IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: **COR 2015 4475**

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MR JOHN OLLE, CORONER**
Deceased:	**REBECCA VICTORIA POKE**
Date of birth:	**14 DECEMBER 1985**
Date of death:	**2 SEPTEMBER 2015**
Cause of death:	**GLOBAL CEREBRAL ISCHAEMIC INJURY IN THE SETTING OF NECK COMPRESSION**
Place of death:	**AUSTIN HOSPITAL** **145 STUDLEY ROAD** **HEIDELBERG VICTORIA 3084**

HIS HONOUR:

BACKGROUND

1. Rebecca Victoria Poke was born on 14 December 1985. She was 29 years old at the time of her death. Rebecca was married and she had three children.

2. Rebecca completed a nursing degree, but she did not finish her graduate year as she gave birth to her first child in 2008. She subsequently developed post-natal depression and was prescribed fluoxetine. Rebecca's first presentation to a mental health service was in November 2014. She was admitted to Ward E at Casey Hospital from 26 November to 9 December 2014 after taking an overdose of zopiclone. She was transferred to the Mother and Baby Unit on 9 December 2014 and stayed there until 7 January 2015. During this stay, Rebecca was diagnosed with Borderline Personality Disorder. From that time onwards, Rebecca presented at Emergency Departments on a number of occasions after suicide attempts which resulted in her readmission to hospital.

3. On 26 May 2015, Rebecca presented to the Casey Hospital Emergency Department after taking a large overdose of paracetamol, ibuprofen and alcohol. She was found in the car park of the hospital crying and was admitted under a temporary treatment order to Ward E of Casey Hospital, where she remained until her death.

THE PURPOSE OF A CORONIAL INVESTIGATION

4. Rebecca's death constituted a '*reportable death*' under the *Coroners Act 2008* (Vic), as her death occurred in Victoria, and was both unexpected and unnatural.[1]

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial[2]. The purpose of a coronial investigation is independently to 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.

[1] Section 4, definition of 'Reportable death', *Coroners Act 2008.*
[2] Section 89(4) *Coroners Act 2008.*

6. It is not the role of the coroner to lay or apportion blame, but to establish the facts.[3] It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7. The "cause of death" refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally relevant to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings and by the making of recommendations by coroners. This is generally referred to as the 'prevention' role.

10. Coroners are also empowered:

    (a) to report to the Attorney-General on a death;

    (b) 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

    (c) 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 powers are the vehicles by which the prevention role may be advanced.

11. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. In determining these matters, I am guided by the principles enunciated in *Briginshaw* v *Briginshaw*.[4] The effect of this and similar 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.

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[3] *Keown v Khan* (1999) 1 VR 69.
[4] (1938) 60 CLR 336.

MATTERS IN WHICH THE CORONER MUST, IF POSSIBLE, MAKE A FINDING

Identity of the Deceased pursuant to section 67(1)(a) of the *Coroners Act 2008*

12. Rebecca Victoria Poke was visually identified by her husband Nigel Poke on 2 September 2015. Identity was not in issue and required no further investigation.

Medical cause of death pursuant to section 67(1)(b) of the *Coroners Act 2008*

13. On 7 September 2015, Dr Paul Bedford, Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an examination of Rebecca's body and provided a written report dated 23 September 2015, concluding a reasonable cause of death to be "I(a) Global cerebral ischaemic injury in the setting of neck compression". I accept his opinion in relation to the cause of death.

14. Toxicological analysis of post mortem specimens detected the metabolite of venlafaxine[5], desmethylvenlafaxine (~0.3 mg/L), quetiapine[6] (~0.1 mg/L), zopiclone[7] (~0.02 mg/L), lignocaine[8] and paracetamol.

Circumstances in which the death occurred pursuant to section 67(1)(c) of the *Coroners Act 2008*

15. On 31 August 2015, Rebecca told her nurse that she was looking forward to another day of visiting with her children. At approximately 8.00pm, Rebecca was observed by nursing staff listening to music and she requested Pro Re Nata (PRN) medication as she stated she was having bad thoughts. Rebecca was on 15 minute observations from staff. At approximately 10.15pm, Rebecca was asked by a Nurse Kelly Frenkel if she was ok and Rebecca replied "yes and no, I am fine thanks". At approximately 10.25pm, Nurse Frenkel noticed that Rebecca was not in the dining room and she was not in her bedroom either. Nurse Frenkel alerted other team members and they began searching for Rebecca.

