**FORM 37**

Rule 60(1)

**FINDING INTO DEATH WITH INQUEST**

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

**Court reference:** 2384/10

**Inquest into the Death of AMANDA BILLIE JO KENNEDY**

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| Delivered On: | 14th October 2011 |
| Delivered At: | Coroners Court of Victoria<br>Level 11, 222 Exhibition Street<br>Melbourne Victoria 3000 |
| Hearing Dates: | 10th October 2011 |
| Findings of: | DEPUTY STATE CORONER IAIN TRELOAR WEST |
| Place of death: | Northern Hospital |
| Police Coronial Support Unit : | Sergeant Dave Dimsey |
| Representation: | Ms Janine Gleeson, Northwestern Mental Health |

**FORM 37**

Rule 60(1)

**FINDING INTO DEATH WITH INQUEST**

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

**Court reference:** 2384/10

In the Coroners Court of Victoria at Melbourne
I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

**Details of deceased:**

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|---|---|
| Surname: | KENNEDY |
| First name: | AMANDA |
| Address: | 18 Arndell Street, Thomastown |

AND having held an inquest in relation to this death on 10th October, 2011
at Melbourne

find that the identity of the deceased was AMANDA BILLIE JO KENNEDY
and death occurred on 24 June 2010

at Northern Hospital, 185 Cooper Street, Epping, Victoria 3076

from
1a. COMPRESSION OF THE NECK CONSEQUENT UPON HANGING

**In the following circumstances:**

1. Amanda Kennedy, aged 26 years, was of female gender and engaged in home duties at the time of her death, residing with her de facto partner and four children in supported accommodation at 18 Arndell Street, Thomastown. At the time of her death her children were aged 12, 9, 7 and 5 years. Her de facto relationship, which had commenced in 1998, had been unstable over many years, with police having to be called on several occasions to domestic disputes, culminating in Intervention Orders being imposed between the parties on a number of occasions. Ms Kennedy had a traumatic childhood and adolescence, marred by parental alcohol abuse and violence, family breakdown and alleged sexual abuse. As a result of the home environment, Ms Kennedy left the family home in Queensland when she had completed Year 7 of high school and moved to Victoria. She had a history of illicit drug abuse, using cannabis daily from the age of 11 years and daily intravenous amphetamine use, from 15 years of age. In addition she had a history of heroin use and throughout her life, she had gone through stages of depression, culminating in multiple suicide attempts and numerous threats of suicide. At the time of her death she was subject to a Community Based Order which had been imposed on the 16th

February 2010, at the Broadmeadows Magistrates' Court and with the Order being due to expire on the 15th November 2010. In the period leading up to her death, Ms Kennedy was engaged with a number of agencies, including the Community Correctional Services, the Aboriginal Family Counselling Service, the Merri Outreach Support Service, Kildonan Family Services, Moreland Hall, the Centre Against Sexual Assault, Child First and the Community Offenders Advice and Treatment Service.

2. In the period preceding her death, Ms Kennedy's last contact with Community Correctional Services was a supervision appointment on the 15th June 2010, during the course of which she spoke of housing difficulties which she believed were causing her health issues. She advised that the anti-depressant medication that she was taking was having an effect, however, she reported her intention to attend her general practitioner in order to arrange a referral to a female psychologist. Her next scheduled supervision appointment was for the 22nd June 2010. On the 18th June 2010 at approximately 1.00pm, Ms Kennedy attended in company with her cousin, the Emergency Department of the Northern Hospital. She was seen by the triage nurse at 1.00pm and was in a distressed state, crying and banging on the window and speaking of multiple social issue problems confronting her. She was assessed as hypermanic and given a 2 triage classification. When subsequently called for assessment, Ms Kennedy was not in the waiting room and a call to next of kin, was unanswered. There was no further follow-up.

3. On the 21st June 2010, shortly before 6.00pm, Ms Kennedy attended the Epping Police Station, appearing very distressed, crying and shaking. She stated that she needed to be locked up because she had lied and then further stated, that she had accused her step-father of raping her and that he then killed himself. She was asked to take a seat whilst some enquiries were made, however, shortly afterwards she hurriedly exited the police foyer area, moving off in the direction of High Street. Three or four minutes later Ms Kennedy returned into the foyer of the Police station and on approaching the counter in a distressed state she said, *"I have just walked in front of a truck on the road, it just missed me"*. Ms Kennedy was taken into custody and placed in an interview room where she was observed whilst police notified the Northern Crisis Assessment Treatment Team (CAT team) of her custody status. The CAT team advised that there were no psychiatric assessors available to assess her at the police station until 8.00am. Whilst these enquiries were being made Ms Kennedy was observed to remove an item of clothing from her body and wrap the clothing around her neck in an attempt to strangle herself. The item was removed by a Constable in attendance and she was continued to be closely monitored in the custody area. An ambulance was requested to convey Ms Kennedy to the Northern Hospital for a psychiatric assessment. Whilst awaiting ambulance attendance Ms Kennedy was observed to remove all her clothing. She was still in an agitated state and attending police assisted her in replacing her clothing and calming her down. She commenced hitting her head against the wall repeatedly, uttering words that were indecipherable, crying and rocking back and forth, with police members endeavouring to calm her. A short time later she was again observed removing her clothing to the point where she was naked and again police attended to assist in replacing her

clothing and calming her down. Ambulance paramedics subsequently attended and conveyed Ms Kennedy to the Northern Hospital for psychiatric assessment.

4. Ms Kennedy's attendance at the Emergency Department of the Northern Hospital was pursuant to a Section 10 placement under the *Mental Health Act*. The ambulance notes describe her as being agitated and distressed, crying and stating that her children did not need her and that she missed her mother, who had died eight months earlier. Again her behaviour was inappropriate, in that she took her clothes off and she reported that she was hearing voices telling her that she was a dog and not worth anything. She further stated that she wished to be shot by police.

5. At approximately 8.00am, Ms Kennedy was assessed by a CAT team clinician, Ms Sharon Lont, during which time a history of drug abuse, poor sleep and appetite, and self harming conduct was taken. Throughout the assessment Ms Kennedy repeatedly stated that she wished to die and had plans to jump in front of a train, or truck. She stated that she had informed her partner that she had been unfaithful in the past and she repeatedly expressed concern for the welfare of her children. Risk assessment undertaken by Dr Henry Guo identified her as "low" risk and for general observation (contact nurse to engage regularly). Ms Kennedy was recommended as an involuntary patient and initially agreed to remain in the Emergency Department until a bed became available in the Northern Psychiatry Unit (NPU). At approximately 3.30pm, Ms Kennedy left the Emergency Department prior to being moved to the NPU, following which hospital staff notified police of her missing person status. Ms Kennedy was subsequently located by police at her home address in Thomastown shortly after 8.00pm, with her explanation for absconding from the hospital, being that she wanted to go home to feed her children. She was co-operative with police when she was conveyed back to the hospital.

6. On the 22nd June 2010, Ms Kennedy was again seen by Dr Guo, with her risk assessment remaining as "low". In addition, she was assessed by consultant psychiatrist, Dr Reza Roohi, who noted her extremely labile emotional state, with her presenting tearful, with feelings of hopelessness and worthlessness. She reported suicidal ideations and feelings of guilt over her mother's death and her own past relationships. Current stressors related to accommodation worries and that her partner would not forgive her for past infidelity. A number of provisional diagnoses were entertained including major depression and borderline personality traits and Quetiapine medication was commenced in order to contain her level of agitation and distress. Later in the day Ms Kennedy was seen by the clinical psychologist and again she was noted to be labile, distressed and convinced in her own mind that she had *"lost"* her children and her partner. She settled temporarily with reassurance and support from staff, but again became very distressed and agitated when visited by her partner and children. She responded well to a repeat of the earlier medication together with Diazepam and Temazepam, and slept throughout the night.

7. On the 23rd June 2010, Ms Kennedy became acutely distressed on a number of occasions, as for example at approximately 1.30pm, she was screaming at a staff member to kill her. She was inconsolable, banging her head and throwing herself to the ground, thrashing around, screaming and stating negative things about herself and that she should die. Medication and nursing support resulted in her temporarily settling. During family contact with her partner and children she appeared to experience difficulty relating appropriately to them and later in the day, she became increasingly distressed and agitated. At 6.00pm she was again noted to be expressing suicidal thoughts and wanting to die and by 8.30pm, security needed to be called after she placed herself on the floor, screaming excessively, banging her head on the floor and asking staff to stab her. She was medicated and placed in seclusion and after settling, her seclusion placement was ceased shortly after midnight.

8. Around midday on the 24th June 2010, Ms Kennedy was again seen by Dr Roohi and a psychiatric nurse, with her being asked questions about depressive symptoms and at which time she stated that she had had suicidal thoughts for a long time. She recognised a recent deterioration in her mental status featuring suicidality, anxiety, sleep reduction and appetite reduction. She again raised the issues around her partner and losing her accommodation, but conceded that she believed her partner was kind and supportive and able to look after the children. The assessment terminated with it being agreed that Ms Kennedy required to be commenced on an anti-depressant with sedative and appetite stimulant effects. It was decided to commence her on Mirtazapine, 15mg at night.

9. At approximately 4.00pm on the 24th June 2010, Registered Psychiatric Nurse, Linda Brinnand, had a short conversation with Ms Kennedy in the corridor near her bedroom. On being asked how she felt, given her distressed state the previous night, Ms Kennedy responded, *"a bit better today"* but that she felt, *"bad about last night"*. The nurse assured her not to be concerned about what occurred the previous night and that they were there to help her, either through talking with her, or if necessary giving medication. Ms Kennedy appeared less agitated and stressed and the nurse indicated that she would talk to her again after talking to other patients in her group. At approximately 5.15pm, whilst conducting a check of all patients on the Ward and after talking shortly to the mother of another patient on the Ward, Nurse Brinnand went to Ms Kennedy's room in order to complete her check list. On opening the door Ms Kennedy was seen to be hanging against the bathroom door by a scarf tied around her neck, that was jammed between the closed door and its architrave. A chair used for elevation was positioned adjacent to her.

10. Staff were alerted by Nurse Brinnand activating the alarm system and calling for assistance, with this resulting in the prompt attendance of staff and the "Code Blue" emergency team. Despite full cardio pulmonary resuscitation protocols being implemented by staff from the General Intensive Care Unit, Ms Kennedy could not be resuscitated.

11. Investigation into the circumstances surrounding the death found that Ms Kennedy was given the scarf that she used as a ligature, by the mother of a fellow client in the unit. It appears that the woman was in the unit the previous night when Ms Kennedy was running naked in the corridors, and taking pity on her, brought in items of clothing for her. These clothes were either not bought to the attention of staff, or checked by them.

12. No autopsy was performed in this case as the Coroner, on advice from Dr Matthew Lynch, Senior Pathologist with the Victorian Institute of Forensic Medicine, directed that no autopsy was required. Dr Lynch performed an external examination of Ms Kennedy at the mortuary, reviewed the circumstances of her death, the post mortem CT scan and provided a written report of his findings. During his examination Dr Lynch observed abrasions around the neck consistent with a ligature mark and reported that in all the circumstances, a reasonable cause of death appeared to be hanging. Toxicological analysis of post mortem body fluid, identified anti depressant, antipsychotic and anticonvulsant medications, within therapeutic concentrations.

