IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2009 4252

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: Ms TK

Delivered On:	3 March 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank Victoria 3006
Hearing Dates:	28, 29, 30 31 May, 1 June & 11 December 2012
Findings of:	Coroner Paresa Antoniadis SPANOS
Representation:	Mr R. HARPER, instructed by Maurice Blackburn Lawyers, appeared on behalf of the family of the deceased. Mr N. MURDOCH of Counsel, instructed by DLA Piper, appeared on behalf of Melbourne Health/Orygen Youth Health. Mr R. H. STANLEY of Counsel, instructed by Middletons Lawyers, appeared on behalf of Ms Melissa URIE.
Police Coronial Support Unit	Senior Sergeant Jenette BRUMBY, assisting the Coroner

I, PARESA ANTONIADIS SPANOS, Coroner,
having investigated the death of Ms TK

and having held an inquest in relation to this death at Melbourne

on 28, 29, 30 & 31 May, 1 June and 11 December 2012:

find that the identity of the deceased was Ms TK

born on 27 March 1991, aged 18

and that the death occurred on 31 August 2009

at the Western Hospital, Gordon Street, Footscray, Victoria 3021

from:

I (a) HYPOXIC BRAIN INJURY

I(b) HANGING

in the following circumstances:

BACKGROUND & PERSONAL CIRCUMSTANCES[1]

1. Ms TK was the eldest child and only daughter of her parents. Ms TK was studying civil engineering and management at RMIT and resided in Brunswick with her parents and younger brother TH. Ms TK was a bright, highly motivated and high achieving young woman who had no known history of depression or other mental health issues until early 2009,[2] when she experienced a deterioration in her mental health and commenced displaying self-harming behaviours.

DEPRESSION & SELF-HARMING BEHAVIOURS – APRIL TO EARLY AUGUST 2009

2. Ms TK presented to the Royal Melbourne Hospital emergency department [RMH] as a result of episodes of high risk or self-harming behaviours in early April[3] and early May[4] 2009. On the second occasion Ms TK was assessed by a clinician from the Enhanced Crisis Assessment

[1] This section is a summary of facts that were uncontentious, and provide a context for those circumstances that were contentious and will be discussed in some detail below.

[2] Ms TK had sought counselling through her school counsellor in the period immediately following the sexual assault some two years before her death but, apparently, no medical or psychiatric treatment.

[3] The first presentation resulted from the consumption of an excessive amount of alcohol, reported as 400ml of straight spirits causing vomiting, dehydration and low potassium. See paragraph 28 below.

[4] The second presentation involved intrusive memories of a sexual assault two years' earlier that led to Ms TK reportedly drinking a small amount of ouzo, that she later vomited, going for a walk and finding a piece of glass she used to lacerate her left wrist. See paragraph 29 and following below.

and Treatment Team [ECATT] and referred to Orygen Youth Health [Orygen], part of Melbourne Health, for crisis follow-up.

3. Orygen clinicians assessed Ms TK comprehensively on 21 May 2009 and arrived at an initial diagnosis of Major Depressive Disorder, recurrent and severe, without psychotic features and Post Traumatic Stress Disorder [PTSD], in remission. Thereafter Ms TK was treated by the Orygen Mood and Anxiety Disorders Clinic, and appeared to engage well with treatment.[5]

4. Nevertheless, Ms TK was admitted to the Orygen inpatient unit on three occasions due to concern about the risk of further self-harm. It was during her first lengthy admission from 1 to 29 June 2009 as a voluntary patient that Ms TK was commenced on the antidepressant fluoxetine.[6] Ms TK's second admission to the Orygen inpatient unit, again voluntary, between 10 and 14 July 2009 was initiated by the duty psychiatric registrar when Ms TK reported an inability to manage her impulsivity at home.

FINAL ADMISSION TO ORYGEN INPATIENT UNIT – 14 AUGUST 2009

5. Ms TK continued to experience ongoing suicidal ideation and engage in self-harming behaviours in late July and early August. On 13 August 2009, in light of Ms TK's ongoing risk and heightened acute risk of self-harm/suicide, her treating psychiatrist at Orygen, Dr Mark Phelan initiated the process for making Ms TK an involuntary patient under the ***Mental Health Act 1996*** [MHA]. Ms TK was taken by ambulance to RMH with the assistance of the Orygen Youth Assessment Team [YAT][7] where she remained overnight as a bed was not immediately available for her at the Orygen inpatient unit.

6. On 14 August 2009, Ms TK was transferred to the Orygen inpatient unit [inpatient unit] where she remained until 24 August 2009. The adequacy of clinical management and care provided to Ms TK during this admission was the primary focus of the coronial investigation of her death and will be addressed in some detail below. Suffice for present purposes to say that Ms TK remained an involuntary inpatient until 21 August 2009 when her status under the

[5] Transcript page 22 regarding Ms TK's engagement with treatment and paragraph 27 and following.

[6] Marketed in Australia as "Prozac" and "Fluohexal", fluoxetine is a selective serotonin reuptake inhibitor [SSRI] antidepressant used to treat major depression, among other condition, and sometimes used in combination with olanzapine ["Zyprexa"] to treat depression caused by bipolar disorder or where two other antidepressants have been trialled without success.

[7] Exhibit C, statement of consultant psychiatrist Dr Mark Phelan. See also footnote 37 for provisions of the MHA.

MHA was changed to voluntary, and she was allowed weekend leave with her family from Friday 21 to Sunday 23 August 2009.[8]

7. During a regular observation round shortly after midnight on 24 August 2009, about 15 minutes after she was last observed by him, Registered Psychiatric Nurse [RPN] Brent Hayward[9] found Ms TK's door locked. After unlocking the door, which had been barricaded with a mattress and chairs from the inside, he found Ms TK hanging against the bathroom door, facing him.[10]

RESUSCITATION & TRANSFER TO WESTERN HOSPITAL

8. RPN Hayward activated his personal alarm to alert other staff members and held Ms TK around the waist in an attempt to remove the sheet from around her neck and get her down. It took two attempts before he could lift Ms TK high enough to free her from the door and lower her to the floor. RPN Hayward then left the room to tell other staff where he was and the nature of the emergency, before returning and commencing resuscitation.[11]

9. RPN Andrew Porter responded to the alarm by asking Acting Associate Nurse Unit Manager [A/g NUM] Kevin Pare to get the emergency crash cart and calling extension 444 to "call" a code blue - a request for immediate attendance of a medical emergency team. RPN Porter then ran to Ms TK's room and assisted with her resuscitation by performing chest compressions, while RPN Hayward continued mouth to mouth resuscitation.[12]

10. A/g NUM Pare arrived with the emergency crash trolley at about the same time as RPN Porter. Oxygen was then applied to Ms TK via mask and preparations made for defibrillation. The code blue team arrived a short time later and took over resuscitation.[13] They managed to resuscitate Ms TK and at 0045 hours on 24 August 2009, she was transferred to Western

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[8] Exhibit E, statement of consultant psychiatrist Dr Josephine McKeown dated 5 October 2009.

[9] RPN Blair Douglas William Hayward known as Brent and referred to as such in other witnesses' statements and evidence – transcript page 239.

[10] Exhibit K.

[11] Although I have referred to a "sheet" as do a number of witnesses, as will be seen in paragraph 56 and following below, it was not at all clear what Ms TK had used to improvise a ligature.

[12] Exhibit K and Exhibit J, statement of RPN Andrew Porter dated 14 December 2009.

[13] Exhibit H, statement of A/g NUM Kevin Pare dated 14 December 2009. According to Dr Forbes McGain, Intensivist & Anaesthetist from Western Health, cardiopulmonary resuscitation including the administration of 2mg of adrenaline occurred for 10 minutes prior to the return of spontaneous circulation. His statement appears at pages 98.1 – 98.2 of the coronial brief, Exhibit AA.

Hospital which is adjacent to the inpatient unit, and admitted to the intensive care unit [ICU].[14]

11. In ICU Ms TK was supported with ventilation, cooling for 24 hours and routine ICU care. Myoclonic jerking[15] was observed on 24 August 2009, indicative of a poor neurological prognosis. CT scanning of the brain did not reveal any acute reversible condition, such as an intra-cerebral bleed. Ms TK remained in the ICU for eight days during which her neurological function did not improve, with severe myoclonic jerking continuing unabated, and no purposeful interaction at any stage between Ms TK and her surroundings.[16]

12. Ms TK's family were kept informed about her clinical course and ultimately advised about her dire prognosis. After consultation with treating medical staff, the family agreed to withdrawal of treatment. On 31 August 2009, life support was withdrawn and Ms TK was pronounced deceased a short time later.[17]

INVESTIGATION & SOURCES OF EVIDENCE

13. This finding is based on the totality of the material the product of the coronial investigation of Ms TK's death. That is, the brief of evidence compiled by Senior Constable David Wagner from Footscray Police, additional statements obtained by my assistant Senior Sergeant Jenette Brumby from the Police Coronial Support Unit, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of Counsel. All of this material, together with the inquest transcript, will remain on the coronial file.[18] In writing this finding, I do not purport to summarise all the material and evidence, but will refer to it only in such detail as is warranted by its forensic significance and in the interests of narrative clarity.

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[14] Ibid.

[15] Myoclonic *relating to or marked by myoclonus.* Myoclonus defined in Dorland's Illustrated Medical Dictionary (31st edition) at page 1241 as "*shocklike contractions of a portion of a muscle, an entire muscle, or a group of muscles, restricted to one area of the body or appearing synchronously or asynchronously in several areas. It may be part of a disease process (eg epileptic or post-anoxic myoclonus) or be a normal physiological response (eg nocturnal).*"

[16] See footnote 15 above.

[17] Ibid.

[18] From the commencement of the ***Coroners Act 2008*** (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act. Unless otherwise stipulated, all references to legislation that follow are to provisions of the Act.

PURPOSE OF A CORONIAL INVESTIGATION

14. The purpose of a coronial investigation of a *reportable death*[19] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.[20] 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 all those circumstances which might form part of a narrative culminating in death.[21]

15. The broader purpose of any 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.[22] Coroners are empowered to report to the Attorney-General in relation to 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.[23] These are effectively the vehicles by which the coroner's prevention role can be advanced.[24]

16. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death, and are specifically prohibited

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[19] The term is exhaustively defined in section 4. Apart from a jurisdictional nexus with the State of Victoria (see section 4(1)), reportable death includes *"a death that appears to have been unexpected, unnatural of violent or to have resulted, directly or indirectly, from an accident or injury"* (see section 4(2)(a)). Note that a special status is afforded involuntary psychiatric patients, whose deaths are always reportable, irrespective of the cause of death (see section 4(2)(d)).

[20] Section 67(1).

[21] This is the effect of the authorities – see for example *Harmsworth v The State Coroner* [1989] VR 989; *Clancy* v *West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[22] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, cf: the *Coroners Act 1985* where this role was generally accepted as 'implicit'.

[23] See sections 72(1), 67(3) and 72(2) regarding reports, comments and recommendations respectively.

[24] See also sections 73(1) and 72(5) 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.

from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[25]

FINDINGS AS TO UNCONTENTIOUS MATTERS

17. In relation to Ms TK's death, most of the matters I am required to ascertain, if possible, were uncontentious from the outset. Her identity and the date and place of death were not at issue. I find, as a matter of formality, that Ms TK, born on 27 March 1991, aged 18, died at the Western Hospital, Gordon Street, Footscray, on 31 August 2009.

18. Nor was there any contention about the medical cause of death. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (VIFM) reviewed the circumstances as reported by the police to the coroner, reviewed the medical deposition and medical records from the Western Hospital and performed an autopsy. Dr Burke provided an eight page autopsy report detailing his findings.[26]

19. Dr Burke's main findings were hypoxic brain injury and an ill-defined abraded injury to the neck consistent with hanging. He found no other significant injury (that is that may have contributed to death), and no significant natural disease processes that may have contributed to death. Dr Burke noted the results of toxicological analysis and concluded by attributing the cause of Ms TK's death to *hypoxic brain injury secondary to hanging.*[27]

20. Toxicological analysis of ante mortem samples of blood taken at the Western Hospital at 0433 hours on 24 August 2009 detected venlafaxine[28], quetiapine[29] and fluoxetine[30] at levels broadly consistent with therapeutic use.