16. At approximately 10.35pm, Rebecca was found hanging by a ligature made from her pyjamas from a door handle in the Ward E visitor's toilet. She was unconscious and unresponsive. Staff began cardio pulmonary resuscitation and she was transferred to the

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[5] Venlafaxine is indicated for the treatment of depression.
[6] Quetiapine is an anti-psychotic drug used in the treatment of schizophrenia.
[7] Zopiclone is a cyclopyrrolone derivative used in the short term treatment of insomnia.
[8] Lignocaine is a local anaesthetic often administered to patients prior to surgery of during resuscitation attempts.

Casey Hospital Emergency Department, and then subsequently to the Intensive Care Unit at the Austin Hospital. On 2 September 2015, Rebecca was declared brain dead and her family kindly consented to organ donation.

17. Rebecca left a suicide note on her mobile telephone.

Further Investigation into Medical Care

18. There is no doubt Rebecca Poke was psychiatrically unwell, was difficult to treat and as a result she had high acute and ongoing risks. Monash Health had maintained Rebecca in subacute and acute care and supported by community case management, but the risks associated with her repeated and frequent self-harm behaviours resulted in her admission. Casey Hospital Ward E sought multiple opinions from external and internal specialities, including community support and recovery programs who would provide housing and support options for Rebecca after discharge. The diagnosis of BPD appears appropriate and the treatments, level of engagement and planning with her family, Department of Health and Human Services, Spectrum[9], Addiction Medicine, and other acute supports was considered and appropriate. The liaison with Centrelink and Child Protection and with Rebecca's ex-partner to ensure Rebecca had access to her children in a safe environment was appropriate. During the admission Rebecca had graduated planned leave both escorted and unescorted and returned from each.

19. The fluctuation of Rebecca's distress tolerance and capacity to regulate her emotional responses to personal triggers[10] required a considered and flexible management plan. Rebecca had remained in hospital for many months and was engaging with programs and individual psychologist counselling.

20. The completeness of documented assessments and recording of the rationale for the frequently reviewed level of risk and associated level of frequency of observation suggests the staff were very cognisant of Rebecca's fluctuation in risk and associated mental state. It suggests staff utilised interventions and strategies that were most relevant at each circumstance to promote her safety. Rebecca's prescribed medicines and the use of electroconvulsive therapy were appropriate.

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9 Spectrum supports the treatment of people who have severe or borderline personality disorder and who are being treated by Victorian State Government funded Area Mental Health Services (AMHS, CAMHS and other state-wide mental health services). The service has an emphasis on those who are at risk from serious self-harm or suicide, and who have particularly complex needs. <http://www.spectrumbpd.com.au/pages/about-spectrum.php>

10 Rebecca's triggers are listed in the Behavioural Management Plan as contact with her ex-partner and children; checking phone/social media; other reminders of her relationship; the overnight period and feeling neglected by staff. Monash Health digital medical record page 545.

21. The Monash Health Mental Health Risk Assessment Procedure[11] is contemporary and the review of risk for Rebecca was frequent; at least three times over 24 hours, with additional assessment documented by staff pre and post leave periods. This is in line with the policy.

22. The current Behavioural Management Plan[12] developed with Rebecca on 21 August 2015 was contemporary, appropriate, and promoted Rebecca's safety and transition to self-management, independence and her eventual discharge on 7 September 2015. This is in line with Monash Health procedures.[13] The review of the progress notes confirms the nursing staff complied with the plan including the more flexible use of the frequency of nursing observations to promote planned and approved unescorted and escorted leave. The recommended use of pro re nata (PRN) medications and follow-up direct care staff sessions when Rebecca reported increased thoughts of suicide had a settling effect, as evidenced throughout the medical records.

