IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 002317

FINDING INTO DEATH WITH INQUEST[1]

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

Inquest into the Death of: NARELLE ENA CLANCY

Hearing Dates:	3 March 2014
Appearances:	Mr Robert McCloskey of Counsel – on behalf of North Western Mental Health Service Mr Sean Cash of Counsel – on behalf of Dr Richard Keuneman
Police Coronial Support Unit:	Sergeant David Dimsey, Assisting the Coroner
Findings of:	AUDREY JAMIESON, CORONER
Delivered on:	7 May 2015
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street Southbank VIC 3006

[1] The Finding does not purport to refer to all aspects of the evidence obtained in the course of the Investigation. The material relied upon included statements and documents tendered in evidence together with the Transcript of proceedings and submissions of legal representatives/Counsel. The absence of reference to any particular aspect of the evidence, either obtained through a witness or tendered in evidence does not infer that it has not been considered.

I, AUDREY JAMIESON, Coroner, having investigated the death of NARELLE ENA CLANCY

AND having held an Inquest in relation to this death on 3 March 2014

at Melbourne

find that the identity of the deceased was NARELLE ENA CLANCY

born on 20 February 1962

and the death occurred on 24 June 2011

at Peck Avenue, near Pascoe Vale Road, Strathmore Victoria 3041

from:

I (a) HANGING

in the following circumstances:

1. Ms Narelle Ena Clancy was found deceased on 24 June 2011, hanging from a footbridge at the above location. She was an involuntary patient under the *Mental Health Act 1986* (Vic) (the Mental Health Act),[2] and had absconded from the Broadmeadows Inpatient Psychiatric Unit (BIPU) on the evening of 22 June 2011.

2. The death of Ms Clancy was *reportable* as defined in the *Coroners Act 2008* (Vic) (Coroners Act).

3. An Inquest into Ms Clancy's death was mandated pursuant to section 52(2) of the Coroners Act as Ms Clancy was, immediately before death, a person placed in custody or care as defined in section 3 of the Coroners Act. An Inquest was held on 3 March 2014.

BACKGROUND CIRCUMSTANCES

4. Ms Clancy was born on 20 February 1962 and was 49 years old at the time of her death. She lived in Tullamarine with her son Mr Phillip Bruce,[3] aged 28 at the time.

5. Ms Clancy had had a younger daughter, Simone Bruce. In 1991, Ms Clancy, her husband Mr Peter Bruce, and the children were living in Darwin, NT. Ms Clancy and Mr Peter

[2] As it then was.

[3] All references to "Mr Bruce" refer to Ms Clancy's son, Phillip.

Bruce separated, and Ms Clancy and the children moved to Lismore, NSW in 1995. In 1998, the children moved to Landsborough, Queensland, to live with their father, his new partner and her children.

6. On 16 July 1999, Simone Bruce suicided by hanging at age 14. Ms Clancy was still in Lismore at the time, and Mr Bruce was aged 16 and was living in a youth refuge accommodation in Caloundra.

7. Ms Clancy suffered mental ill health following her daughter's death, and often blamed herself. Mr Bruce went to live with Ms Clancy in Lismore to look after her, following Simone's death. He stated that his mother became isolated, and was using alcohol, cigarettes and marijuana. Mr Bruce moved to Coffs Harbour in early 2000 and he and Ms Clancy maintained infrequent contact.

8. Mr Bruce states that Ms Clancy moved to the opal fields in Lightning Ridge, NSW, between 2004 and 2008. They would speak on the phone about every two months, and Mr Bruce stated that oftentimes she would state that she was sick of life and blamed herself for Simone's death.

9. In 2008, Mr Bruce moved to Melbourne and Ms Clancy contacted him by phone, stating that she was finding living on the opal fields distressing, and that she would kill herself if she remained there any longer. Mr Bruce was in a relationship with Ms Derya Ali at the time and they had moved into a unit in Tullamarine. Ms Clancy moved to Melbourne to live with them in around August or September 2009. Her mother died in Lismore the very same day, and Mr Bruce stated that this affected her greatly. Ms Clancy would use marijuana daily.

10. Around two to three months later, Ms Clancy began seeing a psychologist, and her mood improved, however she became scared and paranoid when out in public. At around this time, Ms Clancy revealed to Mr Bruce and Ms Ali that she had tried to end her life a few times.

