IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2007 2518

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: STACEY JADE SMITH

Delivered On:	24 April 2014
Delivered At:	Coroners Court of Victoria Level 11, 222 Exhibition Street Melbourne 3000
Hearing Dates:	17 January to 21 January 2011
Findings of:	Peter White Coroner
Representation:	Mr P Halley of Counsel for Northern Health Mr J Bushby of Counsel for North Western Mental Health
Police Coronial Support Unit	Leading Senior Constable K Taylor

I, PETER WHITE, Coroner having investigated the death of STACEY JADE SMITH

AND having held an inquest in relation to this death on [*date*]
at Coroners Court Melbourne
find that the identity of the deceased was STACEY JADE SMITH
born on 31 January 1987
and the death occurred on 3 July 2007
at Royal Melbourne Hospital, 300 Grattan Street, Parkville 3050
from:

1 (a) MULTIPLE INJURIES

in the following circumstances:

Background

Glenda Smith

1. Stacey Smith (Stacey) was born on 31 January 1987. At aged 15 Stacey left school and according to her mother Glenda Smith, had been hanging around with the wrong crowd and was drinking.

> *'Stacey just did what she wanted and went out with friends. We had the police all the time at our house, because we could not control her violence. I think that it was about two years ago she stabbed (her father) Keith with a kitchen knife in the hand.*
>
> *Stacey would threaten to kill me and burn the house down. Stacey said things and made threats all the time. Stacey would threaten to kill herself all the time. She has slashed her wrists/arms and stabbed herself in the leg. Sometimes I thought she was not serious but sometimes she was. I know she was raped twice on two different occasions when she was around 18-19 years of age, which obviously affected her. These matters were not reported to police'.* [1]

2. At around 9 am on Monday 2 July 2007, Glenda Smith spoke with Jean Popomilkov[2], who had been the case manager working with Stacey since 23 March of that year. Glenda informed that Stacey had been drinking and taking tablets and that she and her husband had told her

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[1] Statement of her mother, Glenda Smith. See exhibit 3 page 3.

[2] Jean Popomilkov was a Senior Clinical Psychologist employed by the Whittlesea Community Mental Health Centre, a unit within the North Western Mental Health Service.

about a week or so before, that she had to look around for somewhere else to live because they could not stand any more of her behaviour, the arguments or the violence.[3]

Jean Popomilkov

3. For approximately three months, Senior Clinical Psychologist Jean Popomilkov, had been having twice weekly sessions with Stacey where they focused on behavioural therapy, drug and alcohol treatment as well as counselling and case management.

4. On Monday 2 July she was informed by the Northern Crisis and Assessment Treatment Team (NCATT) that Tracey had come to the emergency department on Thursday 28 June and been discharged from their custody on the morning of Friday 29 June, having been transported by the police presenting with suicidal ideation and self harm and that she was intoxicated.

5. Ms Popomilkov did not become aware of this until the following Monday 2 July because she was absent on a training day on the Friday, 29 June. She called Stacey at home. Stacey initially refused to speak to her and as set out above, she spoke with her mother Glenda Smith who informed her of the events leading up to the emergency department admission on the previous Thursday. Glenda Smith also informed that Stacey had again made threats of violence against her parents in the context of having been asked to arrange to find alternative accommodation. Stacey eventually agreed to come to the phone. She presented as,

> *'irritable, expressing themes of helplessness, worthlessness and suicidal ideation. (She) refused offers to attend the clinic and eventually agreed to a home visit'.*[4]

6. Ms Popomilkov attended at the Smith family home at around 10.30am, 2 July with Senior RN Peter Sinclair. She saw Tracey whom she described as irritable with reactive affect. She did not exhibit psychotic behaviour and nor was she delusional. She did express hopelessness and worthlessness.

7. She reported taking an overdose of Valium early that morning and showed Ms Popomilkov some 40-50 empty pill satchels, reporting that she had consumed same intending to kill herself and stating that she wanted to die and that she would go to Plan B, which involved throwing herself in front of a train. She was offered the option of attending the clinic for referral for hospital admission, which she refused. Police and ambulance were then called on Ms Popomilkov's direction, while Tracey was outside having a cigarette.

