine's treating psychiatrist.

48. Shortly before the commencement of the Inquest, additional materials were provided to the Court from Healthscope's legal representatives, and these included:

    - Policy ref. 9.07 Risk Assessment & Observation Levels dated October 2019.

    - Example of On-line learning report for an employee.

    - Example of orientation checklist completed for a staff member.

49. Having considered the additional statements and materials in light of the issues raised at the Directions Hearing and in particular, noting that some changes made to hospital processes have now been embedded in hospital policy, I determined to only hear evidence from a senior hospital representative regarding the changes now in place at the Victoria Clinic. Ms Stokes appeared to be the appropriate senior hospital representative however, I was informed that Ms Stokes no longer held such a position, and an alternative witness was offered as a substitute but instead of providing her own statement, that witness would adopt the statement of Ms Stokes in its entirety – save

for one paragraph.[24] Alison Carr, General Manager and Director of Nursing, the Victoria Clinic was to be that witness.

50. An Inquest was held on 31 August 2021. Senior Sergeant Brumby again appeared to assist me, and Mr Paul Halley of Counsel appeared on behalf of Healthscope.[25] The Inquest was enabled through the use of the Cisco WebEx platform.

Viva Voce Evidence at the Inquest

51. Viva voce evidence was obtained from the following witnesses:

- Alison Carr, General Manager and Director of Nursing, Victoria Clinic

52. Ms Carr read and adopted the statement of Ms Stokes.[26]

COMMENTS

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

Access to personal items that can be used to self-harm

1. When Catherine returned from leave on 10 September 2017, no "pat-down" or physical search was performed. Ms Carr stated that the rationale for this is that the patients at the Victoria Clinic are all voluntary patients and as such, there is no policy for physical searches. She referred to the Chief Psychiatrist's Guidelines on searches stating the Guidelines *certainly do not support any form of physical searches of the patient*.[27] Ms Carr said that searches are performed on patient's bags and anything they have brought from home or if visitors are bringing in things for the patient. She emphasised that if they thought a patient was at high-risk, monitoring for that situation would occur and steps taken to discharge or transfer the patient under the *Mental Health Act*. Ms Carr

[24] See correspondence reflecting this position dated 29 September 2020 at CB at p 164.

[25] Mr Mark Sullivan, instructing Mr Halley, was available via the Cisco WebEx platform.

[26] Exhibit 1 – Statement of Lisa Stokes dated 16 December 2019, as accepted by Alison Carr, General Manager and Director of Nursing, Victoria Clinic, on 31 August 2021.

[27] TP at page 26.

also said that on admission a patient is made aware of what is considered an item of risk,[28] told what not to bring in and what items the Clinic would discourage them from bringing. They are not informed that they could be physically searched.[29]

2. On responding to a question from Mr Halley, Ms Carr said that any potential/proposed policy on "pat downs" either on admission or on returning from leave would have an extremely negative impact with patients rendering them reluctant to seek treatment at the Victoria Clinic and would set the Victoria Clinic apart from all other mental health facilities. Any suggestion subsequently put to Ms Carr by SS Brumby about implementing an open and transparent policy with patients on admission that they may be subject to searches of their personal items on admission, on returning from leave and possibly subject to random "pat-down" searches, was rejected outright by Ms Carr on the grounds it *would deter people from seeking treatment*.[30]

3. I remain unclear about the foundation of this bold statement although I acknowledge that it appears to be widely held by people with organisational responsibilities in the mental health field. I am yet to be provided with any empirical evidence to support these protestations that people will stop seeking treatment when they are advised that the facility they are entering may remove certain personal items, may search their belongings for forbidden/controlled items and may from time to time, pat them down to search their person for such items.

4. The contrary possibility does not appear to have been considered in these protestations, that a patient, such as Catherine, may secrete high risk items on their person in the knowledge that they will not be subject to any search of their person. The possibility remains that Catherine obtained the plastic bag she utilised to take her life, whilst she was on leave on 10 September 2017 and despite the appropriate search of her

[28] I was informed by Ms Carr that shower caps are not considered an item of risk/controlled item and are retained at the Nurses Station. A patient can obtain a shower cap for its intended use and return it to the Nurses Station after their shower – T at page 36.

[29] TP at pages 26 – 27.

[30] Transcript of Proceedings (TP) at page 35.

belongings on her return, the prohibitive high-risk item has somehow come into and/or remained in her possession.

5. The question that needs to be considered by our mental health facilities and the Office of the Chief Psychiatrist is, would the implementation of random "pat-down" searches of patients in mental health wards/units act more as a deterrent to patients seeking treatment or more as a deterrent to secreting prohibited items into their facility ward/unit? It is a vexed question.

