IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2016 2133

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of ELIZABETH ANNE PALMER

Delivered On:	19 March 2018
Delivered At:	THE CORONERS COURT OF VICTORIA 65 KAVANAGH STREET, SOUTHBANK
Hearing Dates:	13 MARCH 2018
Findings of:	MR PHILLIP BYRNE, CORONER
Representation:	MR MICHAEL REGOS ON BEHALF OF LATROBE REGIONAL HOSPITAL MR DIARMAID McGANN ON BEHALF MR NICHOLAS PALMER
Counsel Assisting the Coroner	LEADING SENIOR CONSTABLE, KING TAYLOR, POLICE CORONIAL SUPPPORT UNIT

I, PHILLIP BYRNE, Coroner, having investigated the death of Elizabeth Anne Palmer
AND having held an inquest in relation to this death on 13 March 2018
at The Coroners Court of Victoria
find that the identity of the deceased was Elizabeth Anne Palmer
born on 22 June 1976
and the death occurred 13 May 2016
at Latrobe Regional Hospital, 10 Village Avenue, Traralgon, Vic, 3844

BACKGROUND

1. Mrs Elizabeth Anne Palmer, 39 years of age at the time of her death, a mother of three, resided at 6 Evergreen Close, Drouin. Without going into too much detail in relation to what I will call historical matters, Mrs Palmer had suffered from long term mental health issues, including two previous suicide attempts. The first as an 18 year old, and the second in 2012.

CIRCUMSTANCES

2. As I indicated at the Summary Inquest Hearing, I have, from the outset, focused upon issues proximate to Mrs Palmer's untimely death.

3. Unfortunately, in the period leading to her death, Mrs Palmer and her husband, Mr Nicholas Palmer, had been experiencing some matrimonial difficulties/disharmony that they had been endeavouring to resolve. At the time Mr Palmer was not residing in the family home. Not surprisingly, this situation impacted upon Mrs Palmer's psychological wellbeing.

4. On the afternoon of 10 May 2016, Mr Palmer attended the Evergreen Close address. Upon arrival, Mr Palmer received several text messages from his wife of an alarming nature. Fearing his wife intended self-harm he went to the main bedroom where he located his wife in bed in a drowsy state. There were razor blades, a knife, a bottle of pills and a bottle of vodka and orange on the bedside table. Mr Palmer, concluding that his wife was attempting suicide, called the 000 emergency number resulting in the attendance of Police and subsequently an Ambulance Paramedic.

5. Mr Palmer showed Police a suicide note he located prior to their arrival. Following discussion with Mrs Palmer, the decision was taken to arrest Mrs Palmer under s351 of the

Mental Health Act 2014 and transport her to hospital for a mental health assessment. After some delay in the arrival of an ambulance, Mrs Palmer was conveyed to the West Gippsland Hospital in Warragul. I note that a police member wisely accompanied Mrs Palmer in the ambulance.

6. Upon assessment, Mrs Palmer was considered to be in need of treatment and placed on an Inpatient Assessment Order under the *Mental Health Act 2014* and was transferred to Latrobe Regional Hospital Traralgon, arriving in the early hours of 11 May 2016. Mrs Palmer was seen by a staff psychiatrist at Flynn Ward, Dr Vijay Shankar Prajepati, who upon assessment, placed her on an Inpatient Temporary Treatment Order. On 12 May 2016, Mr Palmer visited his wife at Flynn Ward, bringing several personal items she had requested. At the visit Mr Palmer advised his wife he did not propose to seek to reconcile the marriage. Mrs Palmer was distressed by that information.

7. As part of the admission process, Mrs Palmer's property was searched and several items, including her Kindle, were removed. Later in the day, Mrs Palmer asked if her Kindle could be returned. A nurse conferred with the Associate Unit Manager who approved the return of the Kindle.

8. Shortly prior to 3.00am on 13 May 2016, Mrs Palmer asked Psychiatric Nurse, Ms Nicole Murphy for some analgesic, which was provided. Subsequently, Mrs Palmer was observed by Ms Murphy to be asleep. Ms Murphy stated she observed Mrs Palmer again, apparently asleep, at 6.00am.

