IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2012 5518

**FINDING INTO DEATH WITH INQUEST**

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

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| Deceased: | Thien Cong PHAM |
| Delivered on: | 17 December 2019 |
| Delivered at: | Coroners Court of Victoria,<br>65 Kavanagh Street, Southbank |
| Hearing dates: | Directions Hearings: 15 May & 17 July 2017<br>Inquest: 10 – 12 October 2017<br>Written Submissions: December 2017 |
| Findings of: | Coroner Paresa Antoniadis SPANOS |
| Counsel assisting the Coroner: | Leading Senior Constable Kelly RAMSEY from the Police Coronial Support Unit |
| Representation: | Mr S. CASH appeared on behalf of Forensicare<br>Mr P. HALLEY appeared on behalf of Thien Pham's mother, Ms Pham Le |
| Catchwords: | Homicide, ligature strangulation, treatment-resistant schizophrenia, Thomas Embling Hospital, medication non-compliance, mental state assessment, observations, adequate staffing levels, risk of interpersonal violence |

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I, PARESA ANTONIADIS SPANOS, Coroner, having investigated the death of
THIEN CONG PHAM and having held an inquest in relation to this death
at Melbourne on 10 – 12 October 2017:
find that the identity of the deceased was THIEN CONG PHAM born on 9 April 1985, aged 27

and that the death occurred on 27 December 2012

at Thomas Embling Hospital, 201 Yarra Bend Road, Fairfield, Victoria 3078
**from:**
I (a) LIGATURE STRANGULATION
**in the following circumstances:**

INTRODUCTION[1]

1. Thien Cong Pham (**Mr Pham**), aged 27 years, was born in Melbourne, the youngest of two sons born to his mother Nga Thanh Ti (Tanya) Le and his father Van Do Pham. Mr Pham grew up in the northern suburbs of Melbourne and was a keen sportsman, playing soccer, football, basketball and boxing, as well as participating in weight lifting. He also played classical guitar. In 2000, the family moved to Brisbane and then returned to Melbourne in 2003. After his parents' separation in 2003, Mr Pham continued to live with his mother.

2. Mr Pham had been in contact with mental health services since adolescence and experienced his first episode of psychosis at age 16 years.[2] He was diagnosed with schizophrenia in 2004, when he was about 19 years old. Mr Pham's illness was characterised by disorganised thoughts, persecutory and grandiose delusions and hallucinations and a number of psychotropic medications had been prescribed to manage it since initial diagnosis. He was admitted to psychiatric units on several occasions, particularly in 2007 and 2009, following relapse of his illness in the context of apparent non-compliance with prescribed medications and use of illicit substances.[3]

3. At the time of his death, Mr Pham was serving a two-year sentence of imprisonment for charges of aggravated burglary and intentionally causing injury. During this custodial term, Mr Pham's mental health deteriorated such that he required urgent inpatient treatment pursuant to the *Mental Health Act* 1986 (**MHA**) on three occasions

[1] This section is a summary of background and personal circumstances and uncontentious circumstances that provide a context for those circumstances in which the death occurred.
[2] Inquest Brief [IB], Exhibit 19, page 578.
[3] IB, Exhibit 19 and Exhibit F.

at Thomas Embling Hospital (**TEH**), between 17 March and 7 July 2011, from 17 August 2011 to 11 January 2012 and from 17 April 2012 until his death.[4]

**Thomas Embling Hospital and its Argyle Unit**

4. TEH is Victoria's only secure forensic mental health facility, operated by the Victorian Institute of Forensic Mental Health (**Forensicare**). It accommodates remanded or sentenced prisoners requiring involuntary mental health treatment,[5] individuals detained under a Custodial Supervision Order after being found unfit to stand trial or not guilty of offence(s) due to mental impairment,[6] and those detained as compulsory (civil) patients released from custody but awaiting transfer to a local area mental health service.[7]

5. TEH comprises of seven residential units, six of which are within the high security perimeter and one of which is inside a separate, low security perimeter. There are two male acute admissions units in which male security patients are generally accommodated, the Argyle unit (**Argyle**) and the Atherton unit.[8]

6. Argyle is a 15-bed unit primarily for mental health patients from the criminal justice system who need psychiatric assessment and acute care and treatment.[9] It consists of patient bedrooms, several communal living/dining areas, rooms for activities and group therapy, three seclusion rooms, separate secure courtyards for patients on the open ward or in seclusion, a smokers' lounge, a communal bathroom, interview rooms, a medical surgery, a visiting room and staff facilities.[10]

7. The patient bedrooms of the open ward are situated along two nearly perpendicular corridors; bedrooms on the northern corridor are labelled with numbers (1-10) and those on the eastern corridor with letters (A-E). The enclosed staff station is situated near the apex of the corridors; windows on the upper portion of two of its sides provide an unobstructed view of the northern corridor and, to the west, of a lounge area. The view from the staff station to the eastern corridor is obstructed.[11]

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[4] Exhibit F. See also IB pages 681-689, a Forensicare report dated 13 December 2012 indicating that each of Mr Pham's admissions to TEH were precipitated by deteriorating mental state in the context of interruption of clozapine. Prior to the first and third admissions, Mr Pham had been non-compliant with clozapine, while before his second admission, clozapine had been erroneously ceased for a period of five days.
[5] Pursuant to the Mental Health Act 1986, later superseded by the Mental Health Act 2014.
[6] Findings made by a court pursuant to the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997.
[7] Pursuant to the Mental Health Act 1986, later superseded by the Mental Health Act 2014.
[8] Ibid and Exhibit F.
[9] Exhibit F.
[10] IB Exhibit 4 at page 247.
[11] IB Exhibit 4 at page 247 and Video recorded view at the Argyle Unit of Thomas Embling Hospital conducted by Victoria Police Crime Scene Services on 27 June 2017.

8. Argyle is staffed by a multidisciplinary team consisting of a consultant psychiatrist, unit manager, psychiatric registrar, psychologist, social worker, occupational therapist and nursing staff.

**Mr Pham's admission to TEH in April 2012**

9. Between his second and third admissions to TEH, Mr Pham had been imprisoned at the Acute Assessment Unit (**AAU**) of the Melbourne Assessment Prison (**MAP**) where clozapine[12] and sodium valproate[13] were administered to manage his schizophrenia. Unfortunately, non-compliance with clozapine over time led to deterioration of his mental state such that Mr Pham reported auditory hallucinations and increased feelings of paranoia.[14] Consultant Psychiatrist Dr Clare McInerny, who assessed Mr Pham in the AAU, considered readmission to TEH warranted pursuant to section 16(3)(b) of the MHA.[15]

10. On admission to Argyle on 17 April 2012, Mr Pham was assessed by Consultant Psychiatrist Dr Ranga who concluded that he had a relapse of schizophrenia and commenced him on two newer antipsychotics, paliperidone depot[16] and olanzapine. Psychiatric reviews occurred regularly, during which no abatement in Mr Pham's floridly psychotic symptoms was observed, and he remained largely isolative and resistant to engaging with staff. On 8 May 2012, clozapine was recommenced and titrated over the following weeks given that Mr Pham's symptoms had previously responded well to it.[17]

11. Mr Pham was placed in seclusion between 18 and 27 May 2012 following a physical altercation with a co-patient and threats of violence towards nursing staff, and again between 9 and 14 July 2012 after an assault on a co-patient.[18]

12. Although Mr Pham continued to report auditory hallucinations, by late July 2012 his mental state was showing modest improvement and aggressive behaviour in response to psychotic symptoms had significantly decreased.[19]

[12] An antipsychotic medication reserved for treatment resistant psychotic symptoms, available in Australia as Clopine and Clozaril and prescribed pursuant to a strict protocol.
[13] An anticonvulsant/antiepileptic medication also used to treat mania and to stabilize mood available in Australia as Valpro and Epilim. It was prescribed for Mr Pham for its mood stabilising properties.
[14] Exhibit F.
[15] IB page 621ff (Thomas Embling Hospital Discharge Summary).
[16] 'Depot' refers to a slow-acting, slow release version of a medication administered by injection.
[17] Exhibit F.
[18] Ibid.
[19] Ibid.

13. Dr Prashant Pandurangi took over Mr Pham's care from Dr Ranga in August 2012 when he qualified as a Consultant Psychiatrist. The psychiatrist continued regular reviews of Mr Pham, noting ongoing paranoid delusions and reports of auditory hallucinations. Dr Pandurangi also oversaw planning for Mr Pham's discharge to a Secure Extended Care Unit[20] upon completion of his custodial sentence.

14. In October 2012, Mr Pham reported experiencing adverse side effects from clozapine and asked that paliperidone be re-commenced in its place. After discussing the high probability of deterioration of his mental health if clozapine was withdrawn and securing Mr Pham's agreement to revert to clozapine if this occurred, Dr Pandurangi re-commenced paliperidone depot and gradually reduced Mr Pham's clozapine dose over a few weeks.

15. By 8 November 2012, Mr Pham's mental state appeared to have deteriorated: he presented as guarded, with little insight into his illness, poor sleep and paranoia about the food from the patients' kitchen. He was alleged to have damaged the smokers' lounge and reported 'feeling stressed … [and] angry'. Mr Pham remained resistant to being treated with clozapine and so, first, his paliperidone dose was increased and, later, his olanzapine dose was also increased.[21] Mr Pham remained acutely unwell during his admission to Argyle with ongoing psychotic symptoms.[22]

## CIRCUMSTANCES PROXIMATE TO DEATH

16. Mr A, also referred to during the inquest as Patient A,[23] was about three years older than Mr Pham and was diagnosed with treatment resistant schizophrenia. He was transferred from MAP to TEH on 21 December 2012 and had been admitted to TEH on seven previous occasions, his penultimate admission being in July 2012.[24]

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[20] Secure Extended Care Units (SECUs) provide medium to long-term inpatient treatment and rehabilitation to individuals with unremitting and severe symptoms of mental illness and disorder. Residents of SECUs often lack capacity to live independently, have difficulty living in the community or in a less restrictive environment due to behavioural disturbances, pose a high risk of harm to themselves or others, and have comorbid conditions such as substance misuse issues, acquired brain injury or intellectual disability. SECUs are located in hospital settings.

[21] Exhibit F.

[22] Exhibit F.

[23] An application was made by Victoria Legal Aid on behalf of Mr A and, on 11 October 2017, I made a Pseudonym/Suppression Order which, omitting formal parts, ordered that:

1. The identity of the deceased's co-patient at Thomas Embling Hospital who caused his death and was found not guilty on the basis of mental impairment not be disclosed, published or otherwise broadcast by any person, in any manner whatsoever.
2. The identity of the said patient be protected during the course of the inquest by referring to him as patient A or Mr A.
3. The name of the said patient and any potential identifying details are to be redacted from any documents released to third parties, whether pursuant to section 115 of the *Coroners Act 2008*, or otherwise.
4. This order remains in force until the death of the said patient or until further order.

[24] IB page 314.

17. Mr A was serving his sixth custodial sentence, having been remanded in custody since 2009 and sentenced in 2010 to seven years' imprisonment for offences including false imprisonment and intentionally causing serious injury.[25] Mr A was classified as an 'A1*' high security[26] prisoner with a documented history of non-compliance with medication associated with deterioration of mental state, and a significant history of interpersonal violence (**IPV**), the risk of which increased when his mental health declined.[27]

18. By late 2012, Mr A's mental state appeared to be deteriorating. When psychiatrically reviewed on 16 December 2012, he presented as tormented, suspicious and fearful, had stopped eating meals and had lost weight. As a result, Mr A was transferred from Barwon Prison (**Barwon**) to MAP for assessment for suspected non-compliance with clozapine. On arrival, he denied thoughts of self-harm, suicide or harm to others, and reported he had been taking his medication and wanted to return to Barwon. He was less settled than usual and refused to discuss his mental state.[28]

19. On 19 December 2012, Mr A had a verbally aggressive outburst with staff and, when reviewed by Dr McInerney, was made the subject of an involuntary treatment order under the MHA. Dr McInerney completed the requisite paperwork for transfer to TEH as a security patient and documented Mr A's risks and alerts as suicide/self-harm, violence, security, medical and psychiatric.[29]

20. The clinical management and care provided to Mr A from his transfer to TEH until Mr Pham's death in the early hours of 27 December 2012 was the focus of the inquest and will be discussed in some detail below.

21. Suffice for present purposes to say that at about 6.15am on 27 December 2012, Registered Nurses (**RN**s) