Rule 63(1)

IN THE CORONERS COURT

OF VICTORIA

AT MELBOURNE

Court Reference: COR 2018 1293

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 63(1)

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

Inquest into the death of: VERONIKA ANASTASIA KOUROS

Findings of:	AUDREY JAMIESON, CORONER
Delivered On:	22 June 2023
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street, Southbank 3006
Hearing Dates:	17 February 2021
Appearances:	Ms Jan Moffat on behalf of NorthWestern Mental Health (DTCH Lawyers)
Counsel Assisting the Coroner:	Leading Senior Constable King Taylor – Police Coronial Support Unit

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I, AUDREY JAMIESON, Coroner having investigated the death of VERONIKA ANASTASIA KOUROS

AND having held a Summary Inquest in relation to this death on 17 February 2021

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

find that the identity of the deceased was VERONIKA ANASTASIA KOUROS

born on 30 December 1986

died on 19 March 2018

at the Northern Psychiatry Unit, the Northern Hospital, Cooper Street Epping.

from:

1 (a) PLASTIC BAG ASPHYXIA

In the following summary of circumstances:

VERONIKA ANASTASIA KOUROS was a voluntary patient at the Northern Psychiatry Unit, the Northern Hospital when she was located by staff deceased, with a plastic bag secured over her head.

BACKGROUND CIRCUMSTANCES

1. VERONIKA (also known as Veronica) ANASTASIA KOUROS[1] was 31 years of age at the time of her death. She lived in Northcote with her mother and sister.

2. Veronika's history of mental ill health dates back to May 2013 when her general medical practitioner, Dr Manjit Dhillon (**Dr Dhillon**) diagnosed Veronika with reactive depression with suicidal ideation and Bipolar Affective Disorder. A number of presentations to emergency departments in 2012 – 2013 did not prompt mental health service involvement although she may have been experiencing psychosomatic symptoms on those occasions. In 2017 Veronika presented with manic symptoms, characterised by overspending, promiscuous and disinhibited behaviour which according to Dr Dhillon self-resolved after Veronika refused treatment.

[1] Veronika Anastasia Kouros has been referred to as "Veronika" throughout the Finding save where I have deemed it necessary for formality purposes to refer to her full name.

3. Medical records from the Royal Melbourne Hospital (**RMH**) reflect that from September 2017 Veronika was presenting with symptoms in her hands related to a pre-occupation with cleaning. Her symptoms included swelling, skin tightening, colour changes and unpleasant sensation when touched. She was seen in the dermatology and rheumatology departments with the latter department suggesting to Dr Dhillon that he refer Veronika to a psychiatrist. Dr Dhillon provided Veronika with a referral to a psychologist and prescribed Veronika quetiapine[2] and citalopram[3].

4. There is a lack of evidence whether Veronika ever followed up on Dr Dhillon's referral to a psychologist or if she ever received a referral to a psychiatrist.

SURROUNDING CIRCUMSTANCES

5. On 13 March 2018, Veronika attended an appointment at the RMH rheumatology department. She reported hopelessness and helplessness regarding her hand symptoms and was notably anxious. She also reported daily suicidal ideation with a plan to lie in front of traffic. Veronika was taken to the Emergency Department (**ED**) for a psychiatric assessment.

6. On assessment in the ED Veronika reported that she had been unable to use her hands for daily tasks for approximately 12 months. She was placing plastic bags over her hands to avoid contamination. Collateral information from her mother and GP indicated a decline in physical and mental health since November 2017 and that she had been trialled on various antidepressants but would usually stop taking them after approximately five days. Veronika confirmed that she had suicidal ideation with a plan but denied any intent to follow through. Veronika was transferred to the Behavioural Assessment Unit for the night with plan for further psychiatric assessment on the following day.

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[2] Quetiapine (trade names include Seroquel) is an antipsychotic medication used in the treatment of schizophrenia and Bipolar disorders.

[3] Citalopram is an antidepressant medication of the selective serotonin reuptake inhibitor (SSRI) class and used in the treatment of major depressive disorders and obsessive-compulsive disorder.

7. On 14 March 2018, Veronika was assessed by a Psychiatric Registrar. During the assessment she reported that most of her day was devoted to an extensive cleaning ritual where she wore gloves to avoid contamination. She also reported as having a depressed mood since December 2017 and current suicidal ideation if she was unable to get relief from her symptoms. Again, she stated that she had no intent to act on her ideation.

8. Veronika's admission to the Northern Psychiatry Unit 2 (**NPU2**) was facilitated for longitudinal assessment, diagnostic clarification and treatment. She was transferred to NPU2 on 14 March 2018. On admission to the NPU2 nursing staff removed a number of plastic bags and other items in Veronika's possession. She indicated that she did not want her items disposed of, so they were placed in a locker in the ward storage room that is not accessible to the patients. Some other items were returned to Veronika in a paper bag.

9. Over the following days Veronika either denied suicidal ideation or reported fleeting suicidal thoughts with no plan or intent to act on these thoughts. She believed that her hand symptoms were the sole reason for her depression – if her symptoms could be resolved so too would her depression. She was observed by nursing staff to exhibit obsessive compulsive traits in the way she cleaned her room. She complained about her hands and the television being too loud and she had periods of irritability and anxiety for which she received medication as required.

10. On the morning of 18 March 2018, Veronika was observed awake and in a settled state. Later that day she reported feeling anxious and paranoid of some staff members who she believed were jealous of her and after her. She reported that she was afraid to be in the hospital. Staff provided reassurance and offered Veronika medication, but she refused on the basis that other patients had warned her not to take the medication offered.

11. During the day of 18 March 2018, Veronika's mother visited her in NPU2. At approximately 5.00pm when Mrs Kouros was intending on leaving, she collected some of Veronika's washing to take home. Unable to find a plastic bag to put the washing in,

Veronika's mother utilised a paper bag. Mrs Kouros has stated that Veronika was aware that she was not allowed to have plastic bags in her room at NPU2.[4]

12. In the evening of 18 March 2018, Veronika reported her mood as okay, denied any psychotic symptoms and was compliant with her night medication receiving 5mg Paliperidone (an antipsychotic) and later 50 mg Promethazine (to initiate sleep). She told staff she wanted to be discharged and denied any risk to herself or others. Staff observed some psychomotor agitation, noted no formal thought disorder and that she was not responding to any internal stimuli.

13. On 19 March 2018, shortly after 7.00am staff went to Veronika's room to check on her. She was not in her bed and did not appear to be in her room. The corridors and courtyard were checked and thereafter another staff member was alerted. Staff returned to Veronika's room to check if she was in the bathroom, and it was at that time that Veronika was located on the floor beside her bed. She had a clear plastic bag[5] over her head, wrapped tight around her neck.[6] Staff ripped the bag off Veronika's head. She was cyanosed. She was unresponsive.

14. Cardio-pulmonary resuscitation was initiated, and a Code Blue called however, Veronika was unable to be revived.

JURISDICTION

15. Veronika'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, Veronika'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*.

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[4] Coronial Brief - Statement of Teresa Lojko-Kouros dated 24 June 2018, Correspondence from Themida Legal dated 14 May 2018.

[5] Coronial Brief – Statement of Kelly Tattersall, Psychiatric Clinical Nurse Specialist dated 19 March 2018.

[6] Coronial Brief – Statement of Syltricia Rowland, Registered Psychiatric Nurse, dated 19 March 2018.

PURPOSE OF THE CORONIAL INVESTIGATION

16. The Coroners Court of Victoria is an inquisitorial jurisdiction.[7] 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.[8] 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. [9]

17. 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.[10] 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.[11] These are effectively the vehicles by which the prevention role may be advanced.[12]

18. 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.

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

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

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

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

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

[12] 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.

19. 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 Veronika Anastasia Kouros 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.

20. 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.

21. Having regard to the known circumstances including that Veronika was in a designated mental health facility and appeared to have utilised a personal item to end her life, it was appropriate for an Inquest to be held.

22. This finding draws on the totality of the material; the product of the Coronial Investigation into the death of Veronika. 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, NorthWestern Mental Health and from Counsel Assisting, Leading Senior Constable King Taylor.

23. 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

24. 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. [13] 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.

25. 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

26. On 19 March 2018, Teresa Kouros visually identified her daughter Veronika Anastasia Kouros at the Northern Hospital and completed a Statement of Identification.

27. Identity was not in dispute and required no additional investigation.

[13] (1938) 60 CLR 336.

Medical Cause of Death

1. On 21 March 2018, Dr Melanie Archer, Registrar Forensic Pathologist at the Victorian Institute of Forensic Medicine (VIFM), whilst under the supervision of Forensic Pathologist, Dr Gregory Young, performed an autopsy on the body of Veronika Anastasia Kouros. Available to her at the time of the autopsy were the following materials:

   - Victoria Police Report of Death for the Coroner (Form 83)
   - Post mortem computed tomography (CT) scan
   - Preliminary Examination Report (completed by Dr Michael Burke, Forensic Pathologist at VIFM)
   - VIFM contact log
   - E-Medical Deposition Form (Northern Hospital)
   - Medical Records (High Street Medical and Dental Preston)
   - Scene photographs.

<u>Post mortem examination</u>

28. Dr Archer completed a report of her autopsy findings dated 11 July 2018. In commenting on her findings and other materials available to her she stated that the CT scan revealed no skeletal fracture and there was no evidence of occult injury on autopsy. She identified a single petechial haemorrhage in the left lower eyelid which she said was a nonspecific finding but may be seen in cases of asphyxia. Dr Archer commented that plastic bag asphyxia leaves no specific signs and is diagnosed on the basis of death scene findings and the exclusion of competing causes of death.

<u>Toxicology</u>

29. Toxicological analysis of blood showed no ethanol (alcohol). Hydroxyrisperidone, an antipsychotic agent was detected as was the antidepressant sertraline and the analgesic

paracetamol. The antihistamine promethazine and the calcium channel blocker nifedipine were also detected and were all at levels consistent with therapeutic use.

Forensic pathology opinion

30. Dr Archer ascribed the cause of Veronika Anastasia Kouros' death to plastic bag asphyxia and commented that there were no autopsy or toxicology findings to suggest an alternative cause of death.

Coroners Prevention Unit[14]

31. At my request, the Coroners Prevention Unit (CPU) completed a review and provided a summary of deaths involving ligatures among Victorian mental health inpatients between 2000 – 2017.[15] In this review[16] the CPU identified 58 ligature-involved suicides in Victorian inpatient psychiatric units between 2000 - 2017.[17] 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.

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[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] 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.

[16] 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.

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

32. Reference to this review is pertinent to the circumstances of Veronika in that it also included reference to investigations where the ligature used was a personal item of the deceased. [18]

33. In 2023 I again sought the assistance of CPU to provide me with data on suicides involving personal items in Victorian inpatient psychiatric units between 2000 and 2022.

34. The CPU data report[19] 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. The VSR data was supplemented by a search of the National Coronial Information System (NCIS)[20] 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.

35. 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

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[18] The evidence is equivocal on whether a ligature was used by Veronika to secure the plastic bag over her head – the E-Medical Deposition Form from Northern Hospital states that she was found with **a bag over her head, *tied around her neck*.**(my emphasis); correspondence from Themida Legal dated 14 May 2018 states that: *Mrs Kouros is wondering where did the bag that was **found tied around Veronika's head** come from* (my emphasis); and according to Nurse Rowland in her statement taken on 19 March 2018, she located Veronika with *a **clear plastic bag over her head, wrapped tight around her neck***.(my emphasis).There is no other reference to a tie or a ligature that I have identified including no reference of the same in the report of Forensic Pathologist, Dr Melanie Archer dated 11 July 2018.

[19] 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.

[20] 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

use of plastic bags,[21] including the death of Veronika Kouros. 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

36. The investigation and the preparation of the Coronial Brief was undertaken by Acting Sergeant Shelley Pollard of Victoria Police on my behalf.

INQUEST

Direction Hearing/Summary Inquest

37. On 17 February 2021 a Directions Hearing was held through the medium of the Cisco-WebEx platform due to ongoing restrictions related to the COVID-19 pandemic.

38. Leading Senior Constable King Taylor (**LSC Taylor**) from the Police Coronial Support Unit (**PCSU**) appeared to assist the Coroner and Ms Jan Moffat (**Ms Moffat**) from DTCH Lawyers appeared on behalf of NorthWestern Mental Health.

39. LSC Taylor provided a Summary of the circumstances surrounding the death of Veronika Anastasia Kouros and stated that the investigation into her death thus far indicated:

    - that she had not presented as an acute suicidal risk on the evening of 18 March 2018;
    - there was no evidence that Veronika was awake or distressed throughout the night from 18 March 2018 into 19 March 2018;
    - that she was last observed in bed asleep at 6.00am;

[21] 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'.

- it appears that Veronika placed a plastic bag over her head between 6.00am and 7.00am on 19 March 2018;

- on admission, the plastic bags in Veronika's possession were taken from her and placed in a locker in the ward storage room which she did not have access to;

- the source of/how Veronika sourced a plastic bag that she placed over her own head, had not been identified;

- that the NorthWestern Mental Health policy on "Searching - Inpatient and Residential Services" states: *The scope for dangerous items may include any item that may be used to self-harm, harm others or assist in absconding, for instance, drugs, alcohol, weapons, scarves, belts and plastic bags.* And further states: *Consumers should not have access to items that are dangerous or may lead to harm or to self-harm or to others or assist in absconding.*

40. LSC Taylor also stated that the investigation into the death of Veronika Anastasia Kouros had highlighted yet another death of a person in a mental health unit who had used a personal item to take their own life and that I had requested the Coroners Prevention Unit (**CPU**) to advise me of the number of reported deaths in this group of intentional deaths between the years 2000 and 2020**.** [22] At the time of this hearing, LSC Taylor informed the Court that the number was 54 deaths.