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[3] Exhibit 3 page 1.

[4] See Statement of Jean Popomilkov at exhibit 4 page 1.

8. Police arrived at around 11 am and Stacey became very angry when she found out that police had been called. She locked herself in a bedroom and later officers came into the house and restrained her.

9. According to Mrs Popomilkov she provided the police with a '*handover*' outlining Stacey's serious risk of self-harm, also informing the ambulance officer of her risk issues, and she then rang the Northern Hospital ED triage informing the Duty Nurse Elizabeth Williams of the transfer due to suicidal ideation and alerting her also of the extreme risk of self harm.[5]

LSC Julie McDonald

10. Leading Senior Constable McDonald testified that she was performing divisional van duties on Monday 2 July, and was called together with partner, Constable Damien Mein, to attend at the Mill Park address of Stacey Smith, at around 10.45 am.[6] Checks were made before arrival, which indicated that Stacey Smith had a history of violent confrontational behaviour towards police.

11. On arrival, the police officers were told about Stacey's immediate past history and that she had informed Jean Popomilkov that she had recently consumed 70 tablets in an attempt to take her own life.

12. On entry, Stacey was seen yelling at Ms Popomilkov, who informed police that she was going to have Stacey, *'sectioned'*.[7]

13. Because of her history with police, it was determined to restrain Stacey. This was done with her hands cuffed at her front, and Stacey swearing at all present in the house stating that she would throw herself under a train because the pills consumed the day before, '*did not work*'.[8] When the ambulance arrived, police walked Stacey to the ambulance and LSC McDonald then sat with her in the rear of the ambulance and she was transported to the Northern hospital under restraint.

14. LSC McDonald stated that on arrival she was then strapped to a bed opposite the nurse's station, '*so she could be monitored*'.

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[5] Ibid pages 1 and 2.

[6] I note here that Constable Mein testified as to his previously dealing with Stacey on May 24 i.e. some 6 weeks prior, when Stacey had cut both of her wrists at home and required medical attention. At this time according to Constable Mein, who attended the scene, Tracey was aggressive and uncooperative. See transcript page 59.

[7] See statement of Julie McDonald at exhibit 5 page 2, which was corroborated by her colleague, Constable Mein. See also her evidence on this issue from transcript page 52 and at page 56.

[8] See transcript page 51.

15. Hospital staff spoke to ambulance officers and did not seek further information from her. The handcuffs were removed and hospital staff then informed LSC McDonald that she could leave.[9]

16. Stacey was observed to be calm at this point.[10]

Northern Hospital Emergency Department

RN Scott Clarke[11]

17. Stacey was admitted at around 11.44 hours on July 2, by Hospital Emergency Department triage RN Scott Clark. It is relevant that RN Clarke had not previously dealt with Stacey, but was informed by colleagues that she was well known in the emergency department and had a history of violent behaviour towards hospital staff. This history was confirmed by attending police with whom he spoke.

18. At 12.05 pm, RN Clarke ordered her placed in Cubicle 2, a resuscitation room so she could be restrained in wrist and ankle restraints while undergoing her initial assessment. One on one nursing was provided to all patients allocated a placement in cubicle 2.

> *'At that time I made a verbal agreement with Stacey that I would remove the restraints if she was calm and compliant and posed no threat to staff who continued her care'.*

19. Stacey verbally agreed to behave herself.

20. When triaging Stacey, RN ClarkE used a mental health-triaging tool. He was aware of her earlier threat to run in front of a train and her recent attempts at suicide and also of her multiple hospital admissions.[12] He triaged her at level 2, which required her to be seen by a medical Doctor within 10 minutes.

21. At around 12.20-12.30 pm RN Clark removed the wrist restraints[13] while leaving the ankle restraints in situ, and continued to nrse Stacey intermittently between 12.20 and 1 pm. During this period she behaved and did not try to remove the ankle restraints (which had remained in

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[9] See Exhibit 5, page 2.