9. Shortly after 7.00am, Psychiatric Nurse, Ms Tracey Palmer, who had come on duty shortly prior to 7.00am, attended Mrs Palmer's room. She noted Mrs Palmer was not in her bed, and knocked on the door of the ensuite bathroom, but got no answer. Upon opening the door, which was locked from the inside, Ms Palmer observed Mrs Palmer on the floor surrounded by copious amounts of blood. A Code Blue was called and resuscitation undertaken. Unfortunately, Mrs Palmer could not be resuscitated and was subsequently formally declared deceased.

DEATH REPORTED TO THE CORONER

10. The death of Mrs Palmer was reported to the Coroner. I did not have carriage of the matter initially; it was allocated to me in May 2017. Not having had carriage of the matter from the

outset presents its own problems. In the event, the Coroner with carriage of the matter at the time, directed an external only post-mortem examination and ancillary tests. An Inspection and Report was provided by Senior Forensic Pathologist, Dr Malcolm Dodd, who confirmed Mrs Palmer's death was due to:

1(a) HYPOVOLAEMIC SHOCK

1(b) INCISED INJURY TO THE WRIST

11. At the time I took over carriage of the matter, I noted that in the first contact with the Coroner's Admissions and Enquiries Office (CA&E) Mr Nicholas Palmer raised concerns about "*mental health treatment and security*" commenting that he was "*surprised that this could have happened in a hospital environment*".

THE INVESTIGATION

12. The Coroner who previously had carriage of the matter had requested a Coronial Brief. A brief was lodged in late March 2017. Having examined the Coronial Brief after I took over carriage of the matter, I concluded that the principal issue I had, the adequacy of the search of Mrs Palmer's property upon admission, was not adequately addressed. Consequently, I had my Legal Officer at the time, Ms Rebecca Johnston-Ryan, contact Latrobe Regional Hospital seeking the following information/documentation:

- a copy of procedures/protocols for searches conducted looking for items that may be used for suicide (both on admission and during admission);
- further detail as to whether any refinements have been made to these procedures/protocols following Mrs Palmer's death in Flynn Ward; and
- further detail as to whether an internal review of Mrs Palmer's death was undertaken. If so, details of the outcome of this review.

13. The Chief Medical Officer of Latrobe Regional Hospital, Dr Simon Fraser, inquired as to whether I would accept a response from Ms Cayte Hoppner. Director of Mental Health at Latrobe. Dr Fraser was advised I would welcome a response under the hand of Ms Hoppner on behalf of the Hospital.

14. In a timely manner, a response dated 1 June 2017 was received from Ms Hoppner addressing the matters about which I sought further information. Upon further review of the file, I concluded there was a real prospect that I would make an adverse finding, or at least an adverse comment, to the effect that the search of Mrs Palmer's property upon admission, or subsequently, was inadequate. The principal reason I held that tentative view was that I had possession of Mrs Palmer's Kindle and was able to see that to remove the device from its cover, to see if any dangerous items was secreted therein, was a relatively simple exercise.

15. I had my current Legal Officer, Mr Darren McGee, write to the Hospital advising them of the prospect of an adverse finding or comment, and enquiring as to whether a finding to that effect would be resisted. I was required to take this step as a matter of procedural fairness/natural justice.

16. In a letter under the hand of Mr Michael Regos, dated 31 October 2017, DLA Piper, solicitors for Latrobe Regional Hospital, advised an adverse finding/comment would be resisted. The reasons for that position were articulated in the letter. The principal reason for resistance to the tentative finding is conveyed in the following excerpt from the DLA Piper letter:

> "*The search was done by staff in accordance with Latrobe Regional Hospital policy. That policy is clear that dangerous items or* (sic) *to be removed. The policy was not however so prescriptive to direct that covers of Kindles be removed.*"

17. It was also submitted that I could not, on the evidence available, be satisfied that the razor blade utilized by Mrs Palmer to intentionally take her own life was indeed concealed in the Kindle at the time of her admission.

18. Interestingly, in the DLA Piper letter I was advised as a result of Mrs Palmer's death Latrobe Regional Hospital had alerted staff to the risk of dangerous items being hidden in devices such as Kindles and had refined its relevant protocol/policy to reflect that particular risk.

