IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2008 0778

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of:	**Mairi Elizabeth Noble**
Delivered On:	15 February 2016
Delivered At:	65 Kavanagh Street, Southbank 3006
Hearing Dates:	5, 6, 7 September 2011 and 28 November 2011
Findings of:	AUDREY JAMIESON
Representation:	Mr John Bushby, counsel, on behalf of the NorthWestern Mental Health Service. Ms Deborah Foy, counsel, on behalf of Northern Health (the Northern Hospital).
Counsel Assisting the Coroner	Leading Senior Constable King Taylor, Police Coronial Support Unit.

I, AUDREY JAMIESON, Coroner having investigated the death of MAIRI ELIZABETH NOBLE

AND having held an inquest in relation to this death on 5, 6, 7 September 2011 and 28 November 2011 at Melbourne

find that the identity of the deceased was MAIRI ELIZABETH NOBLE

born on 30 July 1950

and the death occurred on 24 February 2008

on the railway track between Bell and Preston train stations at the Edith Street, Preston pedestrian crossing

from:

1(a) INJURIES SUSTAINED WHEN STRUCK BY A TRAIN

Pursuant to section 67(1) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. Mairi Elizabeth Noble (**Ms Noble**) sustained fatal injuries as a result of being struck by a train at approximately 12.33 am on Saturday 24 February 2008.

BACKGROUND CIRCUMSTANCES

2. Ms Noble, born 30 July 1950, was 57 years old at the time of her death. She is survived by her son, Callum Bruce Kirk (**Callum**). Ms Noble lived at 5 Wymbir Avenue, Preston (**the Home**) for approximately 18 years, during which time she resided, on and off, with Callum.
3. While Ms Noble had a long history of alcoholism, she achieved significant periods of sobriety with the support of Alcoholics Anonymous. Leading up to Ms Noble's death she had a number of stressors including maintaining sobriety and the return of Callum to live in the Home with his pregnant girlfriend.
4. In December 2007, Ms Noble was involved in a motor vehicle accident. It was also around this time that Ms Noble resumed consuming alcohol. Consequently, Ms Noble was admitted as an inpatient at North Western Mental Health, Northern Psychiatric Unit between 4-10 January 2008 for mental health related issues. After her discharge from this facility, Victoria Police attended at Ms Noble's address on three separate occasions prior to her death.
5. On 12 January 2008 police officers attended at the Home to conduct a welfare check in relation to Ms Noble. As a result of this attendance the police officers exercised their power to

apprehend Ms Noble under section 10 of the *Mental Health Act 1986*[1] because she made threats of suicide, including threats to jump in front of a train. The same day, Ms Noble was admitted to the Northern Mental Health Services and she was discharged on 19 February 2008 at 5.45pm to her friend's address because she stated that she would not return to the Home while her son was living there. Despite Ms Noble's indication that she would not return to the Home, later that day police officers again attended at the Home as a result of a request by Callum for assistance with his mother. While Ms Noble was heavily intoxicated and unable to communicate effectively, she expressed no overt suicidal intentions and the police officers took no action.

6. Ms Noble also attended the Northern Hospital Emergency Department **(ED)** twice on 20 and 21 February 2008. The circumstances of these attendances were the subject of an inquest (see below).

7. It is not clear from the evidence if Ms Noble returned to stay with her friend after leaving the ED on Friday 22 February 2008. However, the evidence indicates that eventually Ms Noble returned to the Home and put all of Callum's clothing outside and told him to leave. Ms Noble also told Callum that he was the cause of her wanting to kill herself.

8. On Saturday 23 February 2008, Ms Noble telephoned the Melbourne Alcohol Recovery Centre **(MARC)** requesting to stay there. Due to MARC being full, Ms Noble was advised by Brian Cox, MARC Coordinator, to go back to hospital and Alcoholics Anonymous. Later that day, at 4.00pm, Ms Noble had an argument with Callum after he returned to the Home to collect a bag of tomatoes. Ms Noble stated she was going to get a court order to prevent him from being at the Home. Callum retaliated by saying she would not have anything to do with his child and left.

9. On Sunday 24 February 2008, at 12.33pm, Ms Noble died from injuries sustained from placing herself in front of a train in Preston.

10. It is unknown how Ms Noble spent the hours immediately leading up to her death. However, post-mortem toxicology suggests that Ms Noble had not been drinking alcohol.