[10] See transcript page 54. See the further evidence of Constable Mein, which broadly corroborated the evidence given by Constable McDonald as set out above.

[11] Nurse Scott Clark was an associate nurse manager which included responsibilities for managing the floor and managing the staff while still undertaking clinical work (Transcript page 71).

[12] Transcript page 73 and clinical notes at exhibit 7(a).

[13] See notes exhibit 7(a), as discussed at transcript page 76.

place). She was also assessed by Dr Michael Wolf, who had medically cleared her with a plan to await ECATT assessment.

22. According to RN Clarke, he later removed the ankle restraints, this at around 12.30, *'following discussion with the treatment team'*.[14]

23. Thereafter she remained without restraint in the resuscitation unit until approximately 1 pm, when RN Clarke was informed by the supervising nurse, Nurse Carolyn Downing of a medical problem concerning another patient, which necessitated the use of the resuscitation room then occupied by Stacey.

24. Shortly afterwards and following consultation between the two nurses, Stacey was moved (untethered) to cubicle 13 in the emergency department, *'to await ECATT'*[15] and RN Clarke returned to care for the new patient in the resuscitation room, with no other specific arrangements having been put in place for Stacey's care or supervision, and without handover to the nursing staff responsible for cubicle 13.

25. At the time he didn't believe that Stacey was at risk of suicide or that there was a *'large'* risk that she would abscond.

26. At 1.20 pm, RN Clarke became aware that Tracey was missing from cubicle 13, and the matter of her disappearance was taken over by ANUM Downing and Dr Wolf.[16]

27. Further clinical notes by RN Clarke record the following,

> *'13.35 patient not in cubicle still.*
>
> *13.55 patient not returned.*
>
> *14.50 police in attendance. Person fitting patient's description struck by train at Lalor station in serious condition. En route to Royal Melbourne Hospital'*.[17]

28. In further testimony RN Clarke stated that he did not recall seeing the assessment made earlier in the day at Stacey's home by Ms Popomilkov.[18]

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[14] See evidence of Nurse Clark at transcript page 69-70. The team contributing to the removal of restraint decision included Dr Wolf and RN Chantelle Vallay, who had looked after Stacey in cubicle 2, as her one on one, immediately after admission. See transcript page 86.

[15] See exhibit 7(a). Cubicle 13 was the cubicle of choice for patients waiting an ECATT review 'with less exit points or access leading to exit points'. See transcript page 90.

[16] Ibid. From exhibits 9 and 9(a) the statements of RN Nicola Beyfus it appears that Tracey's disappearance from Cubicle 13 was first discovered at 1.15pm.

[17] Ibid.

29. RN Clarke also stated that he was not sure if he had seen the ECATT record concerning Stacey, which he agreed would have usually accompanied her file to the emergency department.[19] He agreed that he had seen the ambulance record and was informed by the officers about the valium overdose, and her threat concerning the train.

30. RN Clark also testified of an interaction between Stacey and RPN Harry Johnstone, while she remained in the resuscitation unit.[20] RN Clarke was unable to say whether Tracey was still restrained when RPN Johnstone (briefly) saw her.

31. His understanding following that consultation, was that Stacey was to wait at the hospital, for a formal ECATT assessment, and that RPN Johnstone had to do one other further thing and would then be back to see her, and that they were told it would be a short time only before he returned. [21]

32. He further testified that in the period before any ECATT review the issue of security including the issue of restraint was an issue for, and the responsibility of the medical team, and not ECATT.

33. The decision is made based upon a risk assessment about, *'the patient's safety, the risk of absconding, all those things...causing harm, so it's done independently of the CAT Team or ECATT'.*[22]

34. In response to questions by the court concerning the suggested failure to apply the general principals of management set out in the Emergency Health Mental Triage Project, (concerning both restraint and supervision of patients like Stacey), RN Clark stated that appropriate supervision occurred until she went into cubicle 13 only,-and that the withdrawal of restraint occurred because he could see no justification for maintaining same as Stacey appeared to be behaving herself in accord with the agreement they had earlier reached.[23]

35. RN Clarke testified that he felt that issues around security for a psychiatric patient could properly be made by a medical RN and that he was aware of the danger that such a patient

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[18] See exhibit 4(a). Transcript pages 77-78.

[19] See transcript page 79.

[20] See transcript page 86.

[21] See transcript page 89.

[22] See transcript page 88.

[23] See transcript page 91-93. RN Clarke triaged Stacey under the Australian Triage Scale as a category 2. A review of the Mental Health triage tool indicates that under category 2, *'continual visual supervision should be maintained at all times'.*

might attempt to manipulate a presentation in order to achieve a particular objective such as release or escape.

36. After consultation with ANUM Carolyn Downing, RN Clarke moved Tracey to cubicle 13, and left her there unattended. He did not specifically hand over to either of the two nurses responsible for care in that section, because he was not able to find either, one of whom we know was at lunch.

> *'We again renegotiated our contract from the beginning that she was going to stay and wait to be seen by ECATT and she was completely calm ... and I had no reason to think that she was going to leave'.*[24]

37. RN Clarke further opined that Stacey would have been aware that she was being watched while she remained in cubicle 2, the resuscitation unit, after her wrist and later her ankle restraints, were removed.

38. He further agreed that her later abscondence might have seemed to her to be more likely to be able to be achieved from cubicle 13 (rather than cubicle 2), and without the possibility of confrontation with staff members.

39. He also offered that there was only one ECATT staff on duty at the Emergency Department at 11 am on Monday 2 July, to undertake the planned review. He believed that it might now be possible to call in other ECATT staff to provide assistance, should that staffer be unavailable, for what ever reason.

RN Chantelle Vallay

40. RN Chantelle Vallay corroborated the evidence of RN Clarke concerning her pre lunch involvement with Stacey, on the morning of 2 July. The handover by paramedics confirmed a medical history of violent and suicidal behaviour, and she was handed over at 11.42 am and remained in restraint at that time. She was medicated from her earlier intake of prescription medication, which caused a level of drowsiness but no attempt was made to assess that level of sedation.[25]

41. At approximately 12.20 pm, RN Vallay participated in the decision to remove the restraints and at 12.25 pm she went for lunch and returned approximately one hour later, by which time a new patient had been allocated to her care within the resuscitation unit. At the time of the

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[24] See transcript page 195-196.

[25] See transcript page 114.

making of the decision concerning wrist restraint she was aware of Stacey's background and her earlier ideation and self harm. She made a clinical note concerning the removal of the wrist restraints at 12.20 pm.

42. In response to the suggestion that the removal of the restraints was premature, RN Vallay offered that the decision to restrain was based upon Stacey's previous history and behaviour, when in fact she was actually not agitated and appeared to be quite calm, and was in fact not requiring restraint at all.[26]

43. Her further opinion was that at the time she was moved away from cubicle 2, and one on one nursing support, it was also the case that she no longer required nursing supervision, (while she waited for her ECATT assessment).[27]

44. Counsel for Northern Health properly conceded that the Hospital had a duty under the Northern Health Clinical Services Manual to ensure that Stacey remained in the Emergency Department until she could be assessed by ECATT.[28] Counsel further agreed that keeping Stacey in the hospital in an emergency situation, before assessment, (under Part 3 paragraph 2 of the manual), may also invite compliance with the conditions of retention permitted under the Mental Health Act. It is also true that Northern Health had a duty to keep Stacey in a safe environment.

Associate Nurse Unit Manager Carolyn Downing

45. ANUM Carolyn Downing was the nurse '*operationally*' in charge in the Emergency Department, at Northern on 2 July.[29]

46. Primary carers responsible for Stacey were Dr Michael Wolf and RN Vallay, and later RN Beyfus and RN Clarke, after Stacey was located to Cubicle 13.

47. Stacey was triaged by RN Clarke and put into resuscitation room 2, as she was physically restrained. At 12.36 pm that room was required for another patient who was arrhythmic. By this time Stacey was observed to be sitting up on the side of her bed and no longer restrained.