41. In addressing the legal representative of NorthWestern Mental Health Service, I reiterated the number of deaths in in-patient units from use of personal items and how concerning this was. I also indicated that I did not doubt that a search of Veronika had occurred on her admission and dangerous items – plastic bags – were removed from her possession however, it could not be said to have been completely effective otherwise we would feel comfortable that she would not have had access to anything like a plastic bag.[23] It therefore followed that I would be making adverse comment or findings and

[22] As outlined earlier in this Finding, I have since asked CPU to provide me with data from 2000 – 2022.

[23] Transcript of Proceedings at p7.

informed Ms Moffatt that she was entitled to be heard on this point. I otherwise indicated that unless NorthWestern Mental Health was seeking to have their own witnesses called to give evidence, I felt that the Direction Hearing could be considered the Summary Inquest as there was no other contentious issues in respect of the management of Veronika whilst an in-patient.

42. Technical problems hampered my communication with Ms Moffatt and I considered it would have been unfair to conclude the matter until she had an opportunity to confer with her client and make written submissions with the focus being on personal items in the inpatient unit and how we can prevent further deaths occurring in like circumstances. The proceedings were adjourned *sine die*.

Information subsequently received from NWMH

43. In correspondence dated 31 March 2021, Mr Peter Kelly, Director Operations NWMH expressed his views, based on many years of experience in mental health services, that most of the objects used by patients in the in-patient units to effect intentional self-harm, an attempted suicide or die of suicide, were benign – in function at least. He said:

    It is difficult to see how these items, particularly some items of intimate clothing, can be completely eliminated from the patient setting – without causing secondary problems and actually increasing the risk of suicide because the environment is undignified, un-therapeutic and dehumanising.[24]

44. Mr Kelly went onto say that he believed there are some absolute limits to controlling the introduction of prohibited items into in-patient units because *despite best efforts families find ways to introduce all manner of potentially harmful (and prohibited) items* – sometimes this is accidental or unintentional, a consequence of misunderstanding or language difficulties but sometimes intentional and deliberately introduced. Mr Kelly was however confident *the search procedures for patients are competently and consistently done, as was the case with Ms Kouros.*

[24] The emphasis by underlining was Mr Kelly's.

45. Mr Kelly also informed me of measures implemented by NWMH to manage the introduction of contraband into the in-patient units and to attend to ligature safety and that these initiatives exceeded that of any other mental health service in Australia. Mr Kelly did not specifically state that these measures were implemented in response to Veronika's death and given their divergence from the circumstances of Veronika's death, I have assumed not. The shift to shift *environmental checks* to which he referred certainly were more germane to the circumstances of Veronika's death and involves the AM and PM Registered Nurses (RN) conducting a walk through inspection of the bedrooms of the patient the PM RN will be caring for with the purpose of discovering any prohibited or potentially harmful objects or any infrastructure items in need of repair.

46. Mr Kelly also provided me with his reasons why he did not support NWMH staff being provided with powers to conduct searches on visitors which I have not considered in this Finding as there was no evidence that a visitor had brought in the plastic bag that was in Veronika's possession and used by her.[25]

47. Mr Kelly also provided me with a statement he made to the Royal Commission into Victoria's Mental Health System (RCVMHS) on in-patient suicides for which I am grateful.

CONCLUDING MY INVESTIGATION

48. As foreshadowed at the Directions Hearing, receipt of additional information from NWMH sufficiently supplemented the information in my Coronial Brief such that I deemed it unnecessary to return to Court for the purposes of summoning witness to give evidence. The pertinent issue surrounding the death of Veronika was how she came to still have a plastic bag in her possession despite the removal of the same on her admission or how did she come to be in the possession of a plastic bag if all of her plastic bags were removed from her possession on admission; seemed unlikely to ever be resolved by the calling of witnesses.

[25] Conversely, there is no definitive evidence that it was not brought in by a visitor save from the statement made by Veronika's mother.

49. I therefore determined that the Directions Hearing would be deemed my Summary Inquest.

COMMENTS

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

1. In a custodial or institutional type setting such as a low dependency unit in a mental health facility, 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.