JURISDICTION

11. At the time of Ms Noble's death the *Coroners Act 1985* (Vic) applied. From 1 November 2009, the ***Coroners Act 2008*** **(the Act)** has applied to the finalisation of investigations into deaths that occurred prior to the commencement of the Act.[2]

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[1] Section 10 of the *Mental Health Act 1986* has now been replaced by section 351 of the *Mental Health Act 2014*.
[2] *Coroners Act*, section 119 and Schedule 1.

12. Ms Noble's death was a reportable death under section 3 of the *Coroners Act 1985* because her body was located in Victoria, the death occurred in Victoria and it was unexpected and arose directly from an accident or injury.

PURPOSE OF A CORONIAL INVESTIGATION

13. The purpose of a coronial investigation is to independently investigate a reportable death to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred. The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[3]
14. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention' role.[4] Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice. These are effectively the vehicles by which the prevention role may be advanced.
15. It is not the Coroner's role to determine criminal or civil liability arising from the death under investigation. Nor is it the Coroner's role to determine disciplinary matters.
16. Senior Constable Lucas Betts was the nominated coroner's investigator[5] and he prepared the inquest brief.
17. Section 52(2) of the Act provides that it is mandatory for a coroner to hold an inquest into a death if the death or cause of death occurred in Victoria and a coroner suspects the death was as a result of homicide, or the deceased was, immediately before death, a person placed in custody or care, or the identity of the deceased is unknown.

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[3] 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).

[4] The "prevention" role is now explicitly articulated in the Preamble and purposes of the Act of the Coroners Act 1985 where this role was generally accepted as "implicit".

[5] A coroner's investigator is a member of the police force nominated by the Chief Commissioner of Police or any other person nominated by the coroner to assist the coroner with his/her investigation into a reportable death. The coroner's investigator takes instructions directly from a coroner and carries out the role subject to the direction of a coroner.

18. Ms Noble's identity was not in dispute, she was not a person placed in "custody or care" as defined by section 3 of the Act and her death was not the result of a homicide. Therefore, it was not mandatory to conduct an inquest into the circumstances of her death. However, I exercised my discretion, pursuant to section 52(1) of the Act, to hold an inquest because I had identified matters of public health and safety relating to her attendances at the Northern Hospital ED in the days leading up to her death that required further investigation.
19. This finding draws on the totality of the material, the product of the coronial investigation of Ms Noble's death. That is, the Court records maintained during the coronial investigation, the inquest brief and the evidence obtained at the inquest.
20. In writing this finding, I do not purport to summarise all of the evidence, but refer to it only in such detail as appears warranted by its forensic significance and the interests of narrative clarity.

STANDARD OF PROOF

21. All coronial findings must be made based on proof of relevant facts on the balance of probabilities and, in determining this; I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[6] These principles state that in deciding whether a matter is proven on the balance of probabilities, in considering the weight of the evidence, I should bear in mind:
    a. the nature and consequence of the facts to be proved;
    b. the seriousness of an allegation made;
    c. the inherent unlikelihood of the occurrence alleged;
    d. the gravity of the consequences flowing from an adverse finding; and
    e. if the allegation involves conduct of a criminal nature, weight must be given to the presumption of innocence, and the Court should not be satisfied by inexact proofs, indefinite testimony or indirect inferences.
22. The effect of the authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

CORONIAL INVESTIGATIONS

Identity of the Deceased

23. The Deceased's identity was not in dispute and required no further investigation.

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[6] (1938) 60 CLR 336.

Medical Cause of Death

24. On 25 February 2008, Dr Matthew Lynch (**Dr Lynch**), Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination on Ms Noble's body in the context of the senior next of kin objecting to an autopsy.

25. Dr Lynch concluded that the reasonable cause of death was 'injuries sustained when struck by a train.'

26. Toxicology testing was conducted and I agree with Dr Lynch's conclusion that a rational interpretation of the results is difficult in the absence of a complete post-mortem examination.

Directions hearing and the Inquest

27. On 28 February and 28 March 2011, I conducted a Directions Hearing where I directed the scope of the Inquest and witnesses to be called. I also granted leave for the NorthWestern Mental Health Service; and Northern Health (the Northern Hospital) to be interested parties at the Inquest.