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[25] Section 69(1). However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if they believe an indictable offence may have been committed in connection with the death. See sections 69 (2) and 49(1).

[26] Exhibit Q is Dr Burke's autopsy report, which includes his formal qualifications and experience and appears at page 104.1 and following of the coronial brief, Exhibit AA.

[27] See also the statement of Dr McGain (at pages 98.1-98.2 of Exhibit AA) who concurs with this formulation of the cause of Ms TK's death.

[28] Venlafaxine (marketed in Australia as Efexor) is indicated for the treatment of depression.

[29] Quetiapine (marketed in Australia as Seroquel) is an antipsychotic drug used in the treatment of schizophrenia, bipolar disorder, treatment resistant major depression and generalised anxiety disorder. In Ms TK's case, Dr Phelan explained that he had prescribed quetiapine from 11 August 2009, not as an antipsychotic but to help her sleep and as an adjunct treatment for depression – transcript page 60 and Exhibit D statement of Dr Phelan dated 15 June 2011. I note that in Exhibit D Dr Phelan refers to being concerned that Ms TK's feelings of guilt were approaching delusional intensity but at inquest he testified that he was not considering a differential diagnosis of psychosis. Rather the antipsychotic effect of quetiapine was a *"potential additional benefit … my assessment at the time wasn't that she was experiencing a psychotic illness but that that medication could help should that be the case."* – transcript page 61.

21. Toxicological analysis of post mortem samples collected at VIFM on 4 September 2009 detected fluoxetine, and metoclopramide,[31] morphine[32] (free) and traces of midazolam[33] and 7-aminoclonazepam,[34] consistent with therapeutic use in the palliative setting.

22. I find that Ms TK's death was as a result of a hypoxic brain injury secondary to hanging.

FOCUS OF THE CORONIAL INVESTIGATION AND INQUEST

23. There were a number of concerns raised by family in correspondence with the court and in their statements that were not the focus of the coronial investigation because I considered them insufficiently proximate to the death to warrant investigation, not necessarily because they lacked merit. That said, the sexual assault reported by Ms TK to her case manager and other clinicians, and to Victoria Police by way of formal complaint (a precursor to a criminal investigation and possible prosecution), was clearly a significant stressor, potentially the main cause of her deteriorating mental health from early 2009. But there were others, none the least of which apprehension about her family's reaction if they were to become aware of the sexual assault and her fear of falling behind in her studies.[35]

24. The coronial investigation did not focus on the period from Ms TK's resuscitation, commenced by RPN Hayward and continued by the code blue team, and her transfer to Western Hospital and clinical management and care thereafter. No issues were raised by the family about this aspect of her clinical management and care, and none were apparent from the medical deposition and records provided by Western Hospital.

25. The primary focus of the coronial investigation was on the adequacy of the clinical management and care provided to Ms TK from her first presentation to RMH in early April 2009, to her engagement with Orygen Youth Health across both the outpatient and inpatient settings. This encompassed an assessment of the communication between the outpatient and

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[30] Fluoxetine (marketed in Australia as Fluohexal, Lovan, Prozac among others) is a substitute propylamine indicated for the treatment of major depressive disorders and obsessive compulsive disorders.

[31] Metoclopramide (marketed in Australia as Maxolon among others) is an anti-emetic drug used for the treatment of nausea and vomiting, common symptom of morphine use.

[32] Morphine is a narcotic analgesic used to treat moderate to severe pain, including in a palliative setting.

[33] Midazolam is a short acting sedative/hypnotic benzodiazepine class, used intravenously in intensive care patients.

[34]Clonazepam (marketed in Australia as Rivotril and Paxam) is a benzodiazepine related to diazepam possessing sedative and anticonvulsant properties. It is metabolised in the body to 7-aminoclonazepam, including during the post mortem period.

[35] For example, see Ms Grant's evidence at transcript page 42.

inpatient teams, and the decision to change her antidepressant medication from fluoxetine to venlafaxine.

26. Another focus was on the safety of the physical environment of the inpatient unit, involving consideration of how it was that Ms TK had managed to fashion a ligature and what she had used as a hanging or suspension point, and consequently, on whether there had been any failure in internal processes for assessing, maintaining and improving the safety of the physical environment.

THE ADEQUACY OF CLINICAL MANAGEMENT AND CARE – FROM APRIL 2009

27. On 9 April 2009, Ms TK's parents took her to the RMH with a sudden onset of vomiting. Initially denying alcohol or other drug use, Ms TK later reported 'feeling a bit depressed at the moment' and drinking 400ml straight spirits but denied any suicidal intent. Investigations showed that she was dehydrated and low in potassium. She was treated accordingly and discharged home with a letter to be sent to her university counsellor.[36]

28. Ms TK next presented to RMH early in the morning of 3 May 2009. On this occasion, she was brought in by police in exercise of their powers under Section 10 of the MHA.[37] Ms TK reported to nursing and medical staff that she was having a difficult time due to memories of an alleged sexual assault two years earlier.[38]

29. During subsequent assessment by a clinician from the ECATT, Ms TK reported drinking a small amount of ouzo (that she later vomited), feeling frustrated, going for a walk and cutting her left wrist with a piece of glass she found, hoping at the time she would die, but denying any extant suicide plan or intent.[39] The lacerations were cleaned and dressed, and did not require sutures. As a result of the ECATT assessment, Ms TK was referred to Orygen for

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[36] Exhibit E and RMH medical records under "1st admission."

[37] To paraphrase, this section empowers a member of the police force to apprehend a person who appears to be mentally ill, if the police member has reasonable grounds for believing that the person has recently attempted suicide or is likely to do so. Police may exercise this power by having regard to the behaviour and appearance of the person and are not (of course) expected to form a clinical judgment as to whether a person is mentally ill. Having apprehended a person under section 10 of the **Mental Health Act 1996** [MHA], police must arrange for an assessment by a mental health practitioner, or an examination by a registered medical practitioner as soon as practicable in order for the practitioner to determine if the person meets the criteria for involuntary treatment under section 8 of the MHA.

[38] Exhibit E and RMH medical records under "2nd admission".

[39] This is a paraphrase of the ECATT clinician's assessment dated 3 May 2009, as documented in the RMH medical records under "2nd Admission".

crisis follow-up and also provided with contact details for the Centre Against Sexual Assault [CASA] for counselling.[40]

REFERRAL TO ORYGEN YOUTH HEALTH & ASSESSMENT – 21 MAY 2009

30. Clinicians from Orygen saw Ms TK on 21 May 2009 and conducted a comprehensive assessment. During the assessment, Ms TK reported a deterioration in her mental state since January 2009 characterised by depressive symptoms on a background of an alleged sexual assault that occurred some two years earlier, the memory of which was triggered by recent consensual intimacy. Ms TK presented with perfectionist traits and put great pressure on herself to manage life independently. She described an underlying pervasive sense of low self-worth that drove her to strive to achieve unrealistically high and rigid standards, and reported a family history of depression in extended relatives that suggested the possibility of predisposition or vulnerability.[41]

31. On the protective side, Ms TK was a bright young woman who was seeking help, was well engaged with her studies and reported having benefited from supportive counselling in the past. The diagnoses at assessment were of Major Depressive Disorder, recurrent and severe without psychotic features, and Post Traumatic Stress Disorder [PTSD] in remission.[42]

32. Thereafter, Ms TK was treated by the Orygen Mood and Anxiety Disorders Clinic that offers weekly individual sessions of Cognitive Behavioural Therapy [CBT] to young people aged between 15 and 24, as well as pharmacological treatment and a group program, with an average engagement period of 4-6 months. Ms TK engaged well, attending 13 appointments with her case manager/clinical psychologist and maintaining regular phone contact with her, participating in regular medical reviews with a consultant psychiatrist and seeking crisis support appointments with a duty worker.[43]

33. Unfortunately, on 23 May 2009, within 48 hours or so of her assessment by Orygen, Ms TK presented for a third time to RMH. On this occasion, she reported that 'things got rough at home last night', that she left home around midnight, stayed in a park and self-inflicted lacerations to her left forearm with a razor blade, before walking to RMH. On this occasion, the lacerations were deeper, necessitating admission under the plastics unit and suturing under

[40] Ibid.

[41] Discharge Summary from Orygen dated 7 October 2009, Exhibit B and transcript pages 16 and following.

[42] Discharge Summary from Orygen dated 7 October 2009, Exhibit B.

[43] Transcript pages 9-10, 22 and following.

a general anaesthetic. Following the procedure, Ms TK was reviewed by a psychiatric registrar who also took a history from her father. She was discharged home to her parents on 25 May 2009 with a plan for close follow-up from Orygen.[44]

34. Despite engagement with Orygen, Ms TK had a lengthy voluntary admission to the Orygen inpatient unit between 1 and 29 June 2009 due to concerns about the risk of further self-harm on a background of a major depression.[45] A significant stressor for Ms TK at the time of her admission was her decision to report to police that she had been sexually assaulted two years earlier and to press charges against the perpetrator.[46] Ms TK was discharged on 29 June 2009 on fluoxetine[47] 40mg daily with arrangement for ongoing contact with Orygen, namely an appointment with her case manager on 2 July 2009, daily phone contact with the Youth Assessment Team [YAT] and a home visit/s.[48]

35. During a psychiatric review on 9 July 2009, Ms TK reported particular stress from unwanted contact with another Orygen outpatient who she had met during her inpatient admission in June 2009, to the extent that she had a razor blade in her bedroom, 'if life became too difficult'. She was given the option of re-admission to hospital or giving the razor blade to Orygen staff, and chose the latter. Dr Phelan increased her dose of fluoxetine from 40mg to 50mg daily due to her continuing low mood.[49]

36. However, the following day, Ms TK was seen by the duty psychiatrist and readmitted to the Orygen inpatient unit as a voluntary patient, as she felt she could not manage her impulsivity or guarantee her safety at home. After a four day admission, Ms TK's mood, risk level and insight were assessed as improved, and she was discharged home on 14 July 2009, with her

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[44] See RMH medical records under "3rd admission", especially long clinical progress note from psychiatric registrar Turnbull dated 24 May 2009 and follow-up arrangements documented by RPN Daniel at 0950 on 25 May 2009.

[45] Exhibit C and E, statements of consultant psychiatrists Dr Mark Phelan and Dr Josephine McKeown respectively. It is apparent from the RMH medical records under "4th admission" that this is a voluntary admission.

[46] Other stressors were the suggested need to disclose the fact of the sexual abuse to her parents (potentially therapeutic given her anxiety about their likely reaction and their anxiety for her welfare absent any understanding of the triggers for her mental state and self-harming) and her concerns that she was falling behind in her studies. Transcript pages 30 and following.

[47] Ms TK was commenced on fluoxetine during this admission. Marketed in Australia as "Prozac" and "Fluohexal", fluoxetine is a selective serotonin reuptake inhibitor [SSRI] antidepressant used to treat major depression, among other conditions, and sometimes used in combination with olanzapine ["Zyprexa"] to treat depression caused by dipolar disorder or where two other antidepressants have been trialled without success.

[48] Exhibit C.