11. Mr Bruce and Ms Ali's relationship ended and Ms Ali moved out of the unit, but maintained a friendship with Mr Bruce. Ms Clancy remained living with her son in the unit. In 2011, she began exhibiting paranoid behaviour. She continued to talk about Simone's death and Mr Bruce reassured her that it was not her fault.

12. On 11 June 2011, Ms Clancy was admitted to the John Cade ward at the Royal Melbourne Hospital. A diagnosis of borderline/histrionic traits and situational crisis was

made. Mr Bruce stated that he returned home from work that night to find that his things had been "trashed" by Ms Clancy, and that she had written on the bathroom mirror that Mr Bruce was responsible for Simone's death. Ms Clancy was discharged on 17 June 2011.

13. On 19 June 2011, Ms Clancy telephoned police after an argument with Mr Bruce at their home. Police arrived and were concerned for Ms Clancy's mental health, and transported her to the Royal Melbourne Hospital emergency department (ED) for treatment under section 10 of the Mental Health Act. She was discharged home at around 1.00am the next morning, 20 June 2011, and returned home stating to Mr Bruce that she had tried to hang herself with her mobile phone charger.

14. Mr Bruce stated that Ms Clancy's paranoia had worsened the next morning, and he telephoned the North West Enhanced Crisis Assessment Treatment Team (ECATT). Ms Clancy was assessed as presenting in an agitated and hostile manner towards Mr Bruce and Ms Ali, and as histrionic with acting out behaviour. She was not found to be demonstrating psychotic or acute depressive symptoms and stated that she would not act to take her life due to the impact on her son. She denied thoughts or plans to harm him or Ms Ali. After consultation with the Inner West ECATT in relation to Ms Clancy's previous ED presentation, a decision was made for ongoing follow up by North West CATT. Mr Bruce was advised to call police or an ambulance if Ms Clancy deteriorated overnight.

SURROUNDING CIRCUMSTANCES

15. Ms Clancy's mental health deteriorated and Mr Bruce called an ambulance later that night on 20 June 2011. Ms Clancy was transported to the Royal Melbourne Hospital ED, before being transferred to the BIPU low dependency unit (LDU), an unlocked ward, on 21 June 2011 at around 6.41pm. A mental health assessment was undertaken by Psychiatric Registrar Dr Emre Bora on arrival, during which Ms Clancy expressed suicidal thoughts. At this time, Ms Clancy remained a voluntary patient.

16. On Wednesday 22 June 2011 at 11.00am, Ms Clancy underwent a mental health assessment with Consultant Psychiatrist Dr Richard Keuneman together with Senior Psychiatry Registrar Dr Padmakumar Prabhakaran and contact nurse Ms Jessica Jackson. Dr Keuneman also perused her BIPU admission notes, Royal Melbourne discharge summary Hospital, and ECATT assessments.

17. Dr Keuneman stated that Ms Clancy was "*uncooperative and irritable in her mood, was sarcastic rude gesturing*" and "*on attempts to engage her in discussion she was irritable and declined to engage*".[4] Dr Keuneman assessed Ms Clancy's insight and judgement as poor and, in consultation with the treating team, a decision was made to invoke involuntary status under the Mental Health Act. His plan was for

> *close observation of behaviour and risk levels on the LDU, with a low threshold for a decision to transfer to the higher intensity ICA (intensive care) section of the ward should concern emerge in the realm of hyper aroused, agitated, distressed behaviours or manic or delusional symptoms, or should the patient begin again to express frank suicidal ideas or behaviour or should other risk concerns emerge.*[5]

18. Throughout the course of the afternoon, nursing staff observed Ms Clancy at 15-minute intervals. She was observed to spend time in the courtyard, day room, toilets and her bedroom. Occupational Therapist Mr Tom Domjancic attempted to engage with her at 4.00pm, but Ms Clancy was uncooperative and refused to leave her room. She was last documented to have been sighted by nurse Mr Mathew Canty at 5.30pm. Mr Canty took his meal break just after 5.30pm and informed the shift leader, Ms Komal Preet, of his absence from the ward due to his meal break.

19. Ms Preet states that she took over the visual observations and last saw Ms Clancy at 5.40pm, smoking a cigarette in the courtyard. Ms Clancy could not be found by the time Mr Canty returned from his break at 6.00pm, and staff determined that she had absconded from the unit. Staff commenced the 'absent without leave protocol', and notified local police and Mr Bruce that Ms Clancy was missing.