Issues investigated at Inquest

28. The main issues for examination at the Inquest concerned the circumstances leading up to Ms Noble's death and whether it could have been prevented. Ms Noble had been an inpatient approximately five days before her death and with two subsequent presentations at the ED after her discharge with some evidence of self harming during that time.

29. The scope of the Inquest was to investigate how Ms Noble was managed in the last two presentations to the Northern Hospital rather than the method of which she chose to end her life.

Viva voce evidence at the Inquest

30. A four-day inquest was held on 5, 6, 7 September 2011 and 28 November 2011. *Viva voce* evidence was obtained from the following witnesses at the Inquest:
    a. Dr Michelle Mok, Emergency Registrar.
    b. Douglas John MacLeod, Clinical Psychologist.
    c. Dr Warrick James Pill, Intern.
    d. Robyn Moreland, Psychiatric Nurse.
    e. Dr Shu-Haur Ooi, Emergency Consultant.
    f. Dr Sharanjeet Sidhu, ED Registrar.
    g. Brian Arthur Cox, founder of the Melbourne Alcohol Recovery Centre Incorporated.
    h. Dr Vaidy Swaminathan, Consultant Psychiatrist

i. Dr Helen Evnomia Stergiou, Director Northern Hospital ED.

31. Dr Vaidy Swaminathan (**Dr Swaminathan**), consultant psychiatrist, detailed his involvement with Ms Noble. He first saw her on 4 February 2008, reviewed her extensively on 15 February and again on 19 February 2008. Dr Swaminathan's evidence was that he became familiar with Ms Noble's circumstances during that time. He gave evidence about her diagnosis and he referred to a transition from an initial diagnosis of severe psychotic depression to mild/moderate depression. Dr Swaminathan's evidence also acknowledged the upheavals in Ms Noble's life and psychosocial stressors which contributed to her care. Both Dr Swaminathan and psychiatric nurse Robyn Moreland (**Nurse Moreland**), Registered Nurse Division 1 and ECATT Coordinator and triage nurse in the ED, identified that these matters were causing Ms Noble to be distressed and were ongoing. Both gave evidence that Ms Nobel's home situation was what caused her distress and that there was a difficulty for the mental health service to be able to address these particular issues.

<u>20 and 21 February 2008 (second last presentation before death)</u>

32. On 20 February 2008, at approximately 8.54pm Ms Noble was taken to the Northern Hospital ED by Ambulance Victoria with intoxication, superficial self-harm cutting, sad mood and a reported history of wanting to kill herself, including an attempted hanging. Upon admission to the ED, staff were provided with three detailed notes written by Ms Noble containing statements that she wanted to die, deserved to die and her difficulties with her current emotional and social situation. The notes also contained themes of feeling scared, anger towards her son and that the house was dirty and she could not be bothered cleaning.[7]

33. Dr Shu-Haur Ooi (**Dr Ooi**), emergency consultant, initially assessed Ms Noble. Ms Noble told Dr Ooi that she had written the notes the day before, that she had drunk a bottle of brandy and then cut herself with a razor blade and ingested a whole packet of mirtazapine. Dr Ooi's evidence was that Ms Noble advised that she had discharged herself from the Northern Hospital Psychiatric Unit the previous day. Dr Ooi's initial assessment was:

> *Mairi was intoxicated. Vital signs were within normal limits. There were multiple superficial lacerations to wrists and both forearms not requiring sutures. Mental state examination was of an intoxicated woman dressed in night clothes. Difficult rapport as Mairi was evasive answering questions (e.g. when asked what she wanted, replied "a sandwhich (sic)" and did not directly answer questions about suicidal ideation). Mairi described her mood as sad with a restricted affect. No formal thought disorder, content*

[7] Inquest Exhibit 6.

evasive and limited. No overt perceptual abnormalities. Insight and cognition limited due to acute intoxication and as such Mairi needed to remain in hospital until sober enough to be assessed by ECATT"[8]

34. Dr Ooi's evidence was that she did identify Ms Noble as a patient who was potentially at risk of suicide. Despite Dr Ooi acknowledging there was substance abuse she had ruled out organic brain syndrome and intellectual disability.[9]

35. Dr Ooi made a referral to the Emergency Crisis Assessment and Treatment Team (**ECATT**), during which she was advised by the ECATT clinician, Brendan McClelland, that there had been significant alcohol abuse in relation to Ms Noble in the last six weeks after a period of approximately 20 years of being sober, that she faced losing her home due to inability to meet repayments and that her son and pregnant girlfriend moved into her home while she was an in-patient at the psychiatric unit.