COMMENTS:

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

1. This tragedy highlights the dilemma facing health professionals who manage and treat individuals with mental illness and their difficulty in predicting when a patient is at risk of crossing the suicide threshold. Prior attempts and risk factors may be well documented, however, such material can rapidly go out of date and thus be less helpful as an indication of future behaviour. Clinical staff must remain alert to the significance of the impact of external stresses on suicide risk. Ms Kennedy's death occurred in a setting of non-psychotic distress and reinforces the importance of obtaining collateral information from sources such as family, medical records and other health professionals. The Chief Psychiatrist, Dr Ruth Vine, in reviewing the circumstances surrounding Ms Kennedy's death, made the following observations that are relevant to the treatment and care of inpatients, and with which I concur:

> "In relation to the areas of diagnosis, assessment and observation, in my view it would be appropriate that staff continue to receive training and supervision regarding assessment of a person's risk of suicide and the importance of engagement with patients who are admitted as inpatients. It is important that clinical staff develop an understanding of the person's view of their coping capacity and endeavour to engage with the person to better assist them in interpreting the patient's verbal and behavioural cues. In my experience, when a person presents in a 'situational crisis', this often indicates that their ability to cope is overwhelmed and they feel helpless and powerless. Further consideration should be given to the means and frequency of observation and placement within the unit.

Current design policy supports inpatient units being primarily comprised of single person rooms with attached ensuites and a small number of beds in a High Dependency area. In my opinion this needs review. While I appreciate the loss of privacy associated with shared rooms and shared bathroom facilities, I wonder whether there is too great a gap between the level of observation (and loss of privacy) in the High Dependency Unit, and the level of observation possible when patients have full access to their bedrooms and these are all single rooms. I think further discussion is required regarding whether it maybe more appropriate at times for people experiencing mental illness to share their bedroom accommodation, or to have restricted access to their bedrooms, or for bedroom design to enable better observation by clinical staff. We need to recognize that most people admitted to an acute unit will be very unwell and require close observation in order to minimize the risk of harm to themselves, other people or property."

2. The inquest focused on the appropriateness of the "low" risk assessment and Ms Kennedy not being specialled, or placed on higher level observations. I accept the evidence that there was no basis for High Dependency placement, as there was no clear evidence of her being at risk of immediate self harm. Even the brief period of seclusion was not a ground for changing the assessment, as she was secluded out of concern for her safety and to control her behaviour, not for reasons of suicidality. When she was distressed she presented herself and vocalised her distress as a means of seeking help. Her health providers were in no doubt she wanted treatment, as was indicated by her cooperation in returning to the hospital after going home to feed her children. In addition, no plan or intent to self harm was expressed during risk assessment interviews and despite having ample opportunity to do so, there is no evidence to suggest she engaged in self harming behaviour during the period she had absconded. In the circumstances, I am satisfied that there is no evidence in this case to suggest that Ms Kennedy's medication regime, or treatment plan was other than appropriate.

3. Following the death of Ms Kennedy, all ensuite doors in NPU were modified to minimise retention ligature points. This was achieved by reducing the size of the doors and hence creating a gap top and bottom, so that they no longer fitted tightly to their frames. The catching point for a ligature was thereby eliminated. In addition, doors were removed from full length cupboards in client bedrooms.

4. Monthly risk education in service sessions (which include 'Clinical Risk Assessment and Management' guidelines), have been implemented.

5. As previously stated, Ms Kennedy fashioned a ligature out of the scarf she was given by a visiting relative of another patient in the unit. Whilst I do not question the kindness behind this

gesture, it raises an issue that needs to be addressed. Inpatient units are stressful environments and any restrictions on what can be brought into such a unit, would potentially heighten the stress. Nevertheless, there is a duty of care to ensure patient safety, and this requires effective monitoring of what is taken in, and for whom.

RECOMMENDATIONS:

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

1. That the Northern Area Mental Health Service, Melbourne Health examine the level of observation (with a view to harm minimization) that is possible within the Northern Psychiatry Unit, when the patients have full access to their single occupant bedrooms.

2. That staff remain vigilant in obtaining collateral information from sources such as family, medical records and other health professionals, and that consideration be given to introducing an electronic case note system, to facilitate dissemination of the information.

3. That the Northern Area Mental Health Serivce, Melbourne Health develope and implement protocols aimed at monitoring and or restricting, potentially harmful items being taken into the psychiatry unit.

Signature:


Iain T West
Deputy State Coroner

14 October 2011
(Finding amended 30 January 2012)