19. In November, I had my Legal Officer write to the Chief Psychiatrist seeking advice as to whether the policies/protocols/guidelines in relation to the search regime in place at Latrobe Regional Hospital at the time of Mrs Palmer's death were "standard fare" in secure public

mental health facilities throughout the State. I also enquired whether Latrobe's revised Clinical/Departmental Guideline – Mental Health in Searches to Maintain Safety (Inpatients Units) Protocol was adequate to, as best one can, ensure the safety of high risk patients and others within the facility. In a letter dated 18 December 2017, Dr Daniel O'Connor, Deputy Chief Psychiatrist, advised that Latrobe's clinical guidelines referred to in the previous paragraph of this Finding and the Hospital's Mental Health – High Dependency Assessment Unit (HDAU) Management Protocol (reviewed on 11 March 2015) were in accordance with the Chief Psychiatrist Guideline: High Dependency Units, which not surprisingly stated:

> "*...potentially dangerous items may need to be removed from patients prior to placement to reduce the risk of self-harm or harm to others.*"

That of course was precisely the basis upon which I had tentatively considered the search of Mrs Palmer's property upon admission to Flynn Ward to be inadequate.

20. As Mrs Palmer was a compulsory patient within the meaning of the *Mental Health Act 2014* and her death was not due to natural causes, an inquest was mandated. As an adverse finding was resisted I felt that I was required to list the matter for full (rather than summary) inquest to hear viva voce evidence, to enable me to reach a concluded view upon the issue of the adequacy of the search.

21. The matter was listed for hearing on 13 March 2018 to hear viva voce evidence from several witnesses and hear oral submissions, if the parties wished to make them.

22. However, somewhat belatedly, but nevertheless in time, I received a further letter dated 7 March 2018 from DLA Piper under the hand of Mr Regos making what I will refer to as significant concessions, in that it was accepted that the Kindle:

> "*... ought to be removed from its cover and to that extent the search was not thorough enough.*"

The following excerpts from Mr Regos' letter further explains the Hospital's position, he wrote:

> "*I met yesterday with witnesses Cayte Hoppner (Chief Mental Health Nurse at Latrobe Regional Hospital) and Nurse Peta Moore (the nurse who searched Mrs Palmer's*

belongings on admission). I showed them the photographs of the subject Kindle. Mrs Hoppner had not before seen the particular Kindle or photographs of it. Prior to seeing the photographs it was anticipated that the deceased's Kindle might resemble those Kindles with a hard cover and not obvious that the cover is removable and such that a nurse might not be expected to remove the cover."

and

"Latrobe Regional Hospital's position is that it acknowledges that searching Kindles and other electronic devices was not on the list of items to be searched in its search protocols and understands why Nurse Moore might not unilaterally have thought that a Kindle was a place within which dangerous items might be secreted. Having seen the photographs, Latrobe Regional Hospital considers that this Kindle ought to be removed from its cover and to that extent the search was not thorough enough."

23. In light of the concessions made, I decided to convert the scheduled inquest hearing into a summary inquest where I would not take viva voce evidence, but would hear submissions from the legal representatives of both Mr Nicholas Palmer and Latrobe Regional Hospital, if they wished to make them.

24. At the hearing on the 13th of March, Mr Diarmaid McGann of Counsel, instructed by Mr Miceal Ambrose, solicitor, and Mr Michael Regos of DLA Piper attended. As well as Mr Palmer, Mrs Palmer's parents, Mr & Mrs Green, attended the hearing. Before turning to the legal representatives, I explained to Mr Palmer and Mr & Mrs Green the nature of the hearing and the basis upon which I proposed to proceed that morning. I then entertained submissions from both Mr Regos and Mr McGann.

25. Mr Regos submitted that it was possible the razor blade accessed by Mrs Palmer may not have been secreted in the Kindle, but obtained in some other property or manner. I indicated to Mr Regos that on balance it was my firm view that the razor blade was indeed secreted in the Kindle. It is to be recalled that another razor blade was located by investigating police in the cover of the Kindle after Mrs Palmer's death.

26. Mr McGann advised he was instructed to raise the issue not only of the adequacy of the search, but the adequacy of the monitoring of Mrs Palmer in the High Dependency Unit. I indicated to Mr McGann that I had considered that issue, but had come to the view there was

no reasonable basis to conclude that it was inadequate. Mrs Palmer had been regularly monitored in accordance with established protocols, but during the period between observations by staff, had taken the opportunity to execute her tentative plan, even if at that time she had acted on impulse, to take her own life.