2. 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. I have expressed these views previously and most recently in the *Finding into Death With Inquest* of Christopher Traill[26] 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

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

that should be achieved in an in-patient Unit in general, and also specifically, as it did with regard to Christopher Traill.

3. The language used by Mr Kelly in his correspondence regarding Veronika's death used similar language as the experienced clinicians I heard from in the Christopher Traill Inquest referring to the risk of increasing suicide because an undignified, untherapeutic and dehumanising environment would be created by removing all those "benign" personal items. This type of language is defensive and dismissive, emotive and inflammatory particularly as it is not supported by any empirical evidence. It is also disappointing to hear these strident views from such experienced people in their field when an acknowledgement that whatever system/process was in place failed to remove an item of significantly high risk of using for the purposes of self-harm, otherwise Veronika would not have had a plastic bag to use for the purposes of taking her own life.

4. And in acknowledging that the circumstances in the matter of Christopher Traill are not on all fours with the circumstances surrounding Veronika'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.

5. In 2015 I completed a *Finding into Death with Inquest* in the matter of Maria Teresa Nigro[27] 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

[27] COR 2009 0829

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

6. In 2018 Coroner Rosemary Carlin (as she then was) completed a *Finding into Death without Inquest*[28] 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.

7. 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.

8. In the Christopher Traill Findings[29] 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 harm and without identifying all the specifics that should be considered within that

[28] COR 2015 0531

[29] COR 2017 0953

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.

9. 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.[30]

CONCLUDING COMMENTS

10. Veronika had a history of mental illness diagnosed and treated by her general medical practitioner, however, did not have contact with mental health services until six days before her death.

11. Based on the information available to me, there is no evidence that Veronika presented with acute risk of suicide overnight on 18 – 19 March 2018. She presented with some increased distress at 10.25pm but this was not out of the ordinary in the context of this admission where she presented with similar behaviours on other occasions and appeared to settle with medication. She was not presenting with psychotic symptoms or indicators of suicidality.

12. There is no evidence that she was awake or distressed throughout the night. The evidence indicates that she was observed asleep at 6.00am. There is no evidence that she left her room during the night or presented to staff between 6.00am and 7.00am when she was located with a plastic bag[31] over her head, deceased.

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[30] 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

[31] I was informed by DTCH Lawyers in correspondence dated 20 December 2019 that the plastic bag used by Veronika appeared to be "bin liner" bag rather than a retail shopping bag.

13. NWMH procedures state that plastic bags are not permitted on the in-patient unit. It remains unclear how Veronika accessed a plastic bag as I have no reason to doubt the medical records that her belongings were searched on admission and various items that she had been hoarding in plastic bags were put in a locker in the ward storage room which I am informed and accept, is not accessible to patients.

14. I have been unable to determine why the procedure in place and appears to have been carried out, at the time of Veronika's death was not successful in preventing her access to a plastic bag.

15. Nevertheless, noting and acknowledging the procedures and strategies in place at NWMH and having regard to previous and more recent Recommendations to other health facilities regarding the diligence and rigor that is required in the in-patient units surrounding the removal of personal items that can be used for self-harm, I consider it unnecessary to make a Recommendation focused on the aim of preventing like deaths, in this instance.

FINDINGS

1. I find that Veronika Anastasia Kouros born 30 December 1986 died on 19 March 2018 at the Northern Psychiatry Unit, the Northern Hospital, Cooper Street Epping.

2. I find that Veronika Anastasia Kouros, a voluntary inpatient at the Northern Psychiatry Unit, the Northern Hospital had access to a high risk personal item, being a plastic bag despite a hospital procedure in place, and activated to remove these high risk personal items from her possession.

3. I am unable to make any finding on how Veronika Anastasia Kouros still came to be in the possession of a plastic bag except 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. In the circumstances I find that her death was preventable while she was a patient at the Northern Psychiatry Unit, the Northern Hospital.

4. I accept and adopt the cause of death as ascribed by Dr Melanie Archer and I find that Veronika Anastasia Kouros died from plastic bag asphyxia in circumstances where 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:

Mrs Teresa Kouros

Mr Yiannis Kouros

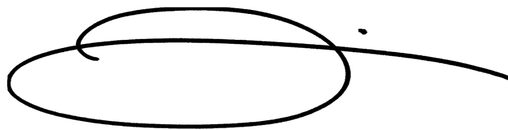
Ms Gabriela Kouros

Mr Peter Kelly

Ms Jan Moffat, DTCH Lawyers on behalf of NorthWestern Mental Health

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.