FORM 38

Rule 60(2)

FINDING INTO DEATH WITHOUT INQUEST

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

Court reference: 4970/07

In the Coroners Court of Victoria at Melbourne

I, IAIN TRELOAR WEST, Deputy State Coroner

having investigated the death of:

Details of deceased:

Surname: LITIS
First name: LOUISE
Address: 6 Hamilton Street, Brighton Victoria 3186

without holding an inquest:

find that the identity of the deceased was LOUISE JACQUELINE LITIS
and death occurred 7th December, 2007

at Austin Hospital, 145 Studley Road, Heidelberg

from

1a. Hypoxic brain injury
1b. Compression of the neck consequent upon hanging

Pursuant to Section 67(2) of the **Coroners Act 2008**, an inquest into the death was not held and the deceased was not immediately before the person died, a person placed in custody or care; but there is a public interest to be served in making findings regarding the following circumstances:

1. Louise Litis was 37 years old at the time of her death. She was a married mother with two children and a history of postpartum depression occurring with each birth. This is an abnormal psychiatric condition, characterized by symptoms that range from mild "postpartum blues," to an intense suicidal depressive psychosis. At the time of her death she was married to Dean Litis, with their first child, Sam, being born in December 2004 and the second, Charlie, born in July 2007

2. On the 30th November 2007, Louise was admitted to Northpark Private Hospital with a diagnosis of recurrent major depression and on the 2nd December, she was transferred to the Mother and Baby Unit (MBU) where she was supported in caring for Charlie. Shortly after midnight on the 5th December, Louise was found in the bathroom adjacent to her room, unconscious and in a state of low suspension hanging. She had removed the nurse call button apparatus from her room to use it's cable as a ligature, after jamming it between the top of the

closed bathroom door and it's architrave. On being found in cardiorespiratory arrest, Louise was promptly treated and transferred to the Austin Hospital, where she was admitted to the Intensive Care Unit with a diagnosis of hypoxic brain injury. Despite appropriate management there was no neurological improvement and, after consultation with family, treatment was withdrawn. Louise became an organ donor, having died at 5:37am on the 7th December 2007, in the presence of family members.

3. An objection to autopsy was lodged and granted by the coroner, as there were no issues to be addressed on the medical deposition and a cause of death could be established from the clinical history. External examination revealed a faint mark consistent with the application of a ligature and areas of bruising beneath the right eye and the left side of the chin, which showed some aging features. There were further areas of bruising over the left hip, both knees and front of the left ankle. There were no relevant toxicological findings.

4. Investigation into the circumstances surrounding the death revealed that Louise was raised in a loving family environment, the youngest of three children. She attained the usual childhood milestones and completed secondary and tertiary studies before spending a period of time overseas. Upon her return she began work at the Stock Exchange where, in October 2000, she met Dean Litis. They married in February 2004 and early in 2005, following Sam's birth, Louise presented with postpartum depression. She was prescribed Sertraline antidepressant medication (brand name Zoloft) by her GP, who referred her for psychiatric assessment to Dr Diana Korevaar. When seen by Dr Korevaar on the 2nd February, Louise described escalating depressive symptoms since the late stages of her pregnancy and following the birth, impaired sleep and fears of not being able to care for Sam. There were no psychotic features to her presentation and although she admitted to occasional suicidal thoughts, they were qualified with her stating, "I couldn't do it to them". On diagnosing moderately severe postpartum depression, the decision was made to augment her medication with Oestrogen (ceased one week later) and Amisulpride, with several months of this drug regime significantly improving her level of confidence and capacity to assume more responsibility. When reviewed in February 2006, after being off all medication for three months, Louise's emotional state had become stronger and more stable and Dr Korevaar did not see her again until after Charlie's birth in 2007.

5. With her second pregnancy, Louise appeared more relaxed, excited and positive about the prospects of having a baby, than she did preceding Sam's birth. She had twelve sessions of ongoing counselling with psychologist Katrina Schlager, a specialist in infant/parent mental health and with seven of the sessions post dating Charlie's birth. Louise had an uneventful delivery and recovery, however, within two months of the birth her mental health began to decline. She became increasingly anxious about her capacity to cope and raise the boys, despite significant family efforts to provide support. Louise reattended Dr Korevaar in late August and at the beginning of October she commenced on Cipramil, Olanzapine and Temazepam medications. When seeing Dr Korevaar on the 1st November, she complained of anxiety and agitation, with her feelings of hopelessness having returned. Louise acknowledged suicidal thoughts, however, was adamant that she would not act upon them. She was advised to increase the dose of her medication and was represcribed Amisulpride, not as an antipsychotic but for its value in augmenting the action of the antidepressants. Non compliance with her medication regime occurred from time to time. Dr Korevaar saw her again on the 3rd and 14th, with increased dose variations occurring on each occasion. Louise rejected a recommendation to involve the Crisis Assessment Treatment Team (CAT Team) for extra support.