[49] Exhibit C.

mother assuming responsibility for her medications and a follow-up appointment scheduled with her Orygen case manager.[50]

37. At her next psychiatric review with Dr Phelan on 22 July 2009, Ms TK reported no improvement in her mood but did report that she no longer had clear plans about how to suicide. Dr Phelan thought Ms TK appeared restless and agitated and was concerned that this may be due to her increased dose of fluoxetine. Nevertheless, he decided to trial a further increase of fluoxetine to 60mg daily to improve her mood and also prescribed "Stilnox"[51] 10-20mg to assist with her insomnia. Dr Phelan arranged for a telephone call from a colleague to review Ms TK's agitation after 24 hours. As her agitation did not seem to have worsened, Ms TK's fluoxetine dose remained 60mg daily.[52]

38. On 30 July 2009, Ms TK met with her case manager Celeste Grant.[53] While she reported mostly improved mood with occasional periods of low mood, she disclosed having four temazepam tablets and a box of travel sickness tablets in her room, "in case" she wanted to end her life. At the same time, Ms TK indicated that she would not suicide before finishing the police interview regarding her sexual assault and agreed to (and did) bring the tablets in to the duty worker the next day as a gesture that she would abide her crisis plan and keep safe in the community.[54]

39. Thereafter, in early August, Ms Grant had some difficulty contacting Ms TK[55] and, in the context of ambivalence from Ms TK regarding ongoing engagement, and concern about her

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[50] Exhibit C and RMH medical records under "5th admission". Note that Ms TK's discharge medications were fluoxetine and zopiclone PRN for insomnia. This drug is marketed in Australia as "Zimovane" and "Imovane" and is a non-benzodiazepine hypnotic drug. Benzodiazepines temazepam and diazepam were not dispensed due to concerns that Ms TK may stockpile these for self-harm purposes in the future as she had alluded to doing during this admission.

[51] Zolpidem is a non-benzodiazepine hypnotic/sedative that is marketed in Australia as Stilnox.

[52] Exhibit C.

[53] Ms Grant is a clinical psychologist employed as an outpatient case manager in the Youth Mood Clinic at Orygen at the time. Exhibit A, her statement dated 17 June 2011, focuses on contact with Ms TK on 20 August 2009 whereas her evidence at inquest was more broad-ranging.

[54] Exhibit C, transcript pages 37-38 and RMH medical records under "Youth-Community Mental Health", note written by Ms Grant dated 30 July 2009. See also note written by duty worker Vicky Sarikoudis dated 31 July 2009 documenting that Ms TK handed over medications, as discussed the previous day with Ms Grant. On this occasion, Ms Sarikoudis noticed a cut to Ms TK's left cheek. When asked about how she had sustained the cut, Ms TK said she didn't know and denied that she had self-harmed.

[55] RMH medical records under "Youth-Community Mental Health" progress notes dated 3-6 August 2009 and referrals to YAT of 3, 4 and 6 August 2009. The complexity of Ms TK's situation is exemplified in Ms Grant's referral to YAT dated 6 August 2009 which documents, among other things that Ms TK had "*Ongoing suicidal ideation. Deterioration in mental state past 1/52 after some improvement. Triggers of K agreeing to surrender her stockpile of medication (her back-up plan to OD if life becomes unbearable) – felt controlled by this and commenced cutting again. After Mo made a comment to K on w/e she became distressed and cut – opening old wounds. Sought medical treatment 5/8/09 after*

risk of self-harm/suicidality, Ms Grant requested assistance from Orygen YAT by way of afterhours contact. Following this contact and at the suggestion of YAT staff, Ms TK attended RMH on 5 August 2009 for treatment of a self-inflicted laceration to her right wrist. The laceration, apparently inflicted some three days earlier, required seven sutures and dressing. Katrina was discharged home for ECATT follow-up and review of her wound by her GP in one week's time.

40. During contact with YAT clinicians on 5 August and at her next appointment with Ms Grant on 6 August 2009, Ms TK reported feeling lower in mood since handing over her stockpile of drugs the previous week and feeling "controlled" by this. Ms TK articulated a plan to kill herself by drowning in the Maribyrnong River as she could not swim but denied any current intent to kill herself saying that she intended to participate in the police interview the following week relating to the sexual assault.[56]

41. It is apparent from the medical records that, at least from 6 August 2009, the outpatient treating team were considering the need for another admission for Ms TK, possibly as an involuntary patient, if her risk of self-harm could not be contained in the community/at home.[57] That day, Ms Grant consulted the duty psychiatrist Dr Chanen and it was decided that an admission was not necessary as Ms TK was not disclosing an immediate plan to harm herself and both she and her parents wished to avoid another admission. Their plan was to pursue management in the community with a duty worker appointment and a YAT home visit prior to Ms TK's next scheduled appointment with Ms Grant.[58]

42. Dr Phelan was informed and agreed with this plan. He also decided that as there was little evidence of a further response to fluoxetine, that Ms TK's dose should be decreased to 40 mg daily with a view to ceasing it one week later and then introducing an alternative

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YAT observed wound. Required 7 sutchers [sic]." And also captured in Ms Grant's progress note dated 6 August 2009 – *"…reports feeling confused and ambivalent about her safety. Had planned to attend appt today and tell OCM that is "fine" so she could be d/c from OYH and K would feel free to suicide…explored impact of surrendering stock pile of medication to YS last week. Felt controlled by OC. When controlled K feels "reckless" and is more likely to hurt self/become suicidal/ Hence, bought razor blades immediately after dropping off medication last week…"*

[56] RMH medical records under "Youth-Community Mental Health" progress notes dated 5-6 August 2009. Note that during these contacts with clinicians Ms TK expressed a desire to *'disengage from treatment so that Ms Grant would not be upset if she dies'* elsewhere documented as *feeling upset that she is engaged with OYH as now she will not end her life due to not wanting to disappoint treating team.'* See also progress notes dated 8 August 2009 where the same plan is reiterated.

[57] Exhibit C.

[58] Exhibit C and RMH medical records under Youth-Community Mental Health, Ms Grant's progress note dated 8 August 2009 1600 hours.

antidepressant, venlafaxine, after a one-week washout period.[59] At inquest, Dr Phelan explained his decision to change Ms TK's antidepressant medication in this manner. He testified that doing so did not necessarily mean that Ms TK would be at increased risk from not having any antidepressant medication in her system. Firstly, he expected fluoxetine to have an enduring effect, beyond its half-life, for up to five weeks and its cessation would not therefore immediately increase her risk. In the second place, the fluoxetine did not appear to be effective for her.[60]

43. Apart from multiple contacts with Orygen staff including Ms Grant,[61] between 6 and 11 August 2009, Ms TK was reviewed by Dr Phelan on 11 August 2009. Ms TK continued to describe suicidal ideation with thoughts of throwing herself into the Maribyrnong River, frequent negative thoughts about herself and deliberate self-harm the night before, in the form of cuts to her abdomen that she described as *superficial*. Ms TK explicitly stated that she did not want an admission. Dr Phelan's plan was for a further review on 13 August, in tacit recognition of her acuity, contact with Ms Grant in the interim, a further decrease of fluoxetine to 20 mg daily (with the aim of commencing venlafaxine on 24 August) and commencement of quetiapine 200 mg at night.[62]

44. Matters came to a head on 13 August 2009, when Ms TK attended for her medical review with Dr Phelan. Initially, Ms TK described a decrease in suicidal ideation, but then revealed to Ms Grant that she in fact had a plan to drown herself on 15 August which she no longer held. Ms TK also said that the abdominal wound she had previously described as superficial may need medical attention. On review of the wound, Dr Phelan was of the view that its

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[59] Exhibits C and D and transcript pages 60 and following. Dr Phelan discussed the change in Ms TK's medication regime with her parents. RMH medical records under "Youth-Community Mental Health" progress note/medical review documented by Dr Phelan at 1510 hours on 11 August 2009.

[60] Transcript pages 61-64. The "enduring effect" is borne out by the results of ante-mortem and post-mortem toxicological analysis outlined in paragraphs 20-21 above. While she stressed that she was not a toxicologist, Dr McKeown testified that she would expect fluoxetine to have a residual effect after it was ceased, depending on its half-life. *"Given the effects of the medicine will take up to four weeks to actually be effective initially, one would assume at a neurotransmitter level that there will be a decline in the effect of that over a more prolonged period of time…"* Transcript pages 114-116.

[61] RMH medical records under "Youth-Community Mental Health" contain notes of contacts with Ms TK by Vicki Sarikoudis on 7 August 2009 (twice), J. Maggs on 8 August 2009 (twice), M. Stevens on 9 August 2009 (twice) and a scheduled appointment with Ms Grant between 1400-1500 hours on 10 August 2009.

[62] Quetiapine was also prescribed on a PRN basis if required during the day. RMH medical records under "Youth-Community Mental Health" progress note written by Dr Phelan at 1510 hours on 11 August 2009. This change to her medication regime was also discussed with Ms TK's parents, according to Dr Phelan's note. See also Exhibit D where Dr Phelan explains what he was hoping to achieve by introducing a new antidepressant at this time – to accelerate Ms TK's recovery from a major depressive disorder, to increase her hopefulness about recovery and give her a sense of things moving forward.

depth was such that it required suturing,[63] and that her parents would have to be informed. Dr Phelan suggested an admission, as a means of dealing with the wound and Ms TK said she would only go to the Orygen inpatient unit.[64]

45. When a bed was not immediately available at Orygen, Dr Phelan made enquiries of other like facilities, finally deciding to recommend Ms TK for involuntary treatment under the MHA on the basis of her ongoing suicidal ideation, ongoing impulsivity with regard to deliberate self-harm and the likelihood that her parents would be distressed by Ms TK's recent self-harm and this would potentially be de-stabilising for her.[65] With the assistance of the YAT, Ms TK was taken by ambulance to RMH where her wound was dressed and where she remained overnight until a bed became available in the Orygen inpatient unit the following day.

INVOLUNTARY ADMISSION TO ORYGEN INPATIENT UNIT – 14 AUGUST 2009

46. On admission to the inpatient unit, Ms TK signed an Admission Contract[66] regarding acceptable behaviour and underwent a physical examination and psychiatric assessment/admission interview by a senior psychiatric registrar.[67] Ms TK was accommodated in the low dependency unit and subject to 15 minutely observations during the day and hourly observations while asleep overnight.

47. While appearing initially settled on the ward and posing no apparent management issues, in the early hours of 15 August 2009, Ms TK was found picking at her abdominal wound that was oozing blood. Nursing staff tried to dress the wound to suppress bleeding before transferring Ms TK to the emergency department where investigations revealed a small cut to the top of the original wound that Ms TK admitted inflicting with a razor blade. The new wound required three sutures and steristrips and dressings were applied to both this and the old wound.[68]

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[63] Transcript pages 71-72.

[64] Exhibit C and RMH medical records under "Youth-Community Mental Health" progress notes dated 13 August 2009 at 1630 and 1810 hours.

[65] Transcript pages 71-72.

[66] According to the Admission Contract Ms TK agreed [my paraphrase] not to engage in sexual activity with another resident, not to use illicit drugs or alcohol, not to steal or damage property and not to assault anyone or to threaten assault. See page 155 of the coronial brief Exhibit AA.

[67] Documented at pages 156-165 of the coronial brief Exhibit AA.

[68] Page 166 of the coronial brief Exhibit AA. The progress note entry written by RPN Russell notes, inter alia, that *Ms TK returned to unit at 0200…handed blade to staff but states "You wouldn't know if I have any more blades" Will need follow-up tomorrow and likely room search. Observed to sleep form 0230 hours and on remainder of checks overnight."*

48. Ms TK was assessed Dr Jaco Erasmus, on call Consultant Psychiatrist later on the morning of 15 August 2009, for the purposes of the MHA. Ms TK admitted that she had lacerated her abdomen on 10 August 2009 but denied that it was a suicide attempt. She self-lacerated the night before in the context of anger at being admitted, denied current suicidal ideation and said she was keen to get back to university. Dr Erasmus upheld Ms TK's involuntary status on the basis of the need to contain her risk. He was aware of, and adopted, the plan to stop fluoxetine with a view to changing to a new antidepressant and continued quetiapine 200mg daily.[69]

49. In August 2009, Dr Josephine McKeown was a Consultant Psychiatrist to the inpatient unit and the community YAT. On 17 August 2009, Dr McKeown returned to the inpatient unit for the first time since Ms TK's admission and reviewed Ms TK together with psychiatric registrar Dr Maite Von Heising.[70] During this review, Ms TK stated that she had been admitted as a precaution so she wouldn't kill herself and described current stressors as the upcoming police interview (which had been postponed until the end of August), university assessments and longstanding family conflicts.