The adequacy of the observations

6. The change to the policy in relation to observations confirming signs of life occurred in August 2017. According to Ms Carr, this change to the policy had not been disseminated to staff as at the 10 – 11 September 2017.[31] She could not say when the new policy was actually distributed to staff save that it was shortly after this event.[32] And despite updates or better utilisation of electronic communication of changed/updated policies, Ms Carr agreed that it could still take 4-6 weeks to communicate it to staff even if the changed policy was about how their nursing staff were to conduct their nursing practice.[33] Regardless of the absence of the updated policy requiring nurses to ensure their observations are sufficient to confirm life, the practice of "observing patients" by implication, and fundamental in a nurse's training, is that you are satisfied from the "observations" that your patient is alive. The absence of that unambiguous articulation in the policy, which I am asked to accept was still in place at the time of Catherine's death, does not absolve a system which enables nursing staff to record they have observed a patient overnight but that the clear and cogent evidence is, she, Catherine had been deceased for some time.

7. Ms Carr confirmed to SS Brumby that the further update to this policy dated October 2019 and provided to the Court approximately one week before the Inquest

[31] TP at page 22, 28.

[32] TP at page 29.

[33] TP at page 31.

commenced, makes no change to the expectation or the requirement of how those observation checks are to be conducted as stated in the August 2017 dated policy.

Agency staff orientation

8. The review and updating of policies and procedures and the focus on staff orientation – in the case of Agency staff, and ongoing education of permanent staff has been a reasonable and appropriate response by Healthscope to the death of Catherine. The orientation process for Agency staff relies on a "walk- through" with a permanent staff member to ensure the unfamiliar Agency staff are shown the layout of the ward and where to access emergency equipment and where to locate the facility's policies and procedures. A computer stored Excel spreadsheet is intended to record when an Agency nurse was orientated to the facility and prevent a first time Agency staff member turning up for a shift and not being provided with orientation. It is intended to ameliorate the risk of an Agency nurse pushing the wrong buzzer as was the case surrounding the discovery of Catherine on the morning of 11 September 2017. But as Ms Carr said in her *viva voce* evidence, in times of panic there is always a risk that a nursing staff member – agency or permanent, fails to act in accordance with appropriate procedures. Panic can set in when confronted by an unusual event she said but the *aim is to do everything we can to make that not happen and to make them aware of how to follow procedure.*[34]

9. I accept Ms Carr's analysis that their orientation policy and procedures is aimed at mitigation of risk, but it is not foolproof particularly in an emergency situation. The pressing of the "Assistance" buzzer rather than the "Emergency" buzzer delayed the attendance of the Code Blue Team but is explicable in the circumstances, did not prevent the commencement of CPR on Catherine, was not a significant delay before the error was rectified and, in all probability, made no difference to the outcome for Catherine as the weight of the evidence indicates that she was deceased when she was discovered, before the subsequent events unfolded. No adverse finding will made in respect of this issue.

[34] TP at page 22.

10. In a custodial or institutional type setting such as a low dependency unit in a mental health facility, whether private or public, eliminating access to means of self-harm is recognised as a significant suicide prevention method. The Chief Psychiatrist has developed Guidelines titled "Criteria for searches to maintain safety in an inpatient unit – for patients, visitors and staff with the first "Key message" of the Guidelines stating:

As the safety of patients, visitors and staff of mental health services is paramount, patients should not have access to items that are dangerous or may lead to harm to self or others or assist in absconding during their inpatient stay.

11. The issue of "pat-down" searches on inpatient units is complex. Despite the Chief Psychiatrist's Guideline and attempts by individual facilities to base their own policies/protocols around the Guideline, it remains a vexed task for the clinicians in an in-patient Unit and requires vigilance on their behalf as risk is not inanimate but fluid and often labile. Some items brought into the Unit by patients are "obvious" high risk items and are removed without hesitation – plastic bags, lighters, for example. But other items, albeit that they are recognised for their potential to be used for self-harm, are allowed to be retained by the patient in the Unit if their risk is assessed at any level other than high. It is not consistent, it is not an equitable approach, and it is clearly fraught. The Court continues to see inpatient suicides on both public and private mental health wards at a consistent rate over several years, despite a focus by individual facilities, DFFH and this Court on preventing such deaths. Mental health wards should strive to reduce harm to their patients and limiting access to means is essential in achieving this, with the World Health Organisation recognising that limiting access to means is an important prevention strategy. Conversely, limiting access to means of suicide on an inpatient unit through the use of pat down searches requires the acknowledgement of the potential impacts, including the disruption of the therapeutic alliance, and patient-centred care; the risks of traumatisation and retraumatisation in a population with higher than average rates of sexual and physical abuse; and infringement on human rights. It is also acknowledged that patients may refuse a pat-down search and such refusal should not result in a refusal to provide treatment, nor would it be appropriate to force a pat-down search in such circumstances without substantial reason. Further, consideration would need to be given to pat-down searches

for families, carers, support workers and staff, given the risks access to means being (inadvertently) provided by those other than the patient, as has been the case in several inpatient suicide deaths. With these complexities in mind, a pertinent recommendation will follow.