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[26] I note that the restraints were in fact, put in place by this witness and that action was consistent with the general principals of management set out in the Emergency Health Mental Triage Project, exhibit 8(d) and the NH Clinical Services Manual, exhibit 8(e).

[27] See transcript page 121-122.

[28] See Exhibit 8(e) the NH Clinical services manual, the discussion found at transcript pages 144-148 and the concession made by the hospital at the commencement of this inquest, (exhibit 1). See also discussion above concerning the Mental Health Triage Tool at footnote 23.

[29] See transcript at page 157.

Following discussion with RN Clarke it was understood that she had been medically cleared in terms of her overdose and was now waiting for ECATT review by RPN Johnstone. RN Clarke was asked to move her to cubicle 13.

48. At 13.20 pm RN Beyfus, who had gone to the unit, and found only her bag, informed ANUM Downing that Stacey was not in cubicle 13.

49. Thereafter it was established that on transfer to cubicle 13, Stacey was *'not involuntary'* and in later discussion with Dr Wolf it was determined that having absconded she was now *'involuntary'*. The police were then called.

50. The witness provided further evidence establishing that the emergency department was particularly busy on the morning of July 2.[30]

51. Anum Downing was not aware that Psychologist Popomilkov had earlier sought to make arrangements, to have Stacey admitted to the hospitals psychiatric unit as an involuntary patient under the Mental Health Act.

52. She was however aware of Stacey's history of threatening behaviour and threatening self-harm. Her further evidence was that Stacey was the only Emergency Department patient waiting for an ECATT review that morning and than when transferred to Cubicle 13 she no longer fitted the criteria or needed to be classified as involuntary. Rather restraints were always to be considered as a place of last resort and that it would have been inappropriate to keep her restrained, *'when she's being compliant*[31]*'*

53. In addition, on arrival at cubicle 13, that she expected a hand over would be made by RN Clarke directly to either RN Nicola Beyfus or RN Jean Warburton, i.e. the 2 nurses who were responsible for 5 cubicles, (cubicles 9 to13).

54. I further note that ANUM Downing was aware of Stacey's category 2 rating and that the protocol[32] stipulated the need for continuous supervision. Nurse Downing considered the protocol to be a guideline only and that this level of supervision was not required in Stacey's case, and that she felt that 15 minute observations would be sufficient, although she was aware that psychiatric patients had the ability to manipulate this sort of situation.[33]

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[30] See witness statement at exhibit 10.

[31] See transcript at page 185.

[32] See exhibit 8(d) The Mental Health Triage Project.

[33] See transcript at pages 173-174.

55. It was also the case that the resuscitation unit, cubicle 2, required one on one nurse assistance for patients, which was not a requirement when a patient was transferred to cubicle 13.[34]

56. She also considered that it was a matter of, *'best judgement'*, when determining how to balance the interests of patients in the Emergency Department, particularly during busy shifts.

57. Faced with the same circumstances again and if she had been aware that Stacey was believed to be at imminent risk of suicide, she would have released her from restraint, but arranged for a security officer to sit with her.

Dr Michael Wolf

58. Dr Wolf an emergency department medical officer reviewed Stacey on the morning of 2 July at around 11.44 am. At the time Dr Wolf was aware of her history of depressive violent behaviour and self harm, and observed that she remained restrained. She was calm and co-operative throughout the examination and told Dr Wolf that her earlier overdose was an attempt to commit suicide.

59. Discussion about the restraints took place with RN Clarke and focused on the fact that she was now co-operative and calm and that they should try and get the restraints off. She was triaged under a medical triage category rather than under the Mental Health Triage Tool according to Dr Wolf, and RPN Johnstone was informed that she had been medically cleared, this in the resuscitation unit at around 12.30 pm.[35]

60. *'Given the fact that the alleged overdose was more than 12 hours ago and ...the level of consciousness was now normal, the patient was medically cleared regarding the drug overdose ... and was to await review by ECATT Nurse Henry Johnstone... The patient remained well behaved, the[restraints] were removed and the patient was transferred to a different cubicle'.*[36]

61. (Dr Wolf) did not examine her again before her transfer to Cubicle 13,[37] but had earlier established that she was not thought disordered or delusional.[38]

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[34] See transcript at page 182.

[35] See transcript page 210 and 214.

[36] See transcript page 200.

[37] Ibid page 210. There was no medical evidence suggesting that Stacey had overdosed to the extent suggested.

[38] See transcript page 211-112.

62. Dr Wolf was informed at 1.20 pm that Stacey had disappeared. He conferred with Emergency Department Consultant Dr Robyn Parker and was told to wait for another 30 minutes in case she returned.

63. At 2 pm, Dr Wolf met with RPN Johnstone and determined to recommend a Section 9, in her absence. Police were told of her threat to throw herself under a train, and asked to find her, and return her to the unit.[39]

64. I further note however, that at this meeting, according to RPN Johnstone, Dr Wolf did not appear to know that Stacey was suicidal. In his testimony, Dr Wolf did not disagree, with this stating that he may not have been aware.[40]

65. Further RPN Johnstone's suggestion that the delay in calling police occurred because Dr Wolf wanted more personal history about Stacey, (rather than additional time to look for her in the Hospital) was not denied by Dr Wolf.[41]

66. According to the witness, this took place at 2 pm. According to RPN Johnstone's statement, it took place at 2.30 pm.

67. Dr Wolf was informed at 3 pm, that a person matching Stacey's description had been hit by a train at Epping Railway Station, and had been taken to the Royal Melbourne Hospitals (RMH) Emergency Department. His later evidence was that police came to the Emergency Department at 2.45 pm and informed of this matter.[42]

RPN Harry Johnstone

68. According to RPN Johnstone, and it is not in dispute, he was the only on duty ECATT Psychiatric Nurse at the Northern Hospital Emergency Department on 2 July 2007, the day of Stacey's admission. RPM Johnstone had earlier reviewed Stacey on several previous occasions. The re-appearance of his patient may have lessened his concern.[43].

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[39] See transcript page 206 and RPN Johnstone's notes at exhibit 11(a).

[40] See transcript page 225. See also self-contradicting evidence at page 226

[41] See transcript page 237.

[42] See transcript page 238.

[43] See transcript page 249. *'You know this is just another presentation of client X...there are certain clients ... the in house term is Frequent Flyers ...I suppose you moderate your response because of that past history.'*

69. His first direct involvement with the case on 2 July 2007 came when he received a call at 11.15 am from an ECATT colleague informing that Stacey was being bought in to the Emergency Department, in connection with a medication overdose and the voicing of plans to jump in front of a train.

70. Stacey had previously been assessed by the witness and he approached the on duty medical RN, Scott Clarke to inform him of the pending arrival. Later RPN Johnstone returned to the Emergency Department and saw that Stacey was in the process of being admitted by RN Clarke to Cubicle 2, (while restrained). He spoke to her briefly and informed her, and later medical staff, that he would return to conduct his review once had been reviewed and cleared medically.

71. He then left to see other patients. Later he received two messages the first at 12.30 to notify that Stacey had been cleared medically and later a second call, which led to a conversation with Dr Wolf,

'who again wanted to inform me that she was ready for psychiatric assessment'.[44]

72. He told Dr Wolf that he would get to Stacey as soon as he could.

73. Later at 13.30 pm, RPN Johnstone was informed by Dr Wolf that Stacey had absconded. According to the witness Dr Wolf then sought advice as to how to proceed and he advised that Dr Wolf should recommend Stacey for remand under the Mental Health Act, and report her to police as an absconded patient.

74. RPN Johnstone stated that he saw Dr Wolf again at 2.20 pm and discovered that nothing had been done to this point and that Dr Wolf was not inclined to proceed as he had earlier recommended unless,

'I could identify a past history of significant suicide attempts by his client'.[45]

75. Nurse Johnstone further stated that he then repeated his earlier advice that the police be notified of the fact that Tracey had absconded. He also agreed to review the ECATT files for Dr Wolf concerning her past psychiatric and suicide history.