50. Dr McKeown's mental state examination revealed good self-care, decreased eye-contact, co-operative but mildly hostile mien, mood described by Ms TK as 8/10 with recent improvement, and ambivalence about suicidal ideation - on the one hand describing ongoing suicidal thoughts and citing her family as a reason for not ending her life, on the other disclosing a firm decision to end her life after finalising her police statement (at the end of August), but then saying she was not going to do anything. Ms TK expressed frustration at being admitted and was keen to be discharged so she could resume her studies. She told Dr McKeown that she was compliant with her medication regime; that quetiapine helped her sleep; that she felt better without fluoxetine and would prefer not to be taking anything.[71]

51. At the conclusion of her first review of Ms TK, Dr McKeown's assessment was that she should remain an involuntary patient, that she was at risk of chronic deliberate self-harm but was not acutely at risk of suicide that day. Dr McKeown formulated a treatment plan that included a family meeting, and consultation with the outpatient team about Ms TK's ongoing

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[69] Pages 166-167 of the coronial brief Exhibit AA for the progress note entry made by Dr Erasmus. Also referred to in Dr Josephine McKeown's statement dated 5 October 2009, Exhibit E.

[70] The relevant entry in the progress notes is made by Dr Von Heising and appears at pages 168-169 of the coronial brief Exhibit AA and forms the basis of Dr McKeown's evidence about this consultation in her statement, Exhibit E.

[71] Ibid.

management, and the need to balance her chronic suicidal thoughts and chronic deliberate self-harm against her level of depression and wish to be involved in decision-making around her treatment. Ms TK's observation regime remained the same with 15 minutely observations during the day and hourly observations while asleep. In light of concerns about possible emergent medical issues, Dr McKeown decreased quetiapine from 200mg to 100mg daily.[72]

52. Dr McKeown did not usually work on Tuesdays and was not involved in Ms TK's clinical management on 18 August 2009 when there were two significant developments. The first was a consultation between Dr Phelan and Dr Von Heising by telephone. At inquest, Dr Phelan accepted that he told Dr Von Heising that Ms TK was difficult to manage in the community, with ongoing suicidal thoughts and severe deliberate self-harm. At inquest, he accepted that he also conveyed that Ms TK had persistent negative thinking, but could not recall saying anything about her appearing superficially sociable.[73]

53. The second significant development on 18 August 2009 was the disclosure made by Ms TK to Ms Grant during a visit to the inpatient unit. In a progress note made in the inpatient section of the medical record, Ms Grant wrote that Ms TK was 'tearful and distressed and that she reported a low mood and was feeling very guilty'. She was thinking about suicide and has a plan with intent but refused to disclose what and when. She hinted that she may attempt suicide while in the inpatient unit saying *"I could do it here"* but refused to disclose details. Ms TK stated that she would not self-harm tonight and agreed to speak to Ms Grant tomorrow on the phone, however, was also apologising to her for not getting better.'[74] As well as making this entry, Ms Grant discussed the disclosures with the inpatient treating team.[75]

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[72] Ibid. The plan also included investigation of intermittent dizziness that Ms TK had complained of during her inpatient admission and anaemia thought secondary to her deliberate self-harm. See medication chart at page 194 of the coronial brief, Exhibit AA where the decreased dose is documented, as is the cessation of fluoxetine @ 14 August 2009. Dr McKeown's discussion with Ms Grant later that day, in furtherance of this plan for consultation, is the subject of a detailed progress note at page 169-170 of the coronial brief, Exhibit AA.

[73] This is the gist of his evidence at transcript pages 72 and following. Dr Von Heising did not give evidence at inquest but her progress note is broadly consistent with Dr Phelan's evidence, including his preference for Ms TK to be commenced on venlafaxine whilst on the ward. As regards the reference in Dr Von Heising's progress note to 'Consider leave over weekend. Aim for discharge next week.' Dr Phelan's evidence was that this was likely something he was told and certainly one of the potential plans envisaged at that time. See transcript page 74 and page 170 of the coronial brief, Exhibit AA.

[74] Page 171 of the coronial brief, Exhibit AA and transcript page 14 and following. An analogous note was made by Ms Grant in the outpatient section of the medical record – see page 49 of the coronial brief, Exhibit AA.

[75] Transcript pages 14-15. See also transcript pages 295-296 – it appears that Ms TK's observation regime during the day changed from 30 minutely to 15 minutely observations in response to this disclosure.

54. On 19 August 2009, Dr McKeown was on pre-arranged annual leave and Ms TK's management was reviewed by Dr Ayla Khan, as part of the weekly ward round discussion with the treating team and Dr Von Heising. The relevant progress note documents that Ms TK appeared bright, reactive and sociable on the ward, and reported a suicidal plan but did not disclose details. There was no material change made to Ms TK's treatment plan as a result of this review and 15 minutely observations were to continue.[76]

55. At about 1620 hours on 20 August 2009, Ms Grant called the inpatient unit and spoke to Ms TK who sounded flat and down, and reported ongoing suicidal ideation, and thinking about ways to self-harm or suicide while in the inpatient unit. Ms Grant called the inpatient unit at about 1700 hours to advise them of Ms TK's level of risk and a recent attempt to engage in deliberate self-harm this morning.[77]

56. RPN Serena Ho was the inpatient unit staff member who received this telephone call from Ms Grant, and, while it appears that the information may have lost something in transmission, advised Ms Grant that Ms TK was absent without leave from the inpatient unit.[78] Ms TK's parents were also advised of this development by RPN Ho, as were the local police, but Ms TK returned to the inpatient unit of her own accord at about 1545 hours having been absent for about one hour.

57. In a one on one discussion with RPN Ho on her return, Ms TK said that she had left the inpatient unit due to frustration at hospitalisation to "get some fresh air" and reported that she had left with the intent to hurt herself but did not go through with plan as she couldn't be bothered. RPN Ho's impression was that Ms TK was guarded about a plan, shrugged when questioned about attempts earlier that day and laughed inappropriately when discussing same

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[76] Page 171 of the coronial brief, Exhibit AA, Exhibit E and transcript page 135 where Dr McKeown testifies that this was a clinical review meeting with the treating team, not involving Ms TK. Dr Kahn's plan did refer to a two week wash-out period for fluoxetine but this discrepancy with Dr Phelan's plan is immaterial for present purposes. Note also that the progress note entries made by nursing staff on 18, 19 and 20 August which refer, inter alia, to ongoing suicidal ideation, bright & reactive affect but low mood, and inappropriate/sexualised behaviour with male co-patients and concerns about her vulnerability within the unit – see pages 171-172.

[77] Page 50 of the coronial brief, Exhibit AA and transcript pages 40-41. According to Ms Grant's progress note entry, she attempted to call the inpatient unit prior to 1700 hours but the phone was engaged.

[78] Transcript page 43 and page 172 of the coronial brief, Exhibit AA. RPN Ho refers to Ms Grant advising that she had spoken with Ms TK earlier that day who had disclosed that she had *"made two attempts to suicide" in the morning though was unwilling to state how she had attempted to do so. Reported…had a plan to end her life – would not disclose same"*

but agreed to approach staff if her suicidal ideation worsened or her desire to self-harm increased.[79]

CHANGE OF STATUS FROM VOLUNTARY TO INVOLUNTARY PATIENT

58. Dr McKeown's second review of Ms TK took place on Friday 21 August 2009. Dr McKeown's evidence was that, at the morning team meeting, she was informed by senior nursing staff that Ms TK's interactions with male co-patients was becoming increasingly difficult to manage, and Dr Rick Fraser a co-consultant psychiatrist, raised the possibility of weekend leave for Ms TK. Dr McKeown noted discrepant views about Ms TK's level of depression, between the outpatient and inpatient teams, and planned to review Ms TK that day and discuss her further management with Dr Fraser.[80]

59. During the first part of the medical review Ms TK said she was still a bit tired but felt okay, was a bit stressed out about university and was not sleeping as well with the reduction of quetiapine to 100mg at night.[81] She denied current suicidal ideation, said she felt good about herself, had future plans and no urge to self-harm. Ms TK said she thinks about suicide and deliberate self-harm when she feels overwhelmed, for example about how to catch up at university, and being hospitalised made things worse in this regard. Ms TK said the admission had been beneficial in some ways mentioning having a social life on the ward. She said her main stressor for deliberate self-harm and suicidal thoughts prior to admission had been the police investigation of the sexual assault, and that this was no longer relevant as she had changed her mind about continuing with the charges and therefore will not plan to suicide in the future.[82]

60. Ms TK's mother joined the discussion for part of the time, providing her input. Mrs TK conveyed her appreciation of the ward support, felt that Ms TK had moved forward and was more relaxed and that she puts herself under too much pressure to achieve.[83]

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[79] Pages 172-173 of the coronial brief, Exhibit AA.

[80] Exhibit E and transcript pages 137 and following.

[81] This reduction of dose was to address the possibility that her reported dizziness might arise from the higher dose of quetiapine – see page 171 of the coronial brief Exhibit AA. Apart from Dr McKeown, Dr von Heising and RPN Ho were involved in discussions, with Dr von Heising writing a progress note at page 173 and Dr McKeown at page 174 of the coronial brief respectively. See also transcript from pages 135 and following and pages 155 and following.

[82] Exhibit E and page 173 of the coronial brief Exhibit AA. This is a paraphrased but almost verbatim account of the relevant progress notes dated 21 August 2009.

[83] Ibid.

61. At the conclusion of her review, the salient features of Dr Keown's plan for Ms TK was to rescind Ms TK's involuntary patient status, to increase quetiapine to 150mg to aid sleep, to allow weekend leave from the afternoon of Friday 21 August till the evening of Sunday 23 August and to aim for discharge from the inpatient unit on Monday. This plan was endorsed by Dr Fraser and, subject to commencement of venlafaxine at a starting daily dose of 37.5mg as soon as possible, agreed to by Dr Phelan.[84]

62. Both Dr Phelan and Dr McKeown were cross-examined at inquest about alleged "discrepant" views of this important aspect of Ms TK's clinical presentation - her risk of deliberate self-harm and/or suicide - between clinicians from the outpatient and the inpatient teams.

63. Dr Phelan recognised that he was under a duty to ensure that the inpatient team, as the team primarily responsible for Ms TK's clinical management, was aware of clinically relevant information held by the outpatient team. As at 21 August 2009, Dr Phelan recognised that there was a discrepancy between Ms TK's self-report of her level of risk to different people. As regards any discharge decision, he wanted to ensure that there was broad discussion prior to discharge between all clinicians.[85] Based on all that he knew about Ms TK, including information from the inpatient team, by the time she was discharged from her involuntary status, Dr Phelan considered Ms TK to be at ongoing risk of deliberate self-harm and suicide. He deferred to Dr McKeown as the clinician best placed to assess Ms TK's level of risk as she was 'on the ground reviewing her on a regular basis and also able to consult with nursing and other inpatient unit staff'.[86]

64. Dr McKeown was cross-examined[87] at some length about discrepant views of Ms TK's risk, the clear inference being that the outpatient team had an established rapport and had formed a more accurate assessment of her risk than the inpatient team. While Dr McKeown conceded the existence of discrepant views between the units, she maintained that she was aware of the

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[84] Exhibit H and page 174 of the coronial brief Exhibit AA. See also transcript pages 74 and following (Dr Phelan's evidence) and pages 122 and following, 138 and following (Dr McKeown's evidence) in this regard. Note that Dr McKeown ensured that Ms TK was provided with venlafaxine to take while on weekend leave and, while it appears that she may not have taken the Sunday morning dose, must have taken some venlafaxine on at least the Saturday as it appeared in the ante-mortem toxicological analysis –see paragraph 20 above and transcript page 112.

[85] Transcript pages 67-68. Email dated 21 August 2009 5.06pm from Dr Phelan to Celeste Grant and John Koutsogiannis at page 101 of the coronial brief, Exhibit AA.

[86] Transcript pages 74-75. I note that these questions and answers were couched in terms of Ms TK's suitability for weekend leave.

[87] Unfortunately, the transcript of Dr McKeown's evidence is incomplete, apparently due to poor recording of responses, in some cases to important questions–for example transcript pages 103, 126, 127, 129, 132, 135, 139-141.

views of the outpatient clinicians, and that this was only one of a number of factors that she was required to synthesise in order to arrive at a risk assessment.[88]

65. Others factors included Ms TK's known history as documented in the RMH medical records,[89] the observations of psychiatric registrars, nursing and other inpatient staff[90] about her mental state/clinical presentation and risk assessed on a 24/7 basis, and her own assessment of Ms TK during reviews. In particular, Dr McKeown was of the view that Ms TK was 'not pervasively depressed nor suffering from melancholic depression' whilst in the inpatient unit.[91] Moreover, Dr McKeown opined that the 'nature of her illness over three admissions displayed quite chronic impulsivity, more so in relation to deliberate self-harm without suicidal intent, as opposed to suicidal intent' and that this historical perspective of her illness was also taken into account in assessing her risk.[92]

66. Ms TK returned to the inpatient unit on the afternoon of 23 August 2009, as agreed, but earlier than expected. In response to their enquiries, Ms TK reported to nursing staff that leave had not gone well, that her mother had been over-protective and that she had suicidal ideation and thoughts of self-harm, but was unwilling to elaborate and unable to guarantee her safety.[93] The nurse who documented this exchange with Ms TK in the progress notes was RPN Edel Fenton who was not available to attend the inquest.[94]

67. However, NUM MacLennan had the opportunity to discuss the case with RPN Fenton and provided hearsay evidence of her assessment of Ms TK's risk at the time. RPN Fenton was aware of the risk assessment documented on 20 August 2009 which indicated that Ms TK was at "significant risk." Pursuant to that risk assessment, Ms TK had expressed suicidal ideation

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[88] Transcript pages 102, 106-107, 138 *"I understood that the discrepancy that we were talking about earlier was between the outpatient unit's sense of her risk and what you or the inpatient unit had experienced in her admission?--- With risk being influenced by her level of depression that they were observing on their intermittent outpatient appointments with her, with what we had observed with the benefit of consistent review on an inpatient unit and discrepancy in terms of the history disclosed by the patient to outpatient versus inpatient…"*

[89] Transcript page 121.

[90] Transcript page 122.

[91] Transcript page 117

[92] Transcript page 109-111. This is consistent with Ms TK's history of admissions since her comprehensive assessment by Orygen on 21 May 2009 – from 1-29 June (29 days), from 10-14 July 2009 (4 days) and from 13 August 2009 (11 days). Disregarding days spent in part in the community and part in hospital, Ms TK spent only about 50 days out of 94 in the community between 21 May and 24 August 2009.

[93] RPN Fenton's progress note dated 230809 at 20:45 hours appears in the RMH medical records volume 2 under "4th admission" [sic] and also at page 175 of the coronial brief, Exhibit AA.

[94] The court was advised that RPN Fenton had returned to Ireland.

with both plan and intent, but was refusing to disclose details.[95] RPN Fenton concluded that Ms TK's risk had not changed and so did not complete a new risk assessment form.[96] Ms TK remained on 15 minutely observations while awake.[97]

68. On the other hand, somewhat at odds with her reported suicidal ideation and thoughts of self-harm, after her return to the inpatient unit on the evening of 23 August 2009, Ms TK was observed by evening and night nursing staff to be interacting well with other patients and to remain in high profile or communal areas where she was easily amenable to staff observation.[98]

69. Ms TK finally retired to her bedroom at about 2330 hours. A short time later, Ms TK asked RPN Brent Hayward[99] to help her retrieve her mouthguard which had fallen down the basin plughole in her bathroom. During this interaction, Ms TK appeared bright and (appropriately) humorous, raising no concerns in RPN Hayward's mind for her immediate safety.[100] This was only some 15 minutes before he returned to perform routine observations rounds and found Ms TK hanging from the bathroom door. It is significant in this regard that RPN Hayward testified at inquest that he was familiar with Ms TK, had nursed her over a period of some months, found her 'always very engageable' and felt he had built a rapport with her.[101]

SAFETY OF THE PHYSICAL ENVIRONMENT

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[95] This risk assessment (dated 20 August 2009 and completed by RPN Ho) also noted that she had engaged in inappropriate and flirtatious behaviour with male co-patients and had previously absconded impulsively from the inpatient unit. See page 183 of the coronial brief, Exhibit AA.

[96] Exhibit M, statement of NUM McLennan dated 10 June 2011 – *"In relation to an entry in the clinical notes: "Stated she cannot guarantee her safety on unit", Nurse Fenton told me that she had asked Ms TK the question "Do you feel that you can guarantee your safety on the unit?" to which Ms TK shrugged. Nurse Fenton did not feel that this response indicated an increase in Ms TK's risk of self-harm as this response was not unusual for Ms TK and was her documented response to similar questions by Nurse Ho on 20/8/09."*

[97] At pages 2-3 of her statement, part of Exhibit M, NUM McLennan explains the commencement of hourly "night time" observations only once the patient is observed to be asleep. See also transcript pages 278 and following. At inquest, Dr McKeown testified that, based on the progress notes documented by RPN Fenton on 23 August 2009, she was comfortable with the assessment that Ms TK's risk was unchanged from "significant" as previously assessed. See transcript pages 142-145.

[98] Page 175 of the coronial brief, Exhibit AA – progress notes made by RPN Fenton and RPN Hayward on 23 and 24 August 2009 respectively.

[99] RPN Blair Douglas William Hayward known as Brent and referred to as such in other witnesses' statements and evidence – transcript page 239.

[100] Exhibit E, RMH medical records volume 2 under "4th admission" *[sic]* total care progress note dated 240809 made by RPN Hayward, and Exhibit K, his statement dated 2 January 2010.

[101] Transcript pages 257-258.

70. In an inpatient psychiatric facility, the safety of the physical environment is only one aspect of patient safety. Others include the underlying severity of the patient's psychiatric illness and propensity to self-harm, the competence of the treating team, the quality of rapport, the frequency of observations and the effect of any treatment modalities. While the physical environment can be therapeutic in itself, and amenity can enhance therapy, a balance is required to be struck between amenity and safety.[102]

71. Hanging is a means to suicide of high lethality that only requires a ligature and a hanging or suspension point. In the coronial jurisdiction, examples abound of ligatures fashioned from varied and ubiquitous items, and of hanging or suspension points ranging from the pedestrian to the ingenious.

72. In relation to Ms TK, identification of the ligature and hanging or suspension point used, preoccupied a significant amount of time at inquest. This was primarily as a consequence of the successful resuscitation of Ms TK and her transfer to Western Hospital proper, and survival for some eight days before death. In such circumstances, the coronial jurisdiction is not enlivened until the death occurs and the opportunity for early scene examination on behalf of the coroner and even investigation is confounded, sometimes irremediably. Obviously, Ms TK's resuscitation was of paramount importance and no criticism of those involved is intended or to be inferred. On the contrary, the resuscitative efforts of RPN Hayward and others is commendable, but there is scope for improvement in scene preservation, about which I will comment below.

73. Being first on the scene, RPN Hayward was in one sense best placed to testify as to both the ligature used by Ms TK and the hanging or suspension point utilised. That is as he was first on the scene and could make observations prior to any interference. On the other hand he was clearly traumatised by the experience and did not have a clear recollection of either the ligature used or the hanging or suspension point.

74. In his statement, RPN Hayward stated that 'at about 0003 hours, on looking into her room, he observed Ms TK hanging against the bathroom door facing towards him with a sheet around her neck. He activated his ASCOM alarm to alert other staff and entered the room and then

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[102] Exhibit R statement of Dr Peter Leonard Burnett, Psychiatrist, North Western Mental Health, dated 25 May 2012 and attachments and transcript page 418 and following. See NUM MacLennan's evidence about this at transcript page 370 – *"We have done a lot of work in the ward in terms of reducing risk reduction and we have – you know, we have gone from wardrobes with doors to without doors, we have got beds that were free moving to bolted to the floor, we have removed …But the more and more we do the less and less there is so it is that balance between patient comfort and risk is quite – quite a difficult one."*

held Ms TK around her waist in an attempt to remove the sheet and get her down. This required two attempts before he was able to raise her high enough to pull the sheet out from around her neck and lower her to the floor.[103]

75. At inquest, RPN Hayward's statement was tendered without any reference to a sheet, as he testified that the reference to a sheet was more from what he had heard from other staff, not from what he actually remembered. His evidence was that he did not recall what was used as a ligature. He did recall being very traumatised and didn't actually visually remember seeing a sheet. He felt that a sheet would be fairly thick and obvious and he recalled seeing *"something thin like a thin material, like it would be a nightie or something, that's what I can visually remember seeing."*[104]

76. In cross-examination, RPN Hayward conceded that his contemporaneous progress note dated 24 August 2009 referred to Ms TK hanging by a bed sheet on the bathroom door, but maintained that this was not his independent recollection.[105] He reiterated his recollection of a ligature made of a thin or very thin material – *"I visually see something very thin and it was like it was almost homemade, it was like a material, like a cotton like off a nightie or something, that's what I visualise seeing."* He could not recall having to untie or untwist anything to get Ms TK down, just having to lift her high enough to free her from what was around her neck.[106]

77. As regards the hanging or suspension point used, RPN Hayward did not embrace the suggestion in RPN Porter's evidence that the sheet/ligature was secured by wedging in between the door and the door jamb or door hinge, as it was his recollection that Ms TK was positioned centrally against the door and quite high up, not appreciably to either side, which he believed he would have noticed had it been the case.[107] While it is clear that he did not investigate what the ligature was connected to, he did not consider that the exposed U-bend of the bathroom vanity was feasible because of its distance from the bathroom door. He

[103] Exhibit K was the statement of RN Blair Douglas Hayward (known as Brent) dated 2 January 2010, as amended in evidence. See transcript page 240-242.

[104] Transcript page 240.

[105] Transcript page 250.

[106] Transcript pages 247 and 253.

[107] Transcript pages 245, 247-248.

assumed that the housing of the robe hook behind the bathroom door had been used as this was consistent with the position in which he found Ms TK.[108]

78. RPN Hayward's description of the ligature was broadly consistent with the evidence of senior forensic pathologist Dr Burke, who performed the autopsy. In the autopsy report he describes an ill-defined healing abraded injury to the neck beginning above the thyroid cartilage anteriorly and extending upwards on both side of the neck measuring 14cm by up to 1.5cm, and a further region of healing skin abrasion to the right upper neck just below the right ear lobe and measuring a further 3.5cm by 1cm.[109]

79. At inquest, he testified that the ligature mark as depicted in photographs, was not consistent with the bulk of a sheet used as a ligature, but could have been caused by a relatively thin part of the sheet being in contact with the neck either by twisting the sheet or by using the seam edge or hem of the sheet.[110] Dr Burke testified that the ligature mark was non-specific in the sense that it was consistent with something *thin-ish*, around 1-1.5cms but was not patterned so as to point to a specific kind of ligature, such as might occur with a rope or other braided ligature.[111]

80. Other witnesses also gave evidence about their observations and/or assumptions made about the ligature and the hanging or suspension point used by Ms TK. A/g NUM Pare and RPN Porter were next on the scene after RPN Hayward arriving at Ms TK's room, for present purposes, at more or less the same time. A/g NUM Pare could not give any evidence about how Ms TK had managed to hang herself, either in terms of the type of ligature or the hanging or suspension point. He could not even recall any discussion among staff following the incident touching on these issues.[112]

81. In his statement, RPN Porter stated that, on arrival at Ms TK's room, a bed sheet he *presumed* was used in the hanging was draped over the bathroom door.[113] At inquest, he reiterated that he made an *assumption* that the sheet had been used but it was 'just a sheet without any creases or knots that didn't look twisted or knotted or anything like'. It was draped over the

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[108] Transcript pages 247-248

[109] Exhibit Q. At transcript page 399 Dr Burke explained that this "sparing" of the back of the neck was very common in circumstances of hanging, compared with (say) ligature strangulation in homicide.

[110] Transcript page 395.

[111] Transcript page 396.

[112] Exhibit H statement of RPN Kevin Pare dated 14 December 2009 and transcript pages 196-198, 202.

[113] Exhibit J statement of RPN Andrew Porter dated 14 December 2009 and transcript page 217.

bathroom door. He did not recall seeing the sheet actually fixed into the right-hand corner of the door, rather he thought it was draped across the middle of the door.

82. RPN Porter's unchallenged evidence was that the bathroom door opened outwards, that is into the bedroom and could be closed but not locked. The bathroom door was modified such that its bottom edge was about one foot off the ground and a similar gap existed between the door frame and the top of the door which had an angled top edge.[114]

83. It was also uncontroversial, at least by the end of the inquest, that there were two bath robe (or towel) hooks [hooks] behind Ms TK's bathroom door, located next to each other without a gap in between them, a few centimetres on the inside of the bathroom door, a few centimetres from the top of the door.[115] At the time, the hooks were commonly used in inpatient psychiatric facilities throughout the state, and were designed to collapse downwards under the force of excess weight so as to foil any attempt to use them as hanging or suspension points.[116]

84. The Nurse Unit Manager of the Orygen Inpatient Unit at the time was Catherine MacLennan [NUM MacLennan] who had instructed staff to leave the room as it was and to lock it overnight.[117] She did so in response to information about Ms TK's attempted hanging from RPN Hayward and others who had been on duty overnight.

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[114] As regards the door, it was something of a saloon bar design without the ability to swing in both direction - see photos at pages 109-110 of the coronial brief Exhibit AA and transcript pages 217-218. The bathroom doors in the inpatient unit had been modified in this way in 2008 to prevent someone securing a ligature by jamming it between the top of the door and the door frame if they were a (normal) tight fit. See Exhibit BB, statement of RPN/CNE Carolyn Lavery at paragraph 6. As regards the sheet, at transcript page 221, RPN Porter reiterated that he 'didn't recall it being twisted, tied or knotted or ripped, he just remembered it being a plain sheet, kind of unremarkable really'. See also transcript page 233.

[115] Exhibit N (second) statement of NUM MacLennan dated May 2012, transcript page 304, 361 and photos at page 111 of the coronial brief Exhibit AA.

[116] Exhibit R statement dated 25 May 2012 from Consultant Psychiatrist Dr Peter Burnett, Acting Executive Director/Director of Clinical Governance, Melbourne Health. Dr Burnett described the hooks in the following terms – *"6…These hooks are purpose built and designed to collapse if subjected to a weight of more than 5 kg. The hooks were manufactured by a United States company Acorn Engineering, specifically for use in institutions where there is a risk of suicide, and have been widely used in psychiatric units throughout Victoria, as well as in penal institutions. 7. In this case, the force would have been applied in the reverse direction, as the ligature went up and over the door. Further there were two hooks mounted side by side. Attempts by staff to replicate the hypothesised method did not identify a reliable means of securing a ligature to the hooks, but it was hypothesised that the presence of the two hooks together may have enabled it to occur."* NUM MacLennan's evidence differed as she expected the hooks wouldn't bear the weight of a person and had a yield weight of 15 to 30 kg according to her understanding – see transcript page 277, 326. See also Exhibit BB, statement of CNE Lavery and her evidence at transcript pages 515 and following.

[117] Transcript page 224-225, 323-324.

85. Later the same morning, at around 8.30am on 24 August 2009, in an effort to understand how Ms TK had managed to hang herself, RPN Porter and NUM MacLennan entered Ms TK's room and attempted a reconstruction or re-enactment of sorts.[118]

86. Despite some initial confusion in his evidence at inquest, it was ultimately clear that RPN Porter felt, as a result of the reconstruction, that it was possible that a bed sheet could be jammed between the opening side of the bathroom door and the door jamb in such a way as to form a ligature and hold *some* weight.[119] At the time, he didn't consider the robe hook or its housing as potential ligature or suspension point as he understood that the hook was a *safety latch/hook.* At inquest, having considered the possibility more recently, he allowed of the possibility that the hook and/or its housing could be used as hanging or suspension points but with some difficulty.[120]

87. NUM MacLennan's evidence about the reconstruction was *broadly* similar with RPN Porter's but there were material discrepancies between them. NUM MacLennan testified that she went into the room specifically to ascertain how Ms TK managed to hang herself as it was not clear to her, despite several discussions with staff including RPN Hayward.[121]

88. The first thing NUM MacLennan noticed was the sheet which slipped to the floor as soon as she touched it gently, without giving any clue as to how it may have been attached, so she was specifically looking for something else that may have been used as a ligature.[122] Contrary to RPN Porter, NUM MacLennan maintained that the two shorter ends of the sheet were tied together in a knot, but one that could be easily untied,[123] turning the sheet into an envelope

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[118] Transcript pages 219 and following, 325. NUM MacLennan's evidence was that she examined the bathroom door on several occasions with several different staff – transcript page 327.

[119] Transcript pages 221 *"it could carry some weight"*, page 227 *"I can't clearly recall the exact details but … that was my impression that maybe it could have been used because if the door's closed and it's got some weight hanging, pushing, then it may keep the door locked and keep it jammed",* page 230-231 *"How hard did you pull down on your hand?---Reasonably hard but with my weight, like it slipped…I remember that it got a bit of traction, that's all I recall…Is it fair to say that all you can really tell Her Honour is that when you pulled at it there was resistance?---There was resistance…It did give way because I put weight on it, like a fair bit of weight*

[120] Transcript page 220. It was not until recently, 'in the week or so before he testified, that he became aware that the bath robe hooks might be the mechanism by which the sheet was kind of held' – my paraphrase of his evidence at transcript page 223. See also transcript pages 235-236 *"…my assumption was that the hooks were safety hooks and that there were there to prevent people, you know , as being a hanging point…So do you want to make any further comment about that now that you've turned your mind to that possibility?---Yeah. No, definitely. Like now I think that it'd be difficult but I think there's still a possibility."*

[121] Transcript pages 296-7.

[122] Transcript page 298-300, 326.

[123] Transcript pages 299-301.

shape that fitted snugly over the bathroom door.[124] NUM MacLennan considered the possibility that the sheet was knotted and anchored around the bathroom door in some way.[125]

89. At inquest, NUM MacLennan testified that having directed staff to lock Ms TK's room overnight so as to preserve the scene as far as possible, and having gone there the following morning with the aim of determining how Ms TK had attempted to hang herself, she saw nothing else in the room that might have been used as a ligature. While she professed no expertise with ligatures, she testified that she would have certainly recognised cords and laces as fairly obvious possibilities and so was looking for those things.[126]

90. NUM MacLennan could not recall what she thought about the hooks on that first morning. Ultimately, although she could not conclude with any confidence that the hooks were implicated as a hanging or suspension point, she could not exclude possibility and was sufficiently concerned that she determined they should be removed and set in train a process for their removal. As a result, all such hooks were removed from the inpatient unit about two weeks after the incident which led to Ms TK's death.[127]

91. Two other aspects of NUM MacLennan's evidence are noteworthy. The first involves her own observation of the sheet which she handled during the reconstruction and found to be really light in texture, not at all like a starchy hospital sheet and with a soft 'cottony' texture. Having heard RPN Hayward's evidence prior to giving evidence herself, NUM MacLennan felt that his description of the ligature/fabric resonated with her experience of the sheet.

92. This evidence is problematic, however, as it is apparent from the transcript that RPN Hayward was talking about *a thin piece of fabric*, something akin to a more traditional notion of a ligature, rather than a fabric that was *thin, light or soft in texture* or weave.[128]

93. The second aspect of NUM MacLennan's evidence of note, is her concession in cross-examination by Mr Harper, for the family, that the hooks were the most likely hanging or suspension point utilised by Ms TK. When cross-examined by Mr Murdoch, for Melbourne Health/Orygen, NUM MacLennan explained that her agreement with this hypothesis was

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[124] Transcript pages 339 and following, 362-363.

[125] Transcript page 327.

[126] Transcript pages 297-300.

[127] Transcript page 329. Also at transcript pages 343-344 where NUM McLennan testifies that the addition or removal of any fixtures or fittings in the inpatient unit involves a process of consultation and consideration.

[128] See paragraphs 75 and 76 above and NUM McLennan's evidence at pages 365 and following.

informed (at least in part, if not entirely) by her knowledge that Ms TK's friend (a co-patient whose identity has been suppressed) had explained the method to her.[129]

94. During the course of the investigation, the coronial investigator Senior Constable Colin Wagner re-attended the inpatient unit at my request, to ascertain among other things, how Ms TK was able to secure a ligature.[130] The hooks had been removed by this time and SC Wagner's evidence was that he was specifically looking for a hanging or suspension point and could not find one. In cross-examination, SC Wagner testified that 'having heard all the evidence, he definitely thought that the hooks did play a role'.[131]

SAFETY OF THE PHYSICAL ENVIRONMENT – INTERNAL PROCESSES @ ORYGEN

95. At the material time, in addition to making a progress note in the relevant patient file (where appropriate), any concerns about the safety of the physical environment held by staff were to be reported verbally to their immediate supervisor as soon as possible, particularly if they involved an immediate risk. In all likelihood, the verbal report would prompt the supervisor to direct the staff member to complete a RiskMan report in relation to the incident or risk perceived.[132]

96. Short for Risk Manager, this involved completion of a computer generated report with multiple drop down options that could take 20-30 minutes to complete. Staff would need prompting to complete RiskMan reports due to the other demands on their time. The value of the RiskMan report lay not only in the written record it provided, but in the in-built online report sent via the system to all relevant managers and other relevant staff thereby minimising the risk that the report would not be actioned. Apart from a verbal report and completion of a RiskMan report, staff could raise any safety concerns that were not urgent, in the weekly business meeting or at Occupational Health and Safety Meetings.[133]

97. In addition to these processes, specific ligature audits were undertaken annually in the inpatient unit, or thereabouts, using a screening tool designed for this purpose. At inquest,

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[129] Transcript page339, 368 and paragraph XX below. For the purposes of this inquest, "hooks" included the housing on which the hooks were mounted, even if the distinction is not always drawn in the transcript – see transcript page 329 for example.

[130] Exhibit Y, statement of Senior Constable Colin Wagner dated 29 November 2011. His first inspection of the room previously occupied by Ms TK was around the time of her death, this second inspection on 11 November 2011 was facilitated by NUM MacLennan who accompanied SC Wagner.

[131] Transcript page 489.

[132] See footnote 131 below.

[133] See the evidence of NUM McLennan transcript page 331 and following, 352, 360

NUM MacLennan produced the ligature audit documents for 2007 and 2010 and testified that her inability to source audit documents for 2008 and 2009 suggested to her that ligature audits had not been undertaken for those years.[134] It was conceded that the ligature audit for 2007 had failed to identify the hooks/housing as potential ligature points.

98. NUM MacLennan gave evidence that some improvements had been made in this regard within the Orygen inpatient unit with ligature audits undertaken at least annually, and more regularly, if there had been any significant infrastructure change. However, she was not entirely satisfied with the current ligature audit tool even though a deal of research had gone into investigating ligature risk or audit tools and felt there was room for further improvement.[135]

99. There are two aspects of the evidence that invite consideration of the adequacy of internal processes at Orygen for assessing the safety of the physical environment in the inpatient unit and compliance with those processes. The first arises from the evidence of A/g ANUM Pare regarding previous and ongoing complaints made by him about the hooks and, more specifically, the housing as being potential hanging or suspension points. The second involves a co-patient and friend of Ms TK's whose identity has been suppressed and who I will refer to hereafter as CL.

100. In the course of testifying, A/g NUM Pare gave evidence that he had raised concerns about the safety of the hooks/housing, on his first day at work in the inpatient unit, while being shown around. This was in October 2008, well before Ms TK's attempted hanging and even before the incident involving CL in June 2009. Based on his experience in mental health institutions over the years, he felt that although the hooks proper were collapsible, the housing protruded from the wall/door and could anchor a ligature.[136]

101. A/g NUM Pare did not remember contemplating the particular risk posed by the placement of the hooks on bathroom doors that had been cut down in the way that they were, but was always concerned that they were dangerous.[137] He specifically recalled raising his concerns about the hooks with RPN Lavery, the Clinical Nurse Educator, who was showing him around

[134] Exhibit P, transcript page 318.

[135] Transcript pages 318 and following.

[136] Transcript pages 192, 199, 206

[137] Transcript page 201. In cross-examination by Mr Murdoch, A/g NUM Pare clarified that it was

on his first day [CNE Lavery],[138] and thereafter "continuously"[139] with others including NUM MacLennan and A/g NUM Asothie Pillay.[140]

102. A/g NUM Pare conceded that he did not complete a RiskMan report about the hooks being a risk to patient safety, but that he was aware that it was an option that was available to him. His explanation for the failure to do so was that he chose to talk to senior staff and try to resolve the matter that way. Nor did he raise the issue in any other formal meeting or forum.[141]

103. RPN Hayward testified that he specifically remembered A/g NUM Pare telling him about his concerns about the housing and that he (that is A/g NUM Pare) said he had mentioned it to NUM MacLennan.[142] This occurred during a nightshift some time before Ms TK's attempted hanging. I note that RPN Hayward's evidence was that he did not know about the incident involving CL.[143]

104. At inquest, Carolyn Lavery, a Registered Psychiatric Nurse and Clinical Nurse Educator at the inpatient unit at the time [CNE Lavery] denied having a conversation with A/g NUM Pare or anyone else about the hook housing being a potential hanging or suspension point. This was a stronger denial than in her statement which was couched in terms of an 'inability to recall'.[144] She also testified that in her role as Clinical Nurse Educator, she would provide orientation to all new staff, including showing them around the inpatient unit, and that it was common for

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[138] Transcript page 199, 202.

[139] Transcript page 203.

[140] Transcript page 208, 210.

[141] Transcript page 201.

[142] Transcript page 251 *"Q: Did you have any concerns of your own about the hooks that were on the doors - - - ? - - - I didn't myself but I do recall hearing Kevin concerns at the time, and another staff member had mentioned their concerns as well. Q: Who was that? - - - I don't recall who that was, but I specifically remember Kevin saying on a nightshift - - -Q: Yes? - - - About his concerns about that, and he had mentioned to Cathy. And another staff member had mentioned that they didn't think it was safe as well, but I don't know how – how far that went, and whether it was - - - The Coroner: When you say "At the time" though Mr Hayward what are you referring to, when you said "I remember Kevin saying at the time", which time? - - - I remember on a nightshift Kevin voicing his concern about the – the mechanism. Even though the – the switch goes down with weight it was more the – the bulkiness it was his concern. And I heard – there was another – a nurse at another time had mentioned that specific concern as well - - -So on a nightshift not related to Ms TK's death just on another nightshift before, or after - - - ? - - -No, it was some time beforehand way before the incident - - - "* It is not entirely clear to me whether another staff member told RPN Hayward about the same concerns about the housing or whether A/g NUM Pare told him that another staff member shared his concerns.

[143] Transcript page 252.

[144] Transcript page 511 cf. Exhibit BB, her statement dated 22 June 2012.

new staff to raise concerns that the hooks were a potential hanging or suspension point until it was demonstrated to them that they would collapse under weight.

105. It was apparent that CNE Lavery was speaking about the hooks proper and not the housing surrounding them, which was the subject of A/g NUM Pare's concerns.[145] Significantly, she was unaware of the information sheet suggesting that the hooks/housing were designed to be mounted on a wall (rather than a door).[146] CNE Lavery also testified that the hooks were considered gold-standard anti-ligature hooks and are widely used in psychiatric facilities in Victoria.[147] Together with NUM MacLennan, CNE Lavery was involved in the decision to remove the hooks following Ms TK's death, as they were potentially implicated and not vital to the utility or amenity of the room.[148]

106. NUM MacLennan testified that she had no recollection of A/g NUM Pare or any other staff member raising concerns with her about the hooks or housing as a potential ligature point.[149] Her evidence at inquest was that had such concerns been brought to her attention she would likely have undertaken the same process of investigation as she did immediately following Ms TK's attempted hanging, and would likely have reached the conclusion that they were a potential ligature point and should be removed.[150]

107. NUM MacLennan was cross-examined about a possible breakdown in communication between A/g NUM Pare and A/g NUM Pillay and herself in relation to this issue, describing it as "curious" that it was not reported to the relevant manager and noting that there were "other avenues" for raising concerns such as the weekly business meeting where these concerns had not been flagged as an issue.[151]

108. A/g NUM Pillay was the third person identified by A/g NUM Pare as someone to whom he had expressed his concerns about the potential use of the hooks/housing as a ligature point.

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[145] Transcript pages 512, 515.

[146] Transcript pages 512-513. The information sheet apparently accompanying the hooks when supplied appears at pages 105-106 of the coronial brief, Exhibit AA.

[147] Transcript page 514 and following. I note that as at the date of the inquest CNE Lavery was employed at Peninsula Health and recommended removal of the same hooks from a new purpose built facility just opened in June because she viewed them as a potential ligature point and they were not vital to the utility of the room.

[148] Transcript page 514 and Exhibit BB.

[149] Exhibit N in which it is apparent that NUM McLennan is addressing the hooks proper/the collapsible part and not the housing and transcript pages 304-305 where she addresses both the hooks proper and the housing and concedes their potential as a ligature point.

[150] Transcript pages 328-330.

[151] Transcript page 332.

A/g NUM Pillay could not recall such a conversation with A/g NUM Pare and, in support of NUM MacLennan and CNE Lavery, testified that they were both very experienced and very responsible and capable people who she would expect to have acted if they had been told of these concerns.[152]

109. The second significant body of evidence giving rise to a consideration of processes for assessing the safety of the physical environment arises from the evidence that Ms TK's friend, patient CL, made disclosures to staff about a hanging attempt when she was in the inpatient unit.

110. The disclosures were made on 5 June 2009, at first instance to Rebecca Creek, CL's Outpatient Case Manager, following a family meeting involving herself, Dr McKeown, RPN Melissa Urie [RPN Urie], CL and CL's father. Ms Creek documented the disclosure in the inpatient progress notes and discussed the disclosure with RPN Urie.[153] Ms Creek's evidence is that she had limited understanding of what CL had actually done, for example it was not clear how CL had been able to attach a ligature capable of bearing her weight and she could not say if CL disclosed using the hook or hooks but was confident that CL had referred to the bathroom door itself.

111. As her main concern was CL's immediate safety, she passed the information on to inpatient nursing staff caring for her at the time, and to the psychiatric registrar later that day.[154] Ms Creek did not see it as her responsibility to complete a RiskMan report in relation to the disclosures, but would have done so as CL's OCM if the disclosures had been made when she was in the community.[155]

112. RPN Urie agreed that Ms Creek passed on information about CL's disclosure to her on 5 June 2009. As a result, RPN Urie spoke to CL about what happened and CL took her to her bathroom and demonstrated how she had placed a leather bag strap around the hook on the

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[152] Transcript pages 471-473.

[153] Exhibit G is an excerpt from the inpatient progress notes of patient CL. In a noted dated 5 June 2009, Ms Creek wrote – "*CL seen alone following family meeting. CL disclosed during barricading self in her room last night CL made attempt to hang self with bag strap in bathroom. Reports having tested strap – which held … weight. Reports stopping going through as security attended. Reports having given strap to nurse afterwards but did not disclose hanging attempt. Discussed with shift leader – Mel."* Also referred to in full in Exhibit S, statement of Ms Rebecca Creek dated May 2012. Ms Creek was a Social Worker employed by Orygen since March 2003. She was working as a Case Manager in the HYPE (Helping Young People Early) clinic and had been CL's Case Manager well before June 2009.

[154] Exhibit S and transcript pages 424 and following. I note that in response to this disclosure, CL's risk assessment was revised and upgraded.

[155] Transcript page 426.

back of her bathroom door and thrown the strap over the top of the door. The demonstration was undertaken without a bag strap using hand gestures. As far as RPN Urie gleaned, CL had managed to get sufficient grip with the strap wrapped around the "straight part of the hook", or the hook proper as I have referred to it as, and then pulled upwards.[156]

113. Ms Urie was sufficiently concerned about what CL had shown her to go straight to the office located within but to the rear of the nurses' station to appraise her superiors – A/g NUM Pillay, RPN Julie Blackburn, a senior nurse, and a Consultant Psychiatrist whose identity she could not recall. She told them what CL had shown her and suggested they go to an unoccupied room so she could demonstrate. A/g NUM Pillay and RPN Blackburn accompanied her and she demonstrated what she had been shown by CL. She was unsure if the Consultant Psychiatrist accompanied them. RPN Urie recalled that both nurses were concerned by what she was saying and then she left to attend to other work duties.[157]

114. RPN Urie could not recall what was said between A/g NUM Pillay and herself about completion of a RiskMan report. She 'vaguely remembered a discussion with Ms Creek about it but couldn't be 100% sure' about whether Ms Creek said she would make the report. As far as her reporting, RPN Urie left it with A/g NUM Pillay on the understanding that a RiskMan report would be completed. However, RPN Urie did make a note in CL's progress notes, discussed CL's risk assessment with an unidentified Consultant Psychiatrist and handed over this new information about CL to the incoming afternoon shift nursing staff.[158]

115. In cross-examination, RPN Blackburn agreed that in telling A/g NUM Pillay, RPN Urie had fulfilled her obligations of reporting her concerns to the nurse unit manager. As to who should compete a RiskMan report, RPN Blackburn was of the view that it should have been done, either by the person who reported the matter or the person who received the report, and that who would complete the RiskMan report should have been sorted out between them explicitly.[159]

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[156] Exhibit U, statement of RPN Urie dated 2012 with attachment and transcript pages 439-441. At transcript page 439, RPN adds that CL did not describe the leather strap to her in detail but she said it was actually a wide strap.

[157] Exhibit U and page 443.

[158] Exhibit U and transcript pages 446-448. See also Exhibit G where there is a note dated 5 June 2009 from Psychiatric Registrar O'Brien indicating that he/she had handed over information about the attempted hanging and other matters to Dr McKeown, and a note from the latter indicating recognition that CL was at increased risk, that nursing staff were completing a request [for recommendation as an involuntary patient] and that she discussed with CL the need for her placement in the intensive care area/high dependency unit.

[159] Transcript page 454, 460.

CONCLUSIONS

116. The standard of proof for coronial findings of fact is the civil standard of proof, on the balance of probabilities, with the *Briginshaw* gloss or explication.[160] The effect of the authorities is that Coroners should not make adverse findings against or adverse comments about individuals or institutions, unless the evidence provides a comfortable level of satisfaction that they materially departed from the standards of their profession and in so doing, caused or contributed to the death.