6. On the 15th November, Louise drove her husband and Sam to the airport in order for them to fly to Perth to visit relatives. In their absence she was to be supported at home by her parents and after returning from the airport and having a rest, she collapsed having taken an overdose of

Temazepan. Her mother requested ambulance attendance and Louise was transported to the Monash Medical Centre where she was subsequently admitted overnight and assessed in the morning by consultant psychiatrist, Dr Juri Gustavson. A suicide note had been left. Dr Gustavson found her anxious and depressed, however, she exhibited no symptoms of psychosis and stated that her action was one of desperation because of her inability to cope, feeling constantly sedated and blaming herself for being an inadequate mother. Louise was agreeable to a modified drug treatment regime (cessation of previous medication and commencement on Sertraline and Alprazolam) and regular CAT Team follow-up. On the 27th November she contacted, for the first time, Dr Karen Price, a Brighton general practitioner and for over an hour discussed the complex triggers for postpatum depression. Dr Price reassured her that her medication was appropriate and that given time, it would work. On the 29th November she rang Dr Price, acutely distressed and reporting a deterioration in her mental state following the return of her husband and Sam from interstate. As she felt she could not cope, she requested admission to the Albert Road Mother and Baby Unit, however, enquires made by Dr Price found nothing was available. The CAT Team was contacted and during the course of a home visit later that afternoon, lack of bed availability at the clinic was confirmed. On the 30th, a further home visit was made by the CAT Team, during which time a review was undertaken by Dr Gustavson, with Louise admitting suicidal ideation, but that she had no plan or intent. Further unsuccessful attempts were made for admission to the Albert Road Clinic, which included direct contact by Dr Korevaar with the consultant in charge of the Mother and Baby Unit. Her sertreline dose was increased by the CAT Team and that afternoon, private bed admission was arranged to Northpark Private Hospital, under the care of Perinatal Psychiatrist, Professor Anne Buist.

7. Louise was admitted to Northpark psychiatry ward (Charlie remaining with family) in the late afternoon of the 30th November and was seen by Senior Psychiatric Registrar, Dr Rumiana Guneva. It was arranged that she would be transferred to the Mother/Baby Unit when a bed was to become available on the 2nd December. On assessment Louise expressed depressive thoughts of hopelessness and not coping, but denied suicidal thoughts. Dr Guneva believed her risk of self harm was moderate, but that she should not be permitted to leave the hospital unaccompanied. She prescribed medications of sertraline, alprazolam and temazepam. Later, after viewing the Mother/Baby Unit, Louise was assessed by Professor Buist, who diagnosed moderate to severe depression and confirmed Dr Guneva's management plan. On the 2nd December, Louise was transferred to the Mother/Baby Unit and reunited with Charlie, and on the 3rd she was reassessed by Professor Buist, who found her agitated and significantly distressed, but denying psychotic symptoms, suicidal ideation, plan or intent. Her medication plan was discussed and what the possible alternatives would be, in the absence of improvement over the next few days. As treatment could require an extended length of stay, possible transfer to a public facility was also discussed, although Louise stated she was reluctant to move as she liked and felt safe in the Northpark unit. Future options of child care and family support were also discussed.

8. At approximately 5.30 am on the 4th December, Louise was observed by a nurse to have blue/black bruising and swelling in the area of her right eye. When asked how the injury was sustained, she responded that she had "walked into the bathroom door" whilst moving around her room and that it had occurred at approximately 4.00pm the day before. The incident was not witnessed and was not reported to a member of nursing staff at the time, however, the attending nurse subsequently completed an Incident Report before finishing her shift at 7.30am. An Agency Nurse then took over responsibility for Louise's care and noted that she had good interaction with Charlie, setting him up on the floor with his play pen, changing him when required, rocking him on her lap and putting him to sleep. After Louise had showered the nurse noted a red mark at her neck and on enquiring what it was, she was told it was a rash that she often got and that it would start on her stomach. This was discussed with other nurses who were not aware of any such rash, resulting in a message being left for Dr Guneva to attend as soon as

she arrived. Whilst waiting the doctor's attendance the nurse in charge of the unit attended Louise and on requesting to see the mark, was also told that it was due to a rash. On examination, she observed what appeared to be two thin lines that did not look to her to be a rash. Following her return to the nurses station, Professor Buist and Dr Guneva were there, with the nurse reporting to them what she had seen and that she felt the explanation unlikely.