20. On Friday 24 June 2011 at around 7.35am, a member of the public was walking east along Peck Avenue, Strathmore, and observed a person who appeared deceased at the end of a concrete base support of the footbridge overpass. The witness telephoned 000 and police and paramedics attended. Police observed the deceased to be a woman with a black nylon stocking around her neck, which was tied to the metal railing of the overpass. She was found near the beginning of the bridge on the western side of Peck Avenue, with her legs resting on the ground, folded underneath her. Police found a piece of paper in her jeans pocket with 'Phil' and Mr Bruce's mobile phone number written on it, a business

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[4] Exhibit 6, Statement of Dr Richard Keuneman, inquest brief page 63.

[5] Ibid, page 64.

card for Mr Bruce's former employer, cigarettes, a lighter, a small amount of cash and a 'Patient Clothing and Valuables' form in Ms Clancy's name from BIPU. Mr Bruce later confirmed Ms Clancy's identity.

INVESTIGATIONS

Identity of the deceased

21. The identity of Narelle Ena Clancy was without dispute and required no additional investigation. I find that the identity of the deceased is Narelle Ena Clancy.

Forensic Pathology

22. Dr Michael Burke, Senior Pathologist at the Victorian Institute of Forensic Medicine, performed an autopsy on the body of Ms Clancy, reviewed a post mortem CT scan and the Form 83 Victoria Police Report of Death. Dr Burke attributed the medical cause of Ms Clancy's death to *hanging*. He commented that *"[t]he post-mortem examination showed an abraded injury and furrow to the neck and fractured left hyoid indicating hanging*".

23. Dr Burke did not identify evidence of any other significant injury and stated that there were no injuries to suggest involvement of any other person. Toxicological analysis of blood retrieved post mortem was negative for the presence of alcohol and revealed the presence of Olanzapine (indicated for the treatment of schizophrenia) at subtherapeutic concentrations at ~0.04mg/L, and Delta-9-tetrahydrocannabinol (cannabis) at ~2ng/mL.

Police Investigation

24. The circumstances of Ms Clancy's death have been the subject of investigation by Victoria Police, specifically Coroner's Investigator (CI) Leading Senior Constable (LSC) Alan Bagnato, on my behalf.

25. Issues identified requiring further exploration included:

    a. the relative proximity of the decision to treat Ms Clancy as an involuntary patient to her absconding and her death;

    b. the adequacy of any risk assessment performed at the time of and following the decision to treat her as involuntary;

    c. communication between treating staff and documentation of any observations of Ms Clancy's behavioural changes; and

d. the appropriateness of the 'open door policy' at the BIPU LDU and staffing arrangements, particularly when managing staff breaks.

JURISDICTION

26. The role of the coronial system in Victoria involves the independent investigation of deaths to determine the cause of death, to contribute to the reduction of the number of preventable deaths and for the promotion of public health and safety and the administration of justice.

27. Section 67 of the Coroners Act sets out the statutory role of the Coroner in that a Coroner must find, if possible, the identity of the deceased, the cause of death and, in some cases, the circumstances in which the death occurred.

28. A Coroner may comment on any matter connected with the death and may also report to the Attorney-General and may make recommendations to any Minister, public statutory authority or entity, on any matter connected with the death, including recommendations relating to public health and safety or the administration of justice.[6]

29. Some deaths are reportable irrespective of the nature of the death, based on the status of the person immediately before death. Ms Clancy's death was reportable as she was a person placed in custody or care.[7] This is one of the ways in which the Coroners Act recognises that people in the control, care or custody of the State are vulnerable, and affords them the protection of the independent scrutiny and accountability of a coronial investigation.

30. Another protection is the requirement for mandatory Inquests. While there is a discretionary power to hold an Inquest in relation to any death a Coroner is investigating,[8] this was a mandatory or statutorily prescribed Inquest as Ms Clancy was, immediately before death, a person placed in custody or care.[9]

INQUEST

31. An Inquest was held on 3 March 2014. Sergeant David Dimsey of the Police Coronial Support Unit acted as counsel assist.

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[6] Coroners Act 2008 section 72(1) and (2).

[7] See section 3 for the definition of a 'person placed in custody or care' and section 4(2)(c) of the definition of 'reportable death'.

[8] Section 52(1) provides that a coroner may hold an inquest into any death that the coroner is investigating.