36. At 10.30pm on 20 February 2008, Dr Ooi attended a shift handover in relation to her patients. After the handover she noted that the results of Ms Noble's blood tests, taken at 9.30pm that night, recorded a blood alcohol level was 0.29%. Dr Ooi's evidence was that it is normal practice to wait for patients who present with psychiatric problems and who are also intoxicated to be sober enough to answer questions with a clear mental state.[10]

37. Dr Ooi's evidence was that Ms Noble had not expressly requested to her that she wanted to go home.[11] Her evidence in relation to not recommending Ms Noble as an involuntary patient was:

    Not while she was intoxicated and willing to stay. As I said, I only saw her for the first hour and a half and she made no indication that she wanted to leave...[12]

    ..we didn't need to detain her under the Mental Health Act, we could keep her in hospital under duty of care. So if she decided to try and leave, we could physically restrain under duty of care because she was intoxicated.[13]

38. Dr Ooi subsequently handed Ms Noble's care to Dr Sharanjeet Sidhu (**Dr Sidhu**), ED Registrar, to await an ECATT assessment once Ms Noble was sober.

39. On 21 February 2008, ECATT registered psychologist Douglas MacLeod was working the nightshift from 11.00pm alone. Mr MacLeod's evidence was:

    I'm basically the one person that's on overnight, so I take calls, like, you know, psychiatric clients or other people from the public may call into the office, you know,

[8] Inquest Exhibit 6.
[9] Transcript, page. 159.
[10] Transcript, page 148.
[11] Transcript, page 165.
[12] Transcript, page 166.
[13] Transcript, page 151.

requesting psychiatric service, and if any psychiatric clients, or people perceived with a psychiatric illness, present at the Emergency Department I go and do the assessment.[14]

40. Mr MacLeod's evidence was that all referrals to the ECATT were documented on a referral form[15] and he was not provided with one in relation to Ms Noble's presentation. Mr MacLeod was unable to explain why this did not occur, and stated that if he had received a referral *"I would've gone and done it."* [16] Mr MacLeod also stated that he would have expected either medical or nursing staff in the ED to call him if he had not attended to do an assessment, and that did not happen. [17]

41. Ultimately, the evidence suggests that at approximately 3.40am on 21 February 2008, Mr MacLeod was telephoned by the ED and asked when Ms Noble was going to be psychiatrically assessed. At this time Mr MacLeod was aware Ms Noble had been admitted to the ED, but was unaware that she had not been assessed by the evening shift. Mr MacLeod's evidence was that he had been informed by the evening shift that there were two psychiatric clients in the ED but that he was not required to see them. Mr MacLeod searched the ECATT office seeking assessment paperwork but could not find anything that indicated that Ms Noble had been assessed.

42. At 4.00am on 21 February 2008, Mr MacLeod assessed Ms Noble as requiring psychiatric registrar or consultant assessment and requested that she be contained, pending assessment, overnight in the ED. This was recorded on the MH-Assessment form, MH/1 Psychiatric registration form and in the ED Observation Chart as the outcome of the ECATT assessment. During Mr MacLeod's psychiatric assessment he noted that Ms Noble appeared to be sober, lucid and coherent. Mr MacLeod was aware that Ms Noble had previously been an inpatient in the hospital's psychiatric unit and had been discharged the previous day. Mr MacLeod's evidence was:

   Mairie (sic) Noble admitted during my assessment that she was an alcoholic and that she had consumed a bottle of brandy before self harming and making the suicidal threats that had led to her admission to the emergency department.. During my assessment I did not gain any evidence to suggest that Marie (sic) Noble was psychotic, significantly depressed or acutely suicidal. As this admissions to the emergency department followed so closely after her discharged from the psychiatric unit I requested (sic) that Marie (sic) remain in the emergency department until she could be reviewed by either the Psychiatry

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[14] Transcript, page 46.
[15] Transcript, page 46.
[16] Transcript, page 48.
[17] Transcript, page 48.

Registrar or the Consultant Psychiatrist when they commenced duty later that morning"[18]

43. Mr MacLeod handed this information to Nurse Moreland. Shortly after Mr MacLeod's assessment, Dr Sidhu was reviewing his patients in the ED and was informed by the ED staff that Ms Noble had not been assessed yet. Dr Sidhu telephoned the ECATT clinician and was told Ms Noble had been assessed earlier in the night. However, there were no ECATT notes available or recorded in the ED files or database.

44. Between 4.30am and 8.30am Ms Noble slept for some part, was escorted outside regularly for cigarettes and was provided with food when she was hungry.

45. At 7.35am Ms Noble was noted to be "*anxious, stating she wants to die, teary, restless and walking around the department*".[19] At 8.00am hospital records recorded "*Patient repeatedly asking to leave.*"[20]

46. Nurse Moreland's notes recorded that she arranged for Ms Noble to have Diazepam 5mgs at 8.35am and that Ms Noble was to be assessed by a psychiatric registrar at 9.30am. The plan of a psychiatric registrar assessment was not communicated effectively to intern Dr Warrick Pill (**Dr Pill**) and his evidence was that he did not have access to Ms Noble's medical records. Dr Pill spoke with Ms Noble at 8.35am on 21 February 2008, assessed her as having symptoms of Meniere's Disease[21] and prescribed Stemetil[22] and discharged her home. Dr Pill also recorded that Ms Noble had been seen by ECATT at this time.

47. Dr Helen Stergiou's (**Dr Stergiou**), Director Northern Hospital ED[23], evidence was that Dr Pill was acting within his scope of practice and authority to discharge Ms Noble and that, in her view, he was diligent in his attendance on Ms Noble and went above and beyond the expectations placed on medical practitioners by writing in the nursing notes when he could not find the medical records.

48. Nurse Moreland went to review Ms Noble at 9.45am and noted she was not in the cubicle allocated for her. Nurse Moreland was informed that Ms Noble had been discharged soon after the Diazepam was administered at 8.35am.

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[18] Inquest exhibit 2, page 1.
[19] Northern Hospital medical records for Ms Noble.
[20] Northern Hospital medical records for Ms Noble.
[21] Meniere's Disease is the name of a disorder or condition of the inner ear. No one knows its cause. There are no specific causes for Meniere's Disease, but the major symptoms of dizziness, vertigo, tinnitus, and hearing loss are debilitating.
[22] Stemetil is a prescription only phenothiazine used to treat nausea, vomiting and dizziness due to various causes, including migraine and Meniere's Disease.
[23] Dr Stergiou's role as Director Northern Hospital ED, was to manage the ED, including the operational and strategic components and the medical staff (see Transcript, p. 300).

49. Nurse Moreland discussed the situation with the psychiatric registrar and it was agreed that Ms Noble should be followed-up, but there was no definition as to what form of follow-up this was to be.

50. Nurse Moreland contacted Mr Steve Brown, ECATT Manager stating Victoria Police had called because Ms Noble's son had telephoned requesting Ms Noble be admitted to the inpatient unit. Nurse Moreland, as part of her follow up plan spoke to Ms Noble by telephone and discussed with her the merits of returning to her friend's home. Nurse Moreland recorded "*Marie (sic) agreed to this but I wasn't convinced that any of this would happen.*"[24] There are no further entries by Nurse Moreland in the hospital records as to how this was reconciled.

21 February 2008 (last presentation before death)

51. On 21 February 2008 at approximately 3.08pm police officers assisted ambulance officers with Ms Noble at the Home because she was 'slashing' her wrists and had several bleeding self-inflicted superficial cuts to her outer arms. Callum was also present at the Home. Ms Noble told the paramedics that she had consumed 30 prescription tablets and the packets were handed to the paramedics. Ms Noble also complained of having tinnitus in her ears. Ms Noble was distressed and she stated that she should just "*end it now and jump in front of train.*"[25] The police officers exercised their power to apprehend Ms Noble under section 10 of the *Mental Health Act 1986* because they formed the belief that Ms Noble had a mental illness and was likely to attempt suicide. Ms Noble was taken by ambulance to the Northern Hospital for assessment.

52. At approximately 7.15pm, Dr Michelle Mok (**Dr Mok**), ED Registrar, initially assessed Ms Noble. Ms Noble had been triaged as a category 3 patient and was seen within the hour.

53. Dr Mok was aware from hospital notes and ambulance records that Ms Noble had been discharged from the Northern psychiatric ward on 19 February after being admitted on 12 February 2008 for alcohol abuse and multiple attempts of self-harm. Dr Mok was also aware that Ms Noble presented at the Northern ED on 20 February 2008 at approximately 9.00pm due to intoxication and was discharged sometime in the morning of the 21 February 2001, following a review by ECATT. Dr Mok was also aware that hospital records recorded that Ms Noble had tried to hang herself with an electrical cord on 20 February 2008. Ms Noble told Dr Mok during her assessment that:

> *she went home that morning (21/2/2008) and drank 4 cans of mixed spirits and had cut her legs with razor blades. She also stated she had taken medications of Tebmion*

[24] Inquest exhibit 5, page 2.
[25] Coronial brief, page 25.

(Ginko Bilboa), Mirtazapine (antidepressant) 30mg (pack of 30) and Zyprexa (Olanzapine, antipsychotic), 2.5mg (pack of 28) but not full packages and she was unsure how many were left... She denied taking any paracetamol or salicylates and stated she was not currently suicidal at the time. She had complained about ringing in her ears to ambulance officers during her transport to hospital but did not have any when asked.[26]

54. Dr Mok's evidence was that while she was predominantly attending to Ms Noble's physical care and had medically cleared her, she was concerned about Ms Noble's recent and multiple admissions to hospital and referred her to be psychiatrically assessed.[27] Dr Mok stated:

    I thought she sounded like she was depressed and had issues with alcohol intoxication and self-harm, and had multiple presentations. [28]

55. Dr Mok also conducted a physical examination at approximately 8.00pm during which she considered that Ms Noble responded appropriately and did not appear intoxicated. Dr Mok's records included:

    ..alert and orientated to time, place and person...denied any suicidal ideation for a second time, and stated she was feeling much better about herself... She had multiple superficial lacerations to both her arms and lower legs that did not require suturing.[29]

56. Dr Mok's evidence in relation to assessing a patient's suicidality was that she asks them specifically whether they were considering suicide if they have any thoughts of self-harm. [30]

57. Blood samples, taken at approximately 9.00pm, excluded toxic levels of alcohol, paracetamol and salicylates.

58. Dr Mok's evidence was that at approximately 9.30pm, Ms Noble informed her that she had called a friend to keep her company while she was being assessed. Dr Mok stated:

    Given her apparent sobriety and assurance that she was no longer planning to self-harm, she was not psychiatrically recommended, but I deemed that she required psychiatric review and management. [31]

59. While Dr Mok had medically cleared Ms Noble for her physical conditions, she referred her to ECATT, because of her recent and multiple admissions she deemed Ms Noble required

[26] Inquest exhibit 1, page 1.
[27] Transcript, page 13.
[28] Transcript, page 14.
[29] Inquest exhibit 1, page 1.
[30] Transcript, page 18.
[31] Inquest exhibit 1, page 2.

follow-up.[32] Dr Mok also attempted to contact Callum via a mobile phone number, but was unsuccessful.[33]

60. While Dr Mok did not document this in the hospital records, she stated that at approximately 10.15pm she contacted the ECATT requesting Ms Noble be assessed and she was verbally informed by the psychiatric triage nurse that Ms Noble would be assessed after the 11.00pm shift hand over. Dr Mok then informed Ms Noble that she would be required to stay at the hospital until the ECATT staff reviewed her that evening. Ms Noble verbally agreed to wait to be assessed by the ECATT staff. Dr Mok said that if Ms Noble had given any indication that she was not prepared to wait for a psychiatric assessment she would "*ask the psychiatric team to see whether they could come and see her urgently.*"[34]

61. At approximately 10.30pm, during a formal handover to the nightshift ED staff, Dr Mok's evidence was that she advised then that Ms Noble was awaiting ECATT review.

62. Dr Mok attended to Ms Noble four times over the course of a three-hour admission. While Dr Mok did not form the view that Ms Noble's circumstances warranted any detention or recommendation under the *Mental Health Act*, she appropriately, out of concern for Ms Noble re-presenting, referred her to ECATT again.