9. Professor Buist and the registrar assessed Louise, finding a slight improvement in her mood, in that she was more spontaneous and forthcoming, however, she was still depressed. Louise stated that she felt safe in the unit and did not want to go to the General Psychiatric Unit, with this giving rise to discussion about increasing her level of observation to hourly. She explained the cause of the bruise and reiterated that the line on her neck was a rash that was similar to what she had had in the past. Louise denied any suicide attempt and adamantly denied any thoughts of self harm. There were no psychotic symptoms. As Louise could not be recommended, the concern was that with any attempt to move her to a more secure environment, she would discharge herself from Northpark. The decision was made to move her to a different room closer to the nurses' station and to put her on hourly visual observations, with this based on the fact that she was still agitated, the past attempt two weeks previously and the uncertainty surrounding the bruise and red mark. The move was facilitated just before lunch and Louise's risk rating was increased from moderate to high with hourly visual observations.

10. During the course of the day, Louise was seen to be detached, but nevertheless, appropriately caring for Charlie, engaging with nursing staff and despite still being withdrawn, attempting to socialize with other patients. When reviewed by Dr Guneva later in the afternoon, she was felt to be engaged, although anxious, with depressed affect. She agreed to tell nursing staff if she felt distressed, although there was nothing in her presentation that alerted Dr Guneva to any increased risk. She appeared to be responding to the support and care provided and denied any suicidal ideation, plan or intent. Although the direction was for her to be nursed on hourly visual observations, her allocated day and evening nurses undertook them every 15 minutes. There was a taped handover to the night shift at 10:00pm and, despite the hourly observation order still being in place, the incoming nurse took it upon herself to do at least half hourly visual observations. At 10:30pm Louise was in her room with the lights off watching television, and following introductory discussions, she requested Xanax medication (Alprazolan: a benzodiazepine for the treatment of anxiety disorders) which was subsequently taken at 10:45pm. When checked half an hour later the television was off and the lights were out and at 11:45 she appeared to be sleeping. At approximately 12:07am Louise was not in her bed and on investigation was located unconscious in the bathroom, bringing about the medical emergency response. A good-bye letter was later found in a book belonging to Louise, explaining her actions and affirming her love of family and friends.

INVESTIGATION INTO THE DEATH

11. Louise's husband and her parents are critical of her psychiatric management, especially whilst in Northpark under the care of Dr Buist. As the investigation into the circumstances surrounding Louise's death necessitated an examination of her management, both pre and post admission to Northpark, the Court sought an independent review of her care, with this being provided by Dr Deborah Wilson. Dr Wilson is a Perinatal and Infant Psychiatrist in Christchurch, running the only inpatient Mothers and Babies Unit in New Zealand. Dr Wilson undertook a thorough review of the clinical notes and statements collected during the course of the coronial investigation and reached the following conclusions:

(1) The medication regimens that were used to treat Louise throughout her illness were all reasonable and well within the scope of usual clinical practice.

(2) *The recording of psychiatric assessment, diagnosis and management plans were minimal in some clinical notes and the written communication between mental health professionals could be improved.*
(3) *The processes for assessment and management of suicide risk at Northpark Hospital need review, as does the safety of the inpatient environment.*
(4) *The team work and team processes on the Mothers and Babies Unit of the Northpark Hospital could be improved.*
(5) *Ideally suicide risk should be assessed thoroughly in all women who are unwell enough to require hospital admission for treatment of major depressive symptoms in the postpartum. It is unclear if the team, led by Dr Buist, did this.*
(6) *Louise had the capacity to present as less unwell than she really was, particularly if time was not taken to explore her concerns with her. She repeatedly reassured people that she was safe when she was not.*
(7) *The clinical notes do not show evidence that family were involved in discussion with staff at Northpark Hospital regarding Louise's care and treatment decisions.*

MEDICATION

12. Family raised concerns regarding Louise's medication regime. They questioned whether the various drugs she was prescribed were appropriate; whether either on their own or in combination they could have contributed to her suicidal thoughts, or whether sudden changes in medication would make her more susceptible to self harming behaviour. Dr Wilson indicated that whilst any change in medication has the potential to destabilize someone's mental state and increase their suicide risk, she did not think the change in medication precipitated Louise's deterioration immediately prior to her admission to Northpark. Further, she did not believe that the change in medication directly contributed to her suicide. She found that the time frame for the changes was reasonable and noted that the effect of medication was complicated by Louise's non compliance to the prescribed regime. Following a review of the medication that was prescribed both pre and post admission, she concluded:

> *"The medication treatment offered to Louise throughout her treatment was appropriate on the basis that the diagnosis was a recurrent depressive disorder, moderate or severe, non psychotic."*

PSYCHIATRIC AND RISK ASSESSMENT

13. Dr Wilson questioned whether the initial assessment undertaken by Professor Buist and Dr Guneva, 'ruled out' bipolar postpartum disorder, since there was no clear evidence of it being excluded and suffering this disorder would alter the sequence and nature of medications used. In responding to Dr Wilson's report, Professor Buist wrote to the coroner on the 11th January 2010, stating that the assessment was undertaken, with there being no personal or family history of bipolar disorder. Dr Wilson raises the possibility of Louise being delusional and hence psychotic, given her conviction that she would not be able to care for her boys, and that she was an inadequate mother that could not be helped. Louise had not been psychotic in the past and denied psychotic features upon assessment, with there being no evidence of psychotic symptoms, delusions or perceptual disturbances. The non psychotic diagnosis, was "Major Depression-Recurrent." Dr Wilson refers to the difficulty of determining if beliefs are held so fixedly as to be deemed delusions, and was not critical of the working diagnosis.

14. In Dr Wilson's report, she refers to the need to undertake a thorough suicide risk assessment, as the risk of self harm and harm to the infant, are core features of assessment of postpartum women with mood and anxiety disorders. Her report states that it would have been particularly

difficult to assess Louise's suicide risk during the time she was an inpatient at Northpark Hospital. She highlights a number of factors which suggested that Louise was high, or very high risk and a number which suggested she was lower risk. She concluded that being deemed high risk at the time of her death, was a reasonable assessment. The risk had been revised on the 4th December from moderate-accompanied, to high, 60 minute sightings with the following file entry:

> Revised risk assessment chart 4/12/07
> - suicidality: high
> - observation level: 60 min
> - rationale : "voiced depressive thoughts:
>   voiced suicidal ideation, but no active thoughts:
>   feels safe on the ward.
>   bruises on face: red mark on neck>both unwitnessed events"

Dr Wilson was of the opinion that the risk assessment form used at the hospital needed revision, as the level of observation were inappropriate for the level of risk. (The hospital indicates that the assessment form has been revised since the death, but not because of it.) The form then in place had Level of Risk categories of Low, Moderate, High and Intensive. Within the High category the observation levels were, 60 minutes, 30 minutes and 15 minutes. Accordingly, whilst Louise's level of risk was raised into the next category, it was to the lowest observation level within the category. In Dr Wilson's opinion:

> *"High risk requires an individual management plan, team discussion as soon as possible, family notification and involvement as soon as possible, consideration of the use of constant observation (specialling) with reasons given if it is not chosen and the option for nurses to institute specialling if discussion with doctors or family is not possible and risk appears to have acutely deteriorated."*

This is Dr Wilson's view, which must be acknowledged, may not be universally accepted. Nevertheless, it appears to have a great deal of merit and should be considered for implementation.

RECORDING ASSESSMENTS

15. Dr Wilson was critical of the lack of detail regarding the assessment contained in the revised risk assessment chart entry and what was recorded in the Progress Notes:

> *"There is no clear medical note in the hand written, chronological part of the file, of an updated analysis of Louise's mental state by the doctors responsible for her care. There is a record of Louise's symptoms and thoughts and then the plan but no "assessment" as such. In my opinion an updated assessment/opinion of Louise's mental state and progress to date would have clarified the doctor's thinking and the communication of this to other staff."*

16. Interestingly, Louise's nurses undertook higher level observations than what was stipulated, with two consecutive shift nurses undertaking them every 15 minutes and the night shift nurse, every 30 minutes. I cannot determine whether this was done through uncertainty as to what level had been ordered, as there appears to have been a delay in recording the order, or whether the nurses felt it more appropriate given their interaction with Louise and concern for her well-being.