[9] Section 52(2) and the definition of 'person placed in custody or care' in section 3.

32. *Viva voce* evidence was obtained from the following witnesses at Inquest:

a. Ms Komal Preet, Psychiatric Nurse;

b. Mr Mathew Canty, Nurse;

c. Ms Elizabeth Bedford, Psychiatric Nurse;

d. Dr Richard Keuneman, Consultant Psychiatrist; and

e. Dr Devapriya Rudolph, Consultant Psychiatrist.

Open door policy and opportunity to abscond

33. Ms Komal Preet made a statement in relation to her involvement with Ms Clancy and gave evidence at Inquest. Ms Preet was the shift leader at BIPU on 21 June 2011 and commenced work at 1.30pm. She received handover from the morning shift and greeted Ms Clancy when she arrived from the Royal Melbourne Hospital. Ms Preet stated that Mr Canty was then responsible for Ms Clancy's nursing care.[10]

34. Ms Preet understood that Ms Clancy was a voluntary patient at that time and was advised by Dr Bora after he completed his mental health and risk assessments that Ms Clancy was low risk and could be managed in the LDU.[11]

35. Ms Preet explained that there are two areas in the ward; the LDU and the Intensive Care Area (ICA). The latter is for patients who need constant monitoring because they are at immediate risk to themselves and others, and these patients cannot leave the unit on their own as the doors are locked. Patients in the LDU are provided with the least restrictive environment possible, and the main doors remain open from 8.00am to 8.00pm (but are locked during patient meal times from 1.00 to 1.30pm and 5.00 to 5.30pm). As a voluntary patient at that time, Ms Clancy could come and go as she pleased between those hours.[12]

36. On 22 June 2011, Ms Bedford was Ms Clancy's contact nurse and Mr Canty was her visual observations nurse. Mr Canty was required to sight Ms Clancy every 15 minutes. If there were any changes in her mental state at any of these observations, according to contact nurse Ms Bedford, Mr Canty *"...would've come to me and we would've gone*

[10] Exhibit 1, Statement of Ms Komal Preet dated 25 October 2011, inquest brief page 33.

[11] Ibid, page 34.

[12] Ibid.

further with it...".[13] Ms Bedford had five patients allocated to her as a contact nurse. Ms Bedford stated that she would make contact with her patients as often as possible, but at least two times during her shift.[14] The contact nurse was responsible for providing patients with their medications.[15]

37. On 22 June 2011, Ms Preet again commenced work at 1.30pm. She received handover from Ms Jackson that Ms Clancy had been assessed by Dr Keuneman and that her treatment status under the Mental Health Act had changed to involuntary, *"but low threshold for intensive care unit"*.[16] At Inquest, Ms Preet explained that this meant that if there were any change in Ms Clancy's behaviour, she would be transferred to the ICA.[17] Ms Preet herself noted that Ms Clancy's behaviour had changed significantly from the previous day.[18]

38. Ms Clancy was kept in the LDU, was being visually observed every 15 minutes and was not allowed to leave. Any behavioural changes were to be observed by regular engagement by the contact nurse. This was separate to the visual observations of Ms Clancy that were to be performed every 15 minutes, and were to be performed by another nurse,[19] Mr Canty. He stated that if he observed any change in a patient's behaviour when conducting his observations, he would attempt to discuss this with the patient and then relay this to the patient's contact nurse for further action.[20]

39. Ms Preet took over the observing duties at 5.30pm when Mr Canty took his meal break (Ms Preet was the last person to see Ms Clancy at the unit at 5.40pm). At Inquest, she testified that at this time Ms Clancy was very dismissive, and would not engage.[21] She was asked whether this caused concern or any consideration of Ms Clancy being transferred to the ICA, and responded that the next step for staff would be to consult their

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[13] Inquest transcript page 42.

[14] Ibid.

[15] Ibid page 43.

[16] Exhibit 1, above no 10, inquest brief page 34.

[17] Inquest transcript pages 6 and 9-10.

[18] Ibid page 9.

[19] Ibid page 6.

[20] Ibid page 33.