63. On 21 February 2008, at approximately 11:30pm Mr MacLeod was called by one of the admitting officers in the ED to review a young man presenting with panic attacks and anxiety disorder. When he arrived in the ED he was informed that Ms Noble had re-presented to the ED earlier in the evening and that she was sober, waiting with a friend and requesting to go home. Mr MacLeod's evidence was that he had not been informed of the reason Ms Noble had re-presented to the hospital. When Mr MacLeod completed his assessment with the young man with panic attacks and anxiety disorder, he was informed that Ms Noble had left the hospital. Mr MacLeod stated:

> *As I had requested that Marie (sic) be reviewed by a senior psychiatric officer the day prior I had assumed this had taken place and that Marie (sic) had been discharged home. At the time I did not have any concern for her safety. I tried to locate Marie's (sic), medical file but was unsuccessful. The clerk I spoke to said that it was probably in transit between departments and would be unavailable until later that morning. At the end of my shift I spoke with Psychiatric Nurse, Margaret Farrell, about Marie (sic) Noble's presentation to the emergency department. I informed Ms Farrell I was unable*

[32] Transcript, page 28.
[33] Transcript, page 29.
[34] Transcript, page 28.

to determine the outcome of the review the previous day and what follow up had been arranged. Ms Farrell undertook to follow this matter up, and if no management plan had been put in place she would investigate why and attempt to initiate appropriate follow up."[35]

64. Hospital records indicate that Ms Noble had pathology taken, was given food and discharged home in the company of a friend. The discharge date recorded on the ED Admission Confirmation (352950) form was recorded as Friday 22 February 2008 at 12.26am. The MH-Intake /Transfer Summary completed by ECATT Clinician A. McLennan records the referral to ECATT as 21 February 2008 at 2215hrs, with a plan for *Ax*[36] *in ED*. However, all relevant witnesses could not confirm whether this assessment took place and there is no record of this assessment taking place.

65. Dr Swaminathan's evidence was that Ms Noble's diagnosis had changed and she was considered to suffer from moderate to mild depression and was unlikely, on the night of 21 February, to have been in a mental state warranting involuntary admission. The evidence of Dr Swaminathan and Nurse Moreland was that Ms Noble's difficulties were psychosocial in nature and that there was little that could be done by the hospital or the mental health services to assist her to deal with her home circumstances. Their evidence was that Ms Noble's depression resulted from psychosocial stressors; that a psychiatric admission would be of limited utility and would not assist in alleviating those psychosocial stresses as they would remain in place whenever she went home unless she was able to do something about them herself. When asked about what impact the argument Ms Noble had with her son, shortly before her death, might have had on her, Dr Swaminathan stated:

    I think it would have further reinforced the fact that - you know, her sense of poor self-esteem and her sense of disempowerment about being unable to actually get her way through, get her viewpoint to her son. It could have made her even feel worse than she was feeling before.[37]

66. In the 48 hours between the time Ms Noble left the hospital and the evening of the Saturday, 23 February 2008, and the morning of Sunday, 24 February 2008, Ms Noble sought assistance from two friends, one of whom was Mr Cox seeking assistance for accommodation on Saturday 23 February 2008. Through no fault of his own, Mr Cox, was not able to assist her, but offered to return with her to the hospital. Mr Cox's evidence was that Ms Noble refused that offer.

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[35] Inquest exhibit 2, pages 1 and 2.
[36] Ax – abbreviation for 'assessment'.
[37] Transcript, page 277.

67. Evidence was also given in relation to the existence of a recording system commonly referred to as the 'Green Book'. The Green Book's purpose was to record all persons requiring ECATT. Evidence produced at the inquest was that although it was relied upon as the key form of communication, it was not effective.

COMMENTS

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

68. The evidence revealed communication problems between the ED and the ECATT, and also within those departments themselves, to the extent that Ms Noble's care was not as optimal as it should have been.
69. I accept Dr Sidhu's evidence that the ED was extremely busy during the times Ms Noble presented at the ED. Hospital records produced at the Inquest confirm this.
70. I also accept Northern Health's concession, through its counsel, Ms Foy, that there were communication gaps in the care of Ms Noble. Most importantly, on the night of 21 February 2008, Dr Sidhu was never informed about the departure of Ms Noble when she should have been.
71. Mr Bushby, counsel for ECATT, made submissions that due to a lack of resources, there was no proper and effective system for the delivery of referral notes or management of patients between the ED and ECATT, which I have noted.
72. Mr Bushby submitted that "*staff and doctors don't make mistakes deliberately - it's just a question of time resource, it's a question of systems that sufficiently cover it.*"[38] Mr Bushy also conceded that the:

> *Northern Hospital and North Western Mental Health Service let Ms Noble down... communication across the board was lacking and contributed to that failure to provide her with the care that she needed and the assessments that she needed at the time."*[39]

73. Nonetheless, the management of the hospital notes remains an issue. Dr Pill, on the morning of 21 February 2008, was unable to find Ms Noble's notes and Mr Macleod says he too was unable to find notes in the early hours of 22 February 2008.
74. Since Ms Noble's death, the Northern Hospital has made a number of improvements, including:
    a. The establishment of a 16 bed short stay unit for observing patients for a prolonged period of time, generally up to 24 hours, in a calmer environment. Dr Ooi's evidence was that had this service been available, Ms Noble could have been referred as *"she was not*

[38] Transcript, pages 371-372.
[39] Transcript, page 374.

aggressive, that she was intoxicated and needed to sleep that off, and that she was not likely to be assessable by ECAT for a significant period of time."[40]

b. The development and implementation of the 'Re-presentation policy' which highlights the need to prioritise care for patients who re-present to the ED.

c. The ECATT has been co-located with the ED to ensure effective communication and continuity of care for patients who present with mental health issues.

d. There is now a direct telephone extension for ECATT.

e. The ECATT now only performs a service at the hospital and has been disassociated from the community referral system. This allows the ECATT to prioritise ED patients.

f. Hospital staff now have better access to the records of the previous admissions by way of scanned notes, and notes of an ED presentation would now be available to the staff of ED within 12 hours.

g. A consultation liaison staff nurse has been appointed by the Northern Hospital, who plays a greater role in training of ED staff.

h. A $15 million expansion to the Northern Hospital which is in part to take into account the allowance for better patient flow and better management of mental health patients when they first arrive.

i. Changes to the physical location of mental health patients in the ED.

75. On Ms Noble's second last presentation, Dr Ooi properly made a referral to ECATT seeking expert advice about Ms Noble's mental state. I make no criticism of any of the hospital staff or mental health clinicians that attended to Ms Noble. I agree with Ms Foy's submissions that the ED's referrals to ECATT were because they relied on the ECATT service to provide them with more expert advice about what should be done in the circumstances.

76. I note Ms Foy's submissions that even if Ms Noble had been assessed on the morning of 22 February by Mr Macleod, the evidence strongly indicates that it was more than likely that Ms Noble would have been discharged either that morning or during the course of the next day.

77. However, the issue is not whether Ms Noble would have been admitted as an involuntary patient, but whether she received appropriate care during her last and second last presentations to the Northern Hospital. The weight of the evidence, however, indicates that even if Ms Noble had been properly assessed it is unlikely she would have been classified as an involuntary.

78. I agree with Ms Foy that these issues are systemic issues and should not result in criticism of individual practitioners of the Northern Hospital.

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[40] Transcript, page 167.

79. While I am concerned that the evidence identified systemic short comings at the Northern Hospital which affected Ms Noble's care, I do not consider that they caused or contributed to her death.

FINDINGS

Pursuant to section 67(1) of the *Coroners Act 2008*, I make the following findings connected with the death:

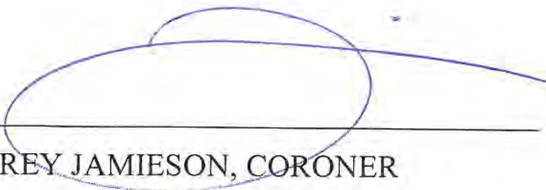
80. I find that the identity of the deceased was Mairi Elizabeth Noble, born 30 July 1950 and her death occurred on 24 February 2008.
81. I accept and adopt the conclusions of Dr Lynch and I find that Mairi Elizabeth Noble's death was as a result of 'injuries sustained when struck by a train.'
82. While evidence demonstrates there were difficulties with Ms Noble's care in the last and second last presentations to the hospital, which represent short comings in managing her complex mental and social issues, I find that those shortcomings were not the cause of her death.

Pursuant to section 73(1) of the *Coroners Act 2008,* I order that this Finding be published on the internet.

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

- Ms Noble's family.
- NorthWestern Mental Health Service.
- Northern Health (the Northern Hospital).
- Senior Constable Lucas Betts, Coroner's Investigator.

Signature:



AUDREY JAMIESON, CORONER

15 February 2016