17. In addition to the lack of detail regarding her mental state, the extent of medical assessment and the medical opinion regarding the face bruising and neck is not documented in the clinical

file. Professor Buist accepts that the records could be improved, but qualifies her acceptance by saying that she doubts records from other facilities would be much better and that it would be unusual to write aims and full details every time a patient is seen. This assessment, however, was not undertaken in a setting of routinely seeing the patient. It is clear that the nurses were requesting attendance because of suspicious marks to the face and neck; there was a history of a recent suicide attempt; there were prior reports of suicidal ideation; there were significant depressive symptoms of hopelessness, helplessness and very low mood; strong and persistent feelings of inadequacy as a mother; doubts regarding the explanation for bruising, with the alleged incident being unwitnessed and unreported; doubts about the cause of the red mark. Yet from the patient's record, it cannot be determined whether an examination of the marks was undertaken by Professor Buist, let alone the nature of that examination and what was concluded from it.

18. The inadequacy of documenting full details raises significant doubts as to what occurred during the assessment. The Nurse in Charge of the Unit, Lee Reeves, in her statement dated 1/2/08, indicates that she reported to Professor Buist that she had observed what appeared to be two thin red lines to the neck, that did not look to her like a rash. Following the assessment by Professor Buist she states that she asked her had she seen the red mark, with Professor Buist responding "*we didn't go that far because you had just seen it*". This exchange was said to take place in the presence of Nurse Melva Langley and Dr Guneva.

19. Professor Buist in her statement dated 6th December 2007, says that she was informed by nursing staff that they were concerned by a bruise on the eye and a red line on the throat and that they felt the explanation of the line being due to a rash, was unlikely. Her statement, however, makes no reference to her conducting an examination of the face, or neck. In addition, the Progress Note entry regarding this assessment, made by Dr Guneva, does not refer to the marks being examined. Further, there is no reference to undertaking an examination of them in the Progress Note entry made by Professor Buist, the day after Louise was found.

20. Professor Buist's first reference to examining the marks is contained in correspondence to the coroner dated 11th January 2010, with this being provided in response to Dr Wilson's report, questioning the issue of examination. Professor Buist states that the face and neck were examined, describing the mark at the neck as a "*barely visible slight redness which did not extend across the neck.*" I note this description differs from two entries in the Progress Notes made by different nurses after Professor Buist saw Louise, describing the mark as a "*red mark around her neck.*"

21. These omissions and contradictions raise serious concerns as to the nature and thoroughness of the examination of the marks undertaken by Professor Buist. As none of the material has been tested in an inquest hearing, however, it is not appropriate that I make findings of fact in regard to the examination issue. Nevertheless, it is extraordinary that the records are not clear as to exactly what did take place during this requested assessment. As Dr Wilson stated:

> "*No clinical opinion was clearly stated. There is no evidence that the doctors have examined Louise's neck and no opinion given as to whether they accepted her explanations or have concerns the bruise and mark on the neck may be the result of a suicide attempt*".

IN-PATIENT ENVIRONMENT

22. Following the assessment, Louise was moved to a room closer to the nurses' station in order to facilitate more regular observation. The room, however, appears to have been one with standard hospital fittings, the appropriateness of which must be questioned given Louise's high suicide risk. As previously indicated, Louise hanged herself by using the nurse call button apparatus as a ligature. This apparatus was made up of a couple of metres (an estimate from photographs, as I do not have the precise length) of insulated cable, on one end of which was a cylindrical multi pin plug and on the other, a handset incorporating a nurse call button, light switch and basic television controls. The fact that it could be unplugged from its bedside socket and had attachments on each end, meant that the cable could be readily jammed between the door and its architrave, without risk of it pulling through the gap when weight was applied to it. Dr Wilson commented: "*The presence of these cords brings into question the safety and suitability of the environment for patients with psychiatric disorders who are acutely unwell*". I share Dr Wilson's concern, as does Louise's family. I accept Professor Buist's assessment that Louise could not be recommended and that she was not prepared to voluntarily go to a more secure environment, however, the presence of this type of apparatus makes for an unsafe environment when managing patients whose level of suicidality can be "high", or possibly "intensive." Consideration needs to be given to their removal in rooms likely to be occupied by high risk patients and for replacement with a more secure and appropriately designed apparatus for calling a nurse, such as a wireless call transmitter, or a button on a fixed patient control panel adjacent to the bed.