[21] Ibid page 7.

colleagues and that she would wait to speak to someone who had been observing the patient for a longer period in order to make such a decision.[22]

40. At Inquest, Ms Preet testified that following the shift handover on 22 June, afternoon shift staff understood that Ms Clancy might attempt to leave and that she should be transferred to the ICA if this occurred.[23]

41. In relation to nursing staff meal breaks, I queried whether it would be advantageous to have the LDU door locked during the times that staff were taking meal breaks (from around 5.00 to 6.30pm), in order to decrease the risk of absconding during times of staff shortages. Ms Preet responded that patients' meal times finished at 5.30pm and that they often demanded to be allowed to go outside for cigarettes afterwards, and that it was difficult to have a staff member opening and closing the door at that time, especially when staff numbers were already reduced.[24] Ms Preet agreed, however, that the practice of leaving the doors open in times of staff shortages increased the risk of absconding.[25]

42. Dr Keuneman testified at Inquest that the issue of managing the open door policy during times of staff shortages was discussed *"quite a lot"* during his time at BIPU, and that if there was a period particular high acuity, the nursing shift leader, unit manager or consultants could recommend that the door be closed more throughout the day. Dr Keuneman added that this did in fact occur during his time at BIPU.[26]

43. Ms Preet explained that no documentation or notes were maintained in relation to staff locking and unlocking the doors.[27] She did state that following Ms Clancy's death, the practice at BIPU was changed so that all the LDU doors were locked at all times.[28]

44. Mr Canty personally sighted Ms Clancy from the beginning of his shift at 2.30pm on 22 June until he took his meal break at 5.30pm. He recorded this on her sight observation

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[22] Inquest transcript page 7.

[23] Ibid page 10.

[24] Ibid page 14.

[25] Ibid page 15.

[26] Ibid page 63.

[27] Ibid page 18.

[28] Ibid pages 18-9.

chart.[29] At Inquest, he explained that his role was to visually sight the patient and where they were at the time, and not to assess the patient's mood or conduct any other behavioural observations.[30] However, Mr Canty did note a significant change in Ms Clancy's behaviour, stating that she was quite tearful and upset the previous day, and that she *"was very carefree, very relaxed...a completely different presentation from the day before"*[31] on 22 June. He stated that she did not express any thoughts of self-harm or suicide.[32]

45. In relation to observations or visual sightings of patients, Ms Preet stated that following Ms Clancy's death, the practice of 15-minute sightings was abolished and replaced with less frequent, more meaningful engagements with patients, conducted by the contact nurses. This involves an assessment and monitoring of the patient's mental state.[33]

46. Dr Devapriya Rudolph, Deputy Director of Clinical Services at North Western Mental Health, explained in his statement that the Mental Health Act requires that restrictions on the liberty of persons with a mental illness must be the minimum necessary to enable effective treatment to occur, and to ensure protection of members of the public. He stated that the practice at the time of the LDU being unlocked is consistent with this principle of the Mental Health Act, to treat patients within the least restrictive environment, and cited research that the effectiveness of locked wards was uncertain and may increase absconding.[34]

Risk assessment

47. Ms Bedford was Ms Clancy's contact nurse on 22 June 2011. She stated that she saw her twice that day from the beginning of her shift at 1.30pm.[35] Ms Bedford noted that Ms Clancy's presentation was *"totally different from when she was admitted"*[36] (based on what was communicated to her about Ms Clancy's presentation at handover), and stated

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[29] Exhibit 2, Statement of Mr Mathew Canty dated 28 August 2013, inquest brief page 44. Exhibit 3 is the sight observation chart.

[30] Inquest transcript page 27.

[31] Ibid page 29.

[32] Ibid page 34.

[33] Ibid pages 19-20.

[34] Exhibit 7, Statement of Dr Devapriya Rudolph, inquest brief pages 55-6.

[35] Inquest transcript page 40.

[36] Ibid.

that whilst she presented as *"a bit depressed"* around the anniversary of Simone's death, at no time did Ms Clancy state that she wanted to suicide or harm herself.[37]

48. Ms Bedford stated that she understood Ms Clancy's involuntary status and her risk of suicide and absconding, and stated that on both occasions that she engaged with Ms Clancy, she gave no indication that she was at risk of absconding. Ms Bedford assessed that she was *"happy to stay in the hospital"* and *"seemed to be coping with that environment"*.[38] Ms Bedford made no entry in Ms Clancy's medical records to this effect.