Self-harm behaviours

23. Rebecca Poke appears to have made 11 known low-lethality suicide attempts in Ward E from 1 to 31 August 2015. Eight of the attempts were self-strangulation without the ligature being attached to any ligature point, for example Rebecca would wrap a piece of clothing or headphones around her neck and tighten it.[14] All attempts occurred in the late evening or overnight. Nursing staff frequently adjusted the required frequency of observations to match the risks associated with the circumstances at that time. In addition, there are many instances where Rebecca told staff she felt unsafe and the response by staff was always appropriate and followed the plan of care. On occasions Rebecca also handed to staff clothing, headphones, and objects she was aware if she retained she would likely self-harm with. Rebecca also would on occasion request staff to check on her at increased frequencies because she said that during those periods she would not harm herself if she knew they would be checking.[15]

24. The decision to discharge Rebecca was made after consultation with Spectrum, the publically funded state wide speciality BPD service, who advised appropriately[16] for decreasing containment and a greater focus on reengaging with her children, engaging with a community based psychologist for long-term and evidence-based therapy, transitional

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11 Monash Health Risk Assessment in Mental Health Procedure.
12 Monash Health digital medical records pages 544 – 548.
13 Monash Health Mental Health Treatment Planning and Review Procedure & Assessment in Mental Health Procedure provided by Monash Health.
14 Monash Health digital medical records pages 1038, 1040 & 1042.
15 Monash Health digital medical records page 910.
16 Long-term hospitalization is not the most beneficial option for a person with a borderline personality disorder. National Health and Medical Research Council. Clinical Practice Guideline for the Management of Borderline Personality Disorder. Melbourne: National Health and Medical Research Council; 2012, reviewed 2015. <www.nhmrc.gov.au/guidelines/publications/mh25>

housing, support, community mental health case management and discharge.[17] The level of consultation with Rebecca's family, including her father and ex-husband, was extensive and repeated. The discharge planning[18] was based on the outcomes of a family meeting which included Rebecca.[19]

25. There is evidence Rebecca experienced periods of increased anxiety associated with her planned discharge[20] however the plan for graduated leave, including a five hour day with her children and parents (28 August 2015), escorted and unescorted leave, and extensive planning and meetings with supporting services suggests the planning was transitional, not precipitous, and was sensitive to the predicted escalation of self-harm behaviours, which did occur. It is also evident in the medical records Rebecca had periods when she was reactive, engaged and denied any suicidal thinking or plans.

26. The clinical documentation is contemporary, complete and complies with Monash Health requirements.[21]

Appropriateness of 15 minute nursing observations and Appropriateness of Contact Nurse's response on 31 August 2015

27. According to the medication charts[22] Rebecca received medications from nursing staff on the evening of 31 August 2016 and she was recorded as sighted at 7.30pm. 7.45pm, 8.00pm, 8.15pm, 8.30pm, 8.45pm, 9.00pm, 9.25pm, 9.40pm, 9.45pm, 10.00pm, 10.05pm and 10.15pm.

28. It appears Nurse Jessy Elanjickmalil was the medications nurse for the whole unit and therefore responsibility for the visual observations of Rebecca Poke was allocated to Nurse Frenkel.[23] Nurse Elanjickmalil did enquire how Rebecca was and offered her medication. It appears Nurse Elanjickmalil was intending to further explore Rebecca's mental state after the medication round, "She agreed to have a chat later regarding her mental state."[24] According to the available information, Rebecca was sighted by staff and/or interacted with frequently, the last at 10.15pm when she was in the day room and spoke with Nurse Frenkel.

29. In the context of the running of the unit, this response appears reasonable. Nurse Elanjickmalil was aware Nurse Frenkel would be completing the observations in 15 minutes

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17 National Health and Medical Research Council. Clinical Practice Guideline for the Management of Borderline Personality Disorder. Melbourne: National Health and Medical Research Council; 2012, reviewed 2015. <www.nhmrc.gov.au/guidelines/publications/mh25>
18 Monash Health digital medical records pages 895- 896 & 902-903
19 Monash Health digital medical records pages 895- 896
20 Monash Health Risk Assessment in Mental Health Procedure provided by Monash Health.
21 Monash Health Clinical Documentation Procedure provided by Monash Health.
22 Monash Health Digital Medical Records pages 1027-1032.
23 Coronial brief of evidence page 6.
24 Coronial brief of evidence page 7.

and it was part of the Behavioural Management Plan to arrange for direct care session with Rebecca after Nurse Elanjickmalil had completed the round.[25]

30. There are no issues identified with the Monash Health procedures for risks assessment and subsequent nursing observation levels that requires further investigation.