117. The assessment of the risk of self-harm and suicide is as complex and difficult as it is crucial to the welfare of patients with mental illness. Risk assessment is a core competency for all those healthcare professionals involved in the clinical management and care of the mentally ill, in both outpatient and inpatient settings.

118. In terms of the circumstances in which Ms TK died, the clinical management and care provided to her and the safety of the physical environment, both need to be assessed against what was known, or should reasonably have been known at the material time, that is during her third and last admission, in particular when Orygen staff were caring for her overnight on 23-24 August 2009.

119. In the course of submissions, Counsel took me to a number of authorities that elucidate the appropriate standard of proof that I should apply to the evidence so as to make my findings as to how Ms TK had attempted to hang herself, and specifically whether I could be satisfied as to the ligature and the hanging or suspension point utilised.[161]

120. On behalf of the family, Mr Harper relied on the Victorian Court of Appeal decision in *Transport Industries Insurance Co. Ltd. v Longmuir* [1996] VR 125[162] as to the standard of

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[160] *Briginshaw v Briginshaw (1938) 60 C.L.R. 336 esp at 362-363.* "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…"

[161] Transcript pages 519 and following.

[162] At page 141 Tadgell, JA quotes with approval from the unreported High Court decision in *Bradshaw v McEwans Pty Ltd (27 April 1951) – "Of course as far as logical consistency goes many hypotheses may be put which the evidence does not exclude positively. But this is a civil and not a criminal case/. We are concerned with probabilities, not with possibilities. The difference between the criminal standard of proof in its application to circumstantial evidence and the civil is that in the former the facts must be such as to exclude reasonably hypotheses consistent with innocence, while in the latter you need only circumstances raising a more probably inference in favour of that is alleged. In questions of this sort, where direct proof is not available, it is enough if the circumstances appearing in evidence give rise to a reasonable and definite inference: they must do more than give rise to conflicting inferences of equal degrees of probability so that the choice between them is mere matter of conjecture…But if circumstances are provided in which*

proof from inferences where no direct evidence of a fact is available, in a civil context. He also relied on Justice Crennan's dissenting judgement in the High Court decision in *Lithgow City Council v Jackson* (2011) 244 CLR 352[163]which quotes from earlier decisions to the effect that a more probable inference is one that on a balance of probabilities might reasonably be considered to have some greater degree of likelihood than another.

121. Mr Murdoch also addressed the issue of the standard of proof and the approach I should take to making factual findings about the ligature and hanging or suspension point utilised by Ms TK. He referred me to the New South Wales Court of Appeal decision in *Guest v The Nominal Defendant [2006] NSWCA 77* and to another decision quoted therein.[164] Mr Murdoch described both as cases involving accidents in circumstances which were difficult to explain. In both cases, the party bearing the onus of proof sought to establish a civil claim by demonstrating that other possible hypotheses were unlikely, leaving only one hypothesis which the plaintiff asserted was *more likely.*[165] I find this authority of limited use and distinguishable. This is not a case of choosing between improbable alternative hypotheses, or feeling bound to accept a single hypothesis which I believe to be extremely improbable or even virtually impossible.

122. In the first place, the occurrence of the incident is unarguable, that is that Ms TK attempted to hang herself and in so doing caused the hypoxic brain injury to which she finally succumbed. Moreover, the attempt occurred within a short window of opportunity of around 15 minutes, in a confined space with finite available means, both as to ligature and hanging or suspension point. Ms TK was found suspended against the middle of the bathroom door, with a ligature holding her up by the neck. The ligature left a thin mark. A number of witnesses investigated the scene with the specific focus of ascertaining how the attempt had been made. The only ligature identified was a bed sheet, although other potential ligatures could have been overlooked or misplaced in the course of resuscitation. The only plausible hanging or suspension point identified in the course of the investigation were the hooks/housing. As

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it is reasonable to find a balance of probabilities in favour of the conclusion sought then, though the conclusion may fall short of certainty, it is not to be regarded as mere conjecture or surmise…"

[163] Although this was the dissenting judgement, the case involved the construction of various provisions of the *Evidence Act 1995 (NSW)* and Justice Crennan is stating propositions that are not at odds with the majority judgement/s. At page 386 – *"Whilst a "more probable inference" may fall short of certainty, it must be more than an inference of equal degree of probability with other inferences, so as to avoid guess or conjecture. In establishing an inference of a greater degree of likelihood, it is only necessary to demonstrate that a competing inference is less likely, not that it is inherently improbable."*

[164] *Rhesa Shipping Co SA v Edmunds ("The Popi") [1985] 1 WLR 948.*

[165] Transcript page 541.

installed and as a function of their sheer bulk and strength, and the laws of physics, both the hook and/or the housing could serve as a suspension point/s.

123. It is clear from the evidence and conceded during submissions that the bed sheet and the hooks/housing were possibly implicated. It is my assessment that the available evidence goes further than mere possibility and supports a finding on the balance of probabilities that the hooks/housing were used as a hanging or suspension point. The same cannot be said of the ligature which may have been the bed sheet or may have been another thin fabric that was overlooked or misplaced during resuscitation.

124. Having applied the applicable standard of proof to the available evidence, I find that:

- The overall clinical management and care provided to Ms TK by the staff of Orygen Youth Health and/or Melbourne Health from early April to 31 August 2009 was reasonable and appropriate.
- In particular, the rapport and therapeutic relationship between Ms TK and Ms Grant was of a high order and Ms Grant's liaison with the inpatient team during Ms TK's admission was timely and appropriate, well-documented in the medical records and enhanced her clinical management and care.
- Dr Phelan's decision to wean Ms TK off fluoxetine and introduce venlafaxine, initially after a two-week wash-out period (later changed to a one-week wash-out period) was reasonable and appropriate.
- The decision to continue with this plan taking opportunistic advantage of Ms TK's involuntary admission to the Orygen inpatient unit was sensible and enhanced safety.
- Dr McKeown's decision on 21 August 2009, to change Ms TK's status under the MHA from involuntary to voluntary, was within a range of reasonable clinical responses to Ms TK's presentation at that time.
- In any event, that change of status is not causally relevant to death, as Ms TK returned to the inpatient unit on the afternoon of 23 August 2009, as agreed, albeit a little earlier than expected, and attempted to take her own life in the inpatient unit and not while she was at large.
- After her return to the inpatient unit, on the afternoon of Sunday 23 August 2009, the observation regime requiring 15 minutely observation of Ms TK was commensurate

with her risk at the time in light of her overall presentation and despite her self-report that leave had not gone well.

- Ms TK was chronically or intermittently at risk of deliberate self-harm and suicide, and there was nothing in her clinical presentation to alert those caring for her that she was at increased acute risk overnight on 23-24 August 2009.
- The hooks/housing, as installed behind the modified bathroom doors, were the probable (and only feasible), hanging or suspension point utilised by Ms TK.
- Ms TK utilised a thin fabric ligature, the precise provenance of which remains undetermined, but could possibly have been a bed sheet, the hemmed edge of a bed sheet or another thin piece of fabric.
- While it is likely that the hooks/housing would have been safe enough if installed on a wall, as implied in the relevant information leaflet - a matter strictly irrelevant to this investigation - as installed on the modified bathroom doors, they posed an unacceptable risk as a hanging or suspension point and were therefore inappropriate for use in an inpatient psychiatric facility.
- To the extent that they failed to identify the unacceptable risk posed by the hooks and/or housing, there was a failure of internal processes at the Orygen inpatient unit for ensuring the safety of the physical environment.
- In the face of contradictory evidence from others and in the absence of a RiskMan or other documented report, I am not prepared to find that A/g NUM Pare effectively communicated his professed concerns about the hook/housing to those senior staff members who could do something about the risk they posed as a hanging or suspension point.
- RPN Urie's report and demonstration to A/g NUM Pillay was an adequate discharge of her obligation to report the risk for all patients inherent in the disclosures made by CL about her recent attempted hanging using the hooks/housing and something as ubiquitous as a handbag strap.
- A RiskMan report should have been completed in relation to the information that CL disclosed as it pertained not only to her own risk in the inpatient unit, but to the safety of all other patients.

- A/g NUM Pillay should have either directed RPN Urie to complete a RiskMan report of the disclosures made by CL, or completed one herself. This would have been the best way to ensure that important information about risk in the inpatient unit was not lost. Information that, if actioned appropriately, would likely have led to the removal of the hooks/housing prior to Ms TK's attempted hanging.
- Ms TK intentionally took her own life by hanging.

COMMENTS

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

1. During the course of this investigation, I was advised that a number of improvements had been made at Orygen Youth Health/Melbourne Health that arose directly or indirectly from the circumstances surrounding Ms TK's death. They are, briefly, as follows –
    a. The hooks/housing were removed as they were recognised as being a potential hanging or suspension point and their utility was not vital or could be replaced by safer means.
    b. The ASCOM personal alarm system used by RPN Hayward, inter alia, was upgraded so that the location of the person utilising the alarm is more readily ascertainable, minimising the need to leave the patient to summon help and staff have been retrained in the use and capabilities of the alarms.
    c. Patients' bedroom doors have been altered so that they open both inwards and outwards preventing a patient from barricading themselves in their room.
    d. A new ligature audit tool has been endorsed and implemented which is considered more suitable for a psychiatric setting. The tool requires more and different people to be involved in the audit, including one external to the workplace.[166]
2. Orygen Youth Health/Melbourne Health are to be commended for these improvements, all of which carry the potential to improve safety for patients in the inpatient unit.

[166] Set out in Exhibit N, NUM MacLennan's second statement.

3. The value of the RiskMan risk management system lies, not only in documenting perceived areas of risk, but in ensuring that the relevant people in an organisation are appraised so as to minimise the risk that risk that information is lost or not actioned.

RECOMMENDATIONS

Pursuant to section 72(3) of the Coroners Act 2008, I make the following recommendations/s connected with the death:

1. In furtherance of the Chief Psychiatrist's responsibility for the safety of patients in the public mental health system, I recommend that the Chief Psychiatrist considers mandating the removal of the particular hook/housing used in the Orygen inpatient unit, particularly from doors or any other placement where they can be utilised as a hanging or suspension point.
2. For the purposes of recommendation 1 above, as the Chief Psychiatrist was not a party to the inquest and by way of assistance, a copy of this finding will be provided to him together with photographs of the hooks/housing and a copy of pages 105-106 of the coronial brief which is an information sheet from the manufacturer.
3. I recommend that Orygen Youth Health/Melbourne health develop a procedure that addresses the need for scene preservation and/or recording, in circumstances where a serious suicide attempt has taken place in an inpatient facility, in anticipation of a foreseeable coronial investigation. Such a procedure could also assist the health service to undertake its own internal review or root cause analysis (whether mandated or otherwise) and to comply, more broadly, with their duty of care obligations.
4. I further recommend that such a procedure identify roles and responsibilities as clearly as possible, in particular as regards the completion of RiskMan report of the incident or any other tool or software being used from time to time in the health service to manage risk.
5. For the purposes of recommendation 3 above, and for the information and assistance of the health service, I have invited the Chief Commissioner of Police through Civil Litigation to develop a guideline to assist health services in this regard. Pending development and promulgation of such a guideline by the Chief Commissioner, the health service can contact the court for further information.

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

The TK Family c/o Maurice Blackburn Lawyers

Orygen Youth Health/Melbourne Health c/o DLA Piper

Clinical Director, Western Hospital c/o Corporate Counsel, Western Health

Ms Melissa Urie c/o Middletons Lawyers

The Chief Psychiatrist

The Chief Commissioner of Police c/o Inspector Senior Sergeant Nolan, Civil Litigation

Senior Constable David Wagner c/o O.I.C. Footscray Police

Senior Sergeant Jenette Brumby c/o Police Coronial Support Unit

Signature:

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PARESA ANTONIADIS SPANOS

Coroner

Date: 3 March 2016