49. Ms Clancy was prescribed Olanzapine as needed,[39] but Ms Bedford stated that she did not administer the drug at any time. Ms Bedford stated that if another staff member had done so, it should have been brought to Ms Bedford's attention, as she was Ms Clancy's contact nurse.[40]

50. Dr Richard Keuneman was the Consultant Psychiatrist responsible for Ms Clancy's inpatient care at BIPU from the morning of 22 June 2011.[41] He first assessed her that morning and stated that,

> *[c]onsidering the history and the varied information available to me, and in discussion with Ms Clancy's contact nurse and my senior registrar Dr Prabhakaran, a team decision was made to invoke involuntary status under the mental health act on the basis of: potentially fluctuating clinical state and judgement, recent suicidal ideation/concerns, potential physical (weight loss) concerns, and diagnostic uncertainty.*[42]

51. As stated earlier, Dr Keuneman's plan was for close observation of Ms Clancy's behaviour on the LDU, with a low threshold for a decision to transfer to the ICA should any risk concerns emerge. Dr Keuneman stated, specifically, that he did not judge that the ICA would be suitable for Ms Clancy, and he *"specifically did not judge any change to her low absconding risk profile"*.[43]

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[37] Inquest transcript pages 41 and 43.

[38] Ibid pages 44-5.

[39] There was no medication chart for Ms Clancy's admission included in the North Western Mental Health Service record. The Court sought a copy of the medication chart and was advised in September 2012 by Counsel for the Mental Health Service that it could not be found.

[40] Inquest transcript pages 43-4.

[41] Exhibit 6, Statement of Dr Richard Keuneman, inquest brief page 59.

[42] Ibid page 63.

[43] Ibid page 64.

52. At Inquest, Dr Keuneman confirmed that he was comfortable with the decision for Ms Clancy to remain in the LDU,[44] and stated that there was nothing from the evidence of other nursing staff that would have indicated imminent risk concerns and warranted a change to the ICA.[45] He had parts of the statements of Ms Jackson and Dr Prabhakaran read to him that referred to his decision, and agreed that their statements accurately reflected his plan.[46] He was satisfied (albeit in the absence of any documentation) that nursing observations were appropriate to satisfy his 'low threshold' requirements.[47] When asked, Dr Keuneman agreed that more documentation of risk assessments and conversations with clients would be helpful.[48]

53. Dr Keuneman further explained that that the ICA is more highly staffed, is a locked ward, and that patients in the ICA have one-to-one contact with nursing staff.[49] He stated that it would be highly likely that behaviourally disturbed patients were present in the unit at the time and agreed that it was thus a serious therapeutic step to place anyone in the ICA.[50]

54. In relation to the open door policy in the LDU, Dr Keuneman was asked whether he considered it a potential risk for Ms Clancy. He explained that it would have been considered in a general sense and factored into his risk assessment.[51] Dr Keuneman also referred to a new formalised safety plan for residents that has come into effect following Ms Clancy's death, and that this plan included a safety plan document that must be completed by the treating team, and could be reviewed at regular intervals. Dr Keuneman stated that this was an improvement in communication of those steps that, whilst previously might have taken place appropriately, were not as clearly articulated in the previous documentation, as is the case now.[52]

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[44] Inquest transcript page 50.

[45] Ibid page 51.

[46] Ibid pages 54-5.

[47] Ibid page 57.

[48] Ibid page 58.

[49] Ibid pages 51-2.

[50] Ibid page 52

[51] Ibid page 62.

[52] Ibid page 64.

Systemic improvement

55. Dr Rudolph elaborated on Ms Preet's evidence about the departure from the practice of performing sight observations of patients every 15 minutes. He stated that the focus is now on *"seeing the patient frequently and ... engaging the patient and the nurse making a judgement at that point about when they should next try to re-engage the patient"*.[53] Dr Rudolph explained that it is expected that a patient is sighted within four times over the course of a day, and that the nurse who makes that assessment must determine how frequently they subsequently engage with the patient depending on the assessment.[54]

56. Counsel for North Western Mental Health tendered its revised Adult & Youth Acute Inpatient Clinical Risk Assessment and Management (CRAAM) guideline (effective August 2013).[55] Dr Rudolph referred to this document and explained that these were the current guidelines and reflected the changes that they introduced.

57. The CRAAM also includes a consumer engagement record for medium risk patients, in order to document the nature of the engagement that has taken place.[56] Dr Rudolph described the focus of the new guideline on *"risk management rather than risk assessment"*,[57] noting that the staff response to the changes has been positive.