Legal status

31. Based on the Monash Health digital/medical records, Rebecca Poke was a voluntary patient under the *Mental Health Act 2014* (Vic) at the time of her death and at the time of her attempted hanging.[26] Consequently, Rebecca Poke's death does not require a mandatory inquest.

Ligature points

32. According to the information from Monash Health Ward E had been previously audited, but Rebecca Poke was able to readily access a D-shaped door handle in a bathroom. Any evidence-based or reliable ligature point audit tool would have identified the D-shaped handle as an issue. This strongly suggests the audit tool used at that time was ineffective.

33. The Casey Mental Health Unit re-audited the Ward E unit following the death of Rebecca Poke and the D-shaped door handles were removed. The re-audit also identified other risk items.[27]

34. According to the statement of Dr Martin Preston, Acting Unit head for Casey Adult Mental Health, the Monash Health Mental Health Program Ligature Audit Procedure and audit tool have been developed.[28] Auditors are trained and do not audit an area/unit in which they work, there is a quarterly audit schedule and it has been subject to the governance requirements of Monash Health.

35. The audit procedure (tool) appears contemporary, however there appeared to be limited guidance on the rating of a ligature point. It is possible that the auditor training referred to by Dr Martin Preston includes additional information about the rating of ligatures. The procedure was not referenced to any evidence-base therefore Monash Health was asked to provide information regarding the evidence base for the procedure.

36. On 14 December 2016 the following response was received from Jo Hall, Medico-Legal Counsel at Monash Health:

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25 Monash Health digital medical records page 546.
26 Monash Health digital medical records; 20/08/2015 Revocation of a Treatment Order under the Mental Health Act 2014 (Vic), page 13.
27 Monash Health September 2015 Ward E Ligature Audit spreadsheet provided and statements by Dr Martin Preston and Ms Tracey Harmer.
28 Statement of Dr Martin Preston dated 12 September 2016.

> I am instructed that the Monash Health Ligature Audit Tool (the LAT) provided to the Coroners Court by email on 12 September 2016 was put together using a variety of evidence-based material. The team that created the LAT obtained the guidelines, policies and procedures used internally at various Victorian Health Services in relation to ligature audits. Information was also obtained from NHS material (from the UK) and one interstate health service. All of the material consulted as guidance in creating the LAT predominantly referred to the Worcestershire Mental Health Partnership NHS Trust Audit of Ligature Risks as a basis for their audit tool and as such, the LAT is also based on this audit tool. [29]

Department of Health and Human Services Response

37. Ms Kym Peake, Secretary of DHHS, responded to the Court's request for information regarding the department's role in safety of ligature points in acute psychiatric units in Victoria.[30] Ms Peake confirms the information contained in the Mental Health Triage Review regarding the 2011 Chief Psychiatrist's investigation of inpatient deaths 2008 – 2010 and the recommendation:

> An environmental safety audit including assessment of ligature points on the unit is conducted on a regular basis and a plan developed for eliminating or managing these risks. The inclusion of external staff for audits is recommended as inpatient staff may not always identify certain safety issues in the familiarity of their everyday environment.[31]

38. In addition, Ms Peake stated:

> That all services have since reported that they conducted regular ligature audits and/or had taken steps to remove potential ligature points.
>
> That the department allocated $1 million to ligature safety programs which impacted on the removal of identified ligature points across 12 health care networks.

39. Ms Peake also made reference to the directive from DHHS in May 2016 for services to remove the hooks identified by Coroner Spanos in the recommendations made in the Death

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29 Department of Health & Human Services Secretary Kym Peake's letter dated 15 September 2016.
30 Department of Health & Human Services Secretary Kym Peake's letter dated 15 September 2016.
31 Victorian Government Department of Health and Human Services (DHS), 2011. Self- assessment tool for mental health services https://www2.health.vic.gov.au/about/publications/formsandtemplates/Self%20assessment%20tool%20for%20mental%20health%20services This tool has been developed to assist mental health services in evaluating their response to the recommendations made in the Chief Psychiatrist's investigation of inpatient deaths 2008-2010 report.

of Katerina Tyros [32] and that all services have since notified the Chief Psychiatrist that such hooks were identified and removed.

FINDINGS

40. Having investigated the death of Rebecca Victoria Poke, and having considered all of the available evidence, I am satisfied that no further investigation is required.

41. On the basis of the available evidence, I am satisfied to the requisite standard that Rebecca Victoria Poke intentionally ended her own life.

42. I make the following findings, pursuant to section 67(1) of the *Coroners Act 2008*:

    (a) that the identity of the deceased was Rebecca Victoria Poke, born 14 December 1985;

    (b) that Rebecca Victoria Poke died on 2 September 2015, at the Austin Hospital, 145 Studley Road, Heidelberg, Victoria from global cerebral ischaemic injury in the setting of neck compression; and

    (c) that the death occurred in the circumstances described in the paragraphs above.

COMMENTS

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

    1. The literature on people with a borderline personality disorder diagnosis supports the notion that many people with the diagnosis suffer from chronic suicidal ideation in response to recurring interpersonal stress.[33] Rebecca Poke had a history of frequent, impulsive self-harm that was usually of low-lethality and that it appears she gained some relief from her overwhelming anxiety and stress through the self-harm act. Kim continued to experience self-harm and suicidal thoughts and chronic suicidal ideation can be present in up to 85% of people diagnosed with BPD.[34]

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32 COR 2009 4252

33 Beatson, J., Rao, S., & Watson, C. (2010). Borderline personality disorder: Towards effective treatment. Victoria: Australian Postgraduate Medicine, p.173.

34 Gunderson, J., Ridolfi, M. (2001). Borderline personality disorder: Suicidality and self-mutilation. Annals of the New York Academy of Sciences, 932, pp.61-77; Paris, J. (2001). Half in love with easeful death: The meaning of chronic suicidality in borderline personality disorder. Harvard Review of Psychiatry, 12, pp.42-48; Paris, J., & Zweig-Frank, H. (2001). A 27-year follow-up of patients with borderline personality disorder. Comprehensive Psychiatry, 42, pp. 482-487.

2. Rebecca left a suicide note on her mobile and it appears she decided she found the prospect of discharge and all the responsibilities this entailed was too hard and she chose to hang herself in the visitor's toilet on Ward E, all within 10 minutes of briefly speaking with Nurse Frenkel.

3. The contributing factor in the death of Rebecca Poke was the immediate accessible ligature point, the D-shaped door handle; a ligature point that was between 1-2 metres high[35], was in an area acutely unwell patients could access unsupervised, and where the door could be locked from the inside.

4. The responsibility for the safety of public mental health units rests with the Area Health Service, in this case Monash Health and ultimately their Board, and safety management systems. It is up to the organisation to identify risks in patient areas and, within reason, mitigate them. In relation to ligature points this can include removal; removal and replacement; protection of the point, and/or local management strategies.

5. The importance of an audit process and tool that will guide staff to reasonably identify ligature risks cannot be understated. It is not the domain of nursing staff to have an innate understanding to the science of hanging and strangulation but they develop knowledge through exposure and experience which results in differing skillsets and relies on their learnings arising from traumatic events. It is therefore reasonable to expect the service adopts or develops an audit tool that has some evidence-base and provides structured guidance in how to navigate the complexities of assessing the risk of a potential or actual ligature point and developing an appropriate response.

6. Monash Health had, as required by the Chief Psychiatrist in 2011, completed ligature point auditing in Ward E however, the presence of the D-shaped door handles remaining in Ward E indicates the audit tool and/or its application were ineffective.

7. The actions undertaken by Monash Health since the death of Rebecca Poke are appropriate and aimed at increasing the safety of patients by reducing the likelihood of hanging by patients using accessible, modifiable ligature points in Ward E and the other Monash Health Mental Health Units.

RECOMMENDATIONS

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35 Considered a medium risk height range.

44. Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I make the following recommendation connected with this death:

> To improve the effectiveness of the required ligature point auditing tools, auditor training and their application in acute care mental health units, the Department of Health and Human Services work with Area Mental Health Services to develop advice and examples of ligature audit tools that are assessed as being appropriate to the task, and effective in meeting their purpose.

45. I convey my sincerest sympathy to Rebecca's family and friends.

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

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

    (a) Rebecca's family, senior next of kin;

    (b) Investigating Member, Victoria Police; and

    (c) Interested Parties.

Signature:

MR JOHN OLLE
CORONER
Date: 12 December 2017