RELEVANT LAW – ROLE OF THE CORONER

27. In the discussion I had at the commencement of the proceedings with family members present, I stressed that it is not my role to lay or apportion blame/fault, but merely to seek to elucidate the facts surrounding the death sufficient to satisfy public expectation. As Justice Calloway stated in Keown v Khan:

> *"In future the function of an inquest should be simply to seek out and record as many of the facts concerning the death as public interest required, without deducing from those facts any determination or blame[1]"*

His Honour added:

> *"In many cases, perhaps the majority, the facts themselves will demonstrate quite clearly whether anyone bears any responsibility for the death; there is a difference between a form of proceedings which affords to others the opportunity to judge an issue and one which appears to judge the issue itself[2]"*

In R v South London Coroner; ex-parte Thompson[3] Lord Lane commented:

> *"It should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning blame"*

Again, in Keown v Khan, Justice Callaway said in considering whether an act or omission can reasonably be seen as a causal factor, as distinct from a "background circumstance", I am required to considered whether, in this case, the failure to adequately search Mrs Palmer's Kindle was an omission in breach of a recognized duty. I regret to say it clearly was.

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[1] (1999) 1VR 69 @ 75
[2] (1999) 1VR 69 @ 75
[3] [1982] 126 SJ 625

28. I concluded that a guideline is just that; a guideline. It is not reasonable to expect that a guideline will be exhaustive and prescribe virtually every individual item in which a dangerous item may be hidden. In other words, just because a Kindle was not specifically referred to in the guidelines of search, does not mean it would not be reasonable and appropriate, in the context of a High Dependency Unit, to carefully examine and if necessary remove a cover from a device to ensure no dangerous item is secreted.

29. While I understand the position put on behalf of Ms Peta Moore, the nurse who searched Mrs Palmer's belongings upon admission, taking into account Mrs Palmer's undoubtedly high level of risk of self harm, and the overriding obligation to ensure a patient in a High Dependency Unit is not in possession of an item which may be used to self harm, a more rigorous search should have been performed and the Kindle should have been removed from its cover.

FINDING

30. I formally find Mrs Elizabeth Anne Palmer died in the High Dependency Unit in Flynn Ward at Latrobe Regional Hospital on 13 May 2016 due to:

1(a) HYPOVOLAEMIC SHOCK
1(b) INCISED INJURY TO THE WRIST

when she accessed a razor blade she had previously secreted in a Kindle in her possession and which was not discovered in a search of her belongings upon admission to the ward.

COMMENTS

31. In submissions, both Mr McGann and Mr Regos canvassed the issue of potential recommendations. He advised that a recent enquiry of the Chief Mental Health Nurse in the Office of the Chief Psychiatrist (OCP) indicated that the OCP were presently reviewing the search guidelines which at this time make no specific reference to Kindles or other electronic devices. Mr Regos further advised that enquiries made by Latrobe of other mental health services indicated that none make specific reference to Kindles, or other similar electronic devices. I was also advised that the present OCP guidelines regarding searches of patients in high dependency units make no specific reference to electronic devices, such as Kindles, and an OCP review is presently underway.

32. On the basis of that information, and assuming revised guidelines will in all likelihood make reference to these types of electronic devices, I believe an interim measure would be appropriate. I acknowledge that it is likely the circumstances surrounding the death of Mrs Palmer are already well known throughout the public mental health fraternity.

RECOMMENDATION

33. I recommend that the Chief Psychiatrist, as an interim measure, issue a revised guideline in relation to search policy of compulsory patients in high dependency units, to the effect that as part of a search, electronic devices such as Kindles be subject to thorough examination.

DISTRIBUTION OF FINDING

34. I direct that a copy of this finding be provided to the following:

Mr Micael Ambrose, Lawyers on behalf of Mr Nicholas Palmer, Senior Next of Kin;

Mr Michael Regos, DLA Piper Lawyers on behalf of Latrobe Regional Hospital;

Mr Paul and Mrs Maureen Green, Parents of the Deceased;

Mrs Margaret Green, Sister of the Deceased;

Ms Paulina Wooky, Sister of the Deceased;

Dr Neil Coventry, Chief Psychiatrist, Office of the Chief Psychiatrist; and

Senior Constable Andrew James Lappin, Coronial Investigator.

Signature:

PHILLIP BYRNE
CORONER
Date: 16 March 2018

Coroners Court of Victoria