76. There was then further discussion about Tracey's situation.

77. According to RPN Johnstone,

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[44] See transcript page 241.

[45] See transcript page 242.

'Dr Wolf did not appear to have prior knowledge of the client's suicidal ideation. At this time,, Dr Wolf agreed to recommend ... under the Act, and report her as an absconded patient. Dr Wolf completed the recommendation and I completed the request in the prescribed format'.[46]

Finding

Transfer to Northern Hospital

78. I find that the transfer under mechanical restraint of Stacey to Northern Hospital, on 2 July 2007 did not comply with the requirements of the Mental Health Act, this despite Mrs Popomilkov's intention to achieve her transfer under that Act. In this regard, I note that Mrs Popomilkov did not fill out a Mental Health Act Schedule 1 (Request) or a Mental Health Act Schedule 3 (Authority to transport) as required.

79. Notwithstanding I am satisfied that the transfer was both in Stacey's interest and in the public interest and was not a factor which contributed to her later death.

80. I am also satisfied that notwithstanding this processing error and her continued status as a voluntary patient, that restraining Stacey after arrival at Northern Hospital, was consistent with the need to protect both Stacey and other patients, as well as staff, from the possibility of violence.

81. I further find that from her the time of arrival until her departure, that Stacey remained an at risk patient who suffered from a psychiatric illness (not reviewed), which had warranted both her earlier transfer to Northern Hospital, and an urgent ECATT review,-this with focus on whether she was suitable for involuntary admission to the Hospitals psychiatric unit.

Removal of mechanical restraints

82. Following admission to the Emergency Department, Nurse Scott Clarke reasonably determined that her mechanical restraint should continue, to await both medical and psychiatric review. He also reasonably determined to allocate her to cubicle 2, where her continued restraint would be monitored by an RN.

83. At the same time, I find that Nurse Clarke entered into an arrangement with Stacey that if she behaved herself he would remove the restraints.

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[46] Dr Wolf did not disagree with the suggestion that he may not have been aware of Stacey's suicidal ideation. See transcript page 242-243.

84. I further find that such an arrangement was undertaken by RN Clarke without an analysis by him of the risks to Stacey and/or others, inherent in such an outcome, and without contemplation of the possibility that such an outcome might also occur in conjunction with the absence of continuous one to one nurse monitoring.

85. The removal of all restraints later occurred following consultation with Dr Wolf, who appears to have given support to RN Clarke's proposal without being fully aware of Stacey's immediate history, or recently voiced suicidal ideation.

86. I also find that in so deciding, neither Dr Wolf or RN Clarke consulted with RPN Johnstone, or gave appropriate consideration to Stacey's immediate history (or to a risk analysis), focusing instead upon her presentation whilst she remained in cubicle 2 under either physical restraint and one on one observation, and later while still in cubicle 2 under one on one observation only.

<u>The later removal of one on one nursing.</u>

87. As above, I note that Stacey was later taken to cubicle 13 at 1 pm, when cubicle 2 was needed for another patient. By this time, her restraints had been removed, from both her ankles and wrists.

88. I also find that the fact that Stacey was seen to have behaved herself without any restraints in place for approximately half an hour before being transferred to cubicle 13, was sufficient to persuade both ANUM Downing and RN Clarke, that such a transfer was a suitably safe course of action.

89. This again occurred without a risk analysis (concerning the safety of her new environment), being undertaken by either of the two nursing officers so involved. [47]

90. I further observe that the evidence does not suggest that either nurse contemplated seeking the assistance of another member of staff to '*special*' for Stacey, during this period.[48] The decision was also reached without further consultation with RPN Johnstone and importantly

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[47] It is also the case that the decision was reached although both nurses were aware of Stacey's immediate past history and that such transfer would remove the requirement for one on one nursing, while she waited in cubicle 13 (untethered and unsupervised), for review by RPN Johnstone.

[48] To provide one on one nursing while she remained in Cubicle 13.

without information, which might have provided a time period as to when he would be available to attend upon her.

91. It is also relevant that both of the senior nurses so concerned, either knew or should have anticipated the possibility that an involuntary admission to the psychiatric unit may follow, and that Stacey was sufficiently aware to contemplate and react to this possibility, while she waited alone and unsupervised in cubicle 13.

92. In these circumstances I consider that the removal of continuous supervision by Emergency Department Staff, breached the Emergency Dept Mental Health Triage Tool and the Hospitals Clinical Services Manual (exhibit 8e), and put Stacey at risk.

NCATT Involvement

93. I further find that RPN Johnstone's own approach to his task was less than optimal. It is relevant in this regard, that he had previously assessed Stacey and of those on duty was most familiar with both her history and self-harm risk presentation.

94. I find that against this background, and despite notification of her readiness for psychiatric review at 12.30 pm, and the ongoing delay in his attendance, - that RPN Johnstone made no attempt to inform Emergency Department staff as to when he would be available, or otherwise provide any recommendation as to what should be done in regard to her security, while they waited upon him.

95. I also record that this occurred in the context of his understanding that he was the only person available to make a recommendation concerning her admission to the hospitals psychiatric unit, this on an unusually busy day in the Emergency Department and in the further setting of Dr Wolf's growing and indicated frustration with him, and his delayed attendance upon her.

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96. I find that it was in these circumstances that at some time between 1 pm and 1.20 pm, Stacey almost certainly walked out of cubicle 13, and through the ED so departing Northern Hospital, from where she hurried to the Lalor Railway Station, with the intention of pursuing her earlier stated plan to end her life, by putting herself in harms way.[49] Upon her arrival at the station Stacey walked to the northern end of the city bound platform and jumped into the path of an

[49] It is known that Stacey sustained the injury which caused her death at approximately 1.30 pm on 2 July, 2007, with hospital authorities being informed of this matter at 2.45pm.

oncoming train, giving the driver of that train no opportunity to prevent a collision. She died the following day at the Royal Melbourne Hospital.

97. It is also relevant that the fact of her absence from cubicle 13, (and her suspected arrangement breach), had been established and was known to all concerned staff by 1.20 pm, and that a report of her disappearance was not made until 2.30 pm, this when those responsible for her care finally determined to communicate their concerns for her welfare to local police.

98. In conclusion, I find that the management and care provided to Stacey Smith on 2 July 2007, referred to above, indicated a failure in communication and teamwork by employees of both responsible agencies. I further find that Tracey's departure from cubicle 13 and subsequent suicide was preventable and that the events described above combined to contribute to her loss.

Recommendation

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

Stacey Smith was a difficult patient with a complex presentation. The Northern Hospital Emergency Department was extremely busy at the time of her admission and staff were quite evidently challenged by the difficulties her admission presented to them.

I accept that there are advantages to the system in allowing for persons with a psychiatric history of challenging behaviour, to be reviewed away from Psychiatric Units and that the only reasonable alternative to review within a Psychiatric Unit, is for such review to continue to take place in a Public Hospital Emergency Department.

However, where delays of the magnitude that occurred in Stacey's case arise, and where delay may lead to a reduced level of security for the patient and others, as again occurred in this case, I consider that there is a need for some greater flexibility in arrangements around where such a review should occur.

...

I recommend that the Department of Health, review existing protocols concerning psychiatric review in Hospital Emergency Department's and seek to ensure that where such delay threatens to lead to a compromise to patient care, that there are arrangements put in place, which will allow for communication at Consultant level and permit such reviews to proceed, either following intra-Hospital (patient) transfer to a Hospital's psychiatric unit, or by an additional RPN being sent to the Emergency Department, for that purpose.

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

The family of Stacey Smith

The Secretary of the Department of Health, in the State of Victoria

The CEO, Northern Health

The CEO, ECATT

Dr Robyn Parker

Dr Michael Wolf

ANUM Carolyn Downing

RN Scott Clarke

RPN Harry Johnstone

Sergeant Graham Brown, Investigating Member, Victoria Police

Signature:

PETER WHTE
CORONER
Date: April 24 2014.