58. Dr Rudolph drew my attention to a 'Consultant Revised Risk Assessment' form and stated that within one calendar day of a patient being admitted to an inpatient unit, the Consultant Psychiatrist must revise the risk assessment, and a specific part of the form concerns management of those risks.[58]

59. Dr Rudolph also confirmed the change in practice regarding the locking of the LDU doors, recalling that the change occurred at least 12 months previously, whereby the doors now remains locked.[59] Patients must now ask their contact nurse to open the doors for them if they wish to leave the hospital. He confirmed that this is a practice, and not a

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[53] Inquest transcript page 68.

[54] Ibid page 70.

[55] Exhibit 8.

[56] Inquest transcript page 70.

[57] Ibid page 76.

[58] Ibid page 69.

[59] Ibid page 70.

formal policy.[60] Dr Rudolph described a range of reasons for the change including patients absconding, complaints from families about the open door policy, and alcohol and drugs being brought onto the ward.[61] He stated that it was *"a work in progress"*, noting that patient safety must be balanced with the need to ensure the liberties and freedoms of patients,[62] and that patients might still abscond from the locked ward in other ways.[63]

Oral Submissions at the conclusion of *viva voce* evidence

60. Closing submissions were made by Counsel for Dr Keuneman only. Counsel submitted that Dr Keuneman clearly and collaboratively discussed his plan with nursing staff, that the 'low threshold' for transfer of Ms Clancy to the ICA was well understood, and that the plan was then clearly conveyed by Ms Jackson to nursing staff at handover. Counsel submitted that there was therefore no basis for any adverse finding or comment in relation to Dr Keuneman's management of Ms Clancy. I agree and accept that submission. Dr Keuneman's clinical entries in the records are thorough, and I accept his *viva voce* evidence at Inquest. I also accept that Ms Jackson clearly communicated the management plan for Ms Clancy at the shift handover. However, I note the lack of documentation of this communication.

CONCLUDING SUMMARY

61. In relation to the circumstances of Ms Clancy's death, I indicated at the conclusion of the Inquest that the main issue of concern was in relation to the documentation of communication of Ms Clancy's clinical management and care and the open door policy.

62. It is appropriate to acknowledge that North Western Mental Health has implemented a number of changes since Ms Clancy's death, including the introduction of the CRAAM guideline and associated record keeping, the change in practice from visual sightings every 15 minutes to more meaningful observations/engagements by contact nurses and the practice of the LDU now being a locked unit. I am satisfied that the changes are significant and adequately address the above issues, and I commend North Western Mental Health in this regard.

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[60] Inquest transcript page 71.

[61] Ibid page 72.

[62] Ibid page 74.

[63] Ibid page 74.

63. As such, I do not make any adverse comment or finding against North Western Mental Health. It appears that Ms Clancy had a significant mental health history, with no clear diagnosis. I am unable to establish a causal connection between clinical management and Ms Clancy's death. Questions of causation in suicide are always complex, and are not central to this investigation. The evidence available to me does not support a finding that any want of clinical management or care on the part of staff of North Western Mental Health caused or contributed to Ms Clancy's death.

FINDINGS

1. **I find** that the identity of the deceased is Narelle Ena Clancy.

2. **I find** that Ms Clancy died from hanging.

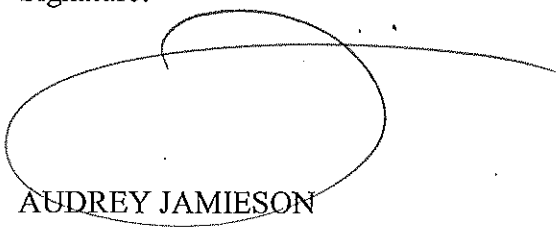
3. And **I further find** that Ms Clancy acted with the intention of ending her own life.

To enable compliance with sections 72(5) and 73(1) of the Coroners Act, I direct that the Findings will be published on the internet.

I direct that a copy of these Findings be provided to the following:

- Mr Phillip Bruce
- North Western Mental Health Service c/o Ms Jan Moffat, Donaldson Whiting & Grindal Lawyers
- Dr Richard Keuneman c/o Ms Bronwyn Francis-Martin, Thomsons Lawyers
- Dr Mark Oakley Browne, Chief Psychiatrist
- Sgt David Dimsey, Police Coronial Support Unit
- LSC Alan Bagnato, Victoria Police, Coroner's Investigator.

Signature:



AUDREY JAMIESON
CORONER
Date: 7 May 2015