FAMILY INVOLVEMENT

23. Louise's family are appropriately critical of the failure to inform them of the change in risk assessment status nor to have the opportunity to contribute to a management plan. Family members were available to provide additional observation assistance as required, but were deprived of the opportunity to do so. In her report, Dr Wilson stated:

> "*It is up to psychiatric health professionals to attempt to involve family in treatment so that everyone is, as best as is possible, 'pulling in the same direction'. It becomes a particularly high and sometimes urgent priority to make contact with a family member in the following situations (provided confidentiality issues have been considered);*
>
> *(i) when the patient is admitted to hospital: this was done by the CAT Team in Louise's case,*
> *(ii) when aspects of assessment are unclear (possibly relevant to assessment of her suicide risk),*
> *(iii) when a patient is not responding to treatment as expected: the course of Louise's response to medication would not be particularly unexpected though the overdose was and it seems family were involved at this time,*
> *(iv) when the patient is assessed to be high risk to themselves or anyone else: relevant on 3rd and 4th of December 2007. There is confusion regarding just what the risk was considered to be and the need to contact family seems to have been obscured by this*".

24. I accept, as does Professor Buist, that family involvement in the treatment plan is an essential component of psychiatric health care management (unless family members have significant anti-social traits, or severe psychopathology, as Dr Wilson points out). In response to the family's criticism, Professor Buist stated that Mr Litis had left the hospital on the day Louise was

admitted, prior to Professor Buist's arrival. She pointed out that in the normal course of events, the partner would be involved and be invited to attend a meeting within the week, or early the following week. She further stated that as Louise had only been on the ward two days when she died, they were still establishing the best options for her management. This response, however, does not address the need for "high and sometimes urgent priority" to make family contact upon admission and when a patient is assessed to be of high risk to themselves. There is no evidence of any attempt being made to contact Mr Litis, and with him adding, that he received no information regarding the revised risk assessment and hence he was not kept informed or updated in regard to it. If the explanation for this failure is that they were "still establishing the best options for her management", it misses the point, as family should have been given the opportunity to contribute to those options.

25. Whilst investigation into Louise's death resulted in criticism of aspects of her care, it cannot be concluded that a different course of management would have prevented the tragic outcome. Sadly there have been cases where patients have taken their life even when one to one observations have been in place and hence, speculation regarding alternative management of Louise, is unhelpful. The death 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.

26. Despite the criticisms, the independent review undertaken by Dr Wilson identified evidence of optimal care, with Dr Wilson stating in her report:

> *"There are many aspects of clinical care which can not be recorded and are therefore not always evident to someone like me writing this report. Factors like the effort that Dr Korevaar put in to trying to arrange an admission for Louise even when Louise was no longer in her care. At this point Louise and/or her mother had chosen not to continue with Dr Korevaar's treatment recommendations and care but Dr Korevaar was prepared to continue to put effort into doing the best she could for Louise. Dr Buist made an effort to find Louise a bed and make the necessary arrangements to have her admitted initially to East wing and then to the Mother Baby Unit. She saw Louise at the end of the working day, on a Friday, no doubt making an effort to accommodate Louise's needs amid a busy work load. Dr Buist took a phone call from the Mother and Baby Unit on a Sunday. I consider all these factors to be part of dedicated clinical practice and evidence that these clinicians were working hard to do what they thought would be in Louise's best interest. Dr Korevaar and Dr Gustavson did home visits in the course of their care of Louise. This is an excellent service which these psychiatrists were willing to provide."*

RECOMMENDATIONS

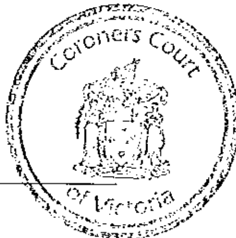
Pursuant to Section 72(2) of the **Coroners Act 2008**, I make the following recommendations connected with the death:

1. Rooms in the Mother Baby Unit at Northpark Hospital that are to be occupied by patients with high or intensive levels of suicidality, be fitted with a nurse call button apparatus that is incapable of being used as a ligature. Potential hanging points within the rooms need to be identified and removed.

2. Protocols be established to ensure family members, willing to be involved in the psychiatric care of their loved one, are engaged at the outset and be given the opportunity to contribute to ongoing management options.

3. That protocols be established to ensure detailed and accurate notes are maintained of a patients psychiatric assessment, diagnosis and management plan.

Signature:



Iain West
Deputy State Coroner
Date: 16th September 2010

DISTRIBUTION

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Chief Psychiatrist, Department of Human Services
Dr Deborah Wilson