12. I have previously expressed my views about the retention of personal items in inpatient units and most recently in the *Finding into Death with Inquest* of Christopher Traill[35] who had been allowed to retain a belt that he ultimately used to facilitate his own death. In that matter I expressed my concern that there had been a move towards an over emphasis on "managing people in the least restrictive means possible" which has confabulated how that should be achieved in an in-patient Unit in general, and also specifically, as it did with regard to Christopher Traill.

13. And in acknowledging that the circumstances in the matter of Christopher Traill are not on all fours with the circumstances surrounding Catherine's death – no two reportable deaths are on all fours; it is the use of personal items used to facilitate death in in-patient units by a cohort of patients, that by the very nature of where they have been admitted to, are at high risk to themselves. It is thus pertinent to refer to previous investigations of like circumstances.

14. In 2015 I completed a *Finding into Death with Inquest* in the matter of Maria Teresa Nigro[36] who died at Werribee Mercy Hospital. Ms Nigro was an involuntary patient and used her dressing gown cord for the purposes of self-harm. At that time, I made the following Recommendation:

    With the aim of minimising risk and preventing like deaths, I recommend Mercy Health develop and implement policies and procedures for the LDU whereby access to items that may be used to self harm are removed or reduced. Such policies and procedures should include checking patients and the unit for potentially harmful belongings and belongings that could be used for self harming purposes, monitoring items brought into

[35] COR 2017 0953 – handed down on 15 December 2022.

[36] COR 2009 0829

the unit by visitors and educating visitors on the potential risks associated with such items.

15. In 2018 Coroner Rosemary Carlin (as she then was) completed a *Finding into Death without Inquest*[37] in the matter of Joy Maree Guppy who while a voluntary patient at the Alfred Road Clinic, a private psychiatric clinic, used her dressing gown tie as a means of self-harm and later died at the Alfred Hospital. Coroner Carlin's Recommendation related to the removal of potential ligatures within the facility but in her Conclusions, she poignantly said:

Patient safety should be the paramount consideration. It is a tragedy that mentally unwell patients are killing themselves in potentially preventable situations. I do not consider it unreasonable to make a condition of entry to inpatient psychiatric facilities that patients surrender any obvious potential ligatures ***and agree to lawful searches on clinical grounds, throughout their stay.*** (my emphasis)

16. I have previously and I again concur with my colleague and reiterate the use of the word "tragedy" to describe the loss of life within our mental health facilities in potentially preventable circumstances. The tragedy is compounded each and every time I, and other Coroners, investigate deaths of like circumstances.

17. In the Christopher Traill Findings[38] I made the following recommendations:

1. With the aim of preventing like deaths and promoting public health and safety within a mental health in-patient unit, I recommend that on admission to the in-patient Unit, Bendigo Health mandate the removal of all personal items that could be used for self-harm as described as "Dangerous Items" in the Chief Psychiatrist's Guideline.

2. With the aim of preventing like deaths and promoting public health and safety within a mental health in-patient unit, I recommend that Bendigo Health review their processes related to identifying personal items that have the potential to be used for

[37] COR 2015 0531

[38] COR 2017 0953

harm and without identifying all the specifics that should be considered within that review, I recommend it should include reference to whose responsibility it is to make the assessment, to document the assessment and whose responsibility it is to implement the removal of said identified items.

3. With the aim of preventing like deaths and promoting public health and safety within a mental health in-patient unit, I recommend that Bendigo Health implement a practice of providing patients alternative items to replace any personal items removed for risk minimising purposes.

18. In correspondence from the Chief Medical Officer of Bendigo Health dated 14 March 2023 I was informed that Bendigo Health had accepted all three recommendations.[39]

19. More recently I have completed a *Finding into Death with Inquest* in the matter of Veronika Kouros[40] who, like Catherine, used a plastic bag to take her own life while an in-patient at the Northern Psychiatric Unit, the Northern Hospital.

RECOMMENDATIONS

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

The Chief Psychiatrist

1. With the aim of preventing like deaths and promoting public health and safety within mental health in-patient units I recommend that the Chief Psychiatrist/Office of the Chief Psychiatrist seek legal advice around the feasibility of implementing "pat-down" searches, including when "pat-down" searches would be appropriate, such as when a patient returns from leave. Such advice should include:

    - The legal basis on which pat-down searches are conducted

[39] For full details of Bendigo Health's response to the Recommendations made in the Finding into Death with Inquest of Christopher Traill go to the Coroners Court website: https://www.coronerscourt.vic.gov.au/inquests-findings/findings?combine=Christopher+Traill

[40] COR 2018 1293

- The implications of completing pat-down searches for staff (role changes, training, protection from litigation etc)
- The feasibility of pat-down searches across the various inpatient settings within the public mental health sector (for example, PARC, CCU etc)
- The implications of Victoria's proposed new *Mental Health and Wellbeing Act 2022*
- And with regards to the impacts outlined above.

2. And I further recommend that the Chief Psychiatrist review relevant guidelines in light of the outcomes of the advice provided, as outlined above.

Healthscope

1. With the aim of preventing like deaths and promoting public health and safety within its mental health in-patient units I recommend that Healthscope Operations Pty Ltd seek legal advice around the feasibility of implementing "pat-down" searches, including when "pat-down" searches would be appropriate, such as when a patient returns from leave. Such advice should include:
    - The legal basis on which pat-down searches are conducted
    - The implications of completing pat-down searches for staff (role changes, training, protection from litigation etc)
    - And with regards to the impacts outlined above.
2. And I further recommend that Healthscope Operations Pty Ltd review relevant guidelines in light of the outcomes of the advice provided, as outlined above.
3. With the aim of preventing like deaths and promoting public health and safety within its mental health in-patient units and ensuring that their nursing staff are immediately notified of changes to policies and procedures that go to nursing competencies and standards, I recommend that Healthscope Operations Pty Ltd address the

"operational" delay(s) in disseminating such changes as was identified in the investigation into the death of Catherine Ann Williamson.

FINDINGS

1. I find that CATHERINE ANN WILLIAMSON born 9 February 1958, died between 10 – 11 September 2017 at a Healthscope Operations Pty Ltd facility, the Victoria Clinic, 324 Malvern Road, Prahran 3181.

2. I find that Catherine Ann Williamson, a voluntary inpatient at the Victoria Clinic had access to a high-risk personal item, being a plastic bag, despite a hospital procedure in place, to remove such a high-risk personal item from her possession.

3. I am unable to make any finding on how Catherine Ann Williamson came to be in the possession of a plastic bag save to say that the procedures in place at the time failed to prevent her from having access to the means that she utilised to take her own life and these same procedures likely failed to recognise the potential high-risk misuse of the shower cap. In all of the circumstances I find that her death was preventable while she was a patient at the Victoria Clinic.

4. AND I further find that the observation policy that pre-existed the August 2017 policy created a system of departure from good nursing practice. AND, I find that had there been adherence to good nursing practice whilst conducting overnight observations at the time that Catherine Ann Williamson was a patient at the Victoria Clinic, her attempt to take her own life may have been thwarted and thus her death prevented.

5. AND furthermore, had the August 2017 policy and procedures regarding the overnight observation of patients been communicated and implemented at the time that Catherine Ann Williamson was a patient at the Victoria Clinic, her attempt to take her own life may have been thwarted and thus her death prevented. AND, although I cannot find that her death would have definitively been prevented, the opportunity to identify her attempt and implement appropriate and immediate interventions was lost to Catherine Ann Williamson because of the failure of Healthscope to communicate its new policy and procedures to its staff in a timely way.

6. I accept and adopt the medical cause of death as ascribed by Dr Michael Burke and I find that CATHERINE ANN WILLIAMSON died from plastic bag asphyxia in circumstances where I also find that she intended to take her own life.

To enable compliance with section 73(1) of the Coroners Act 2008 (Vic), I direct that the Findings will be published on the internet.

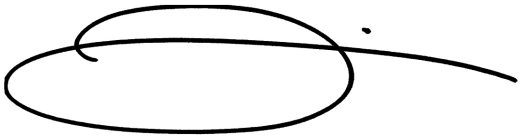
I direct that a copy of this Finding be provided to the following:

Mr Mark Williamson

Minter Ellison Lawyers on behalf of Healthscope Operations Pty Ltd

Dr Neil Coventry, Chief Psychiatrist

Signature:



AUDREY JAMIESON

CORONER

Date: 22 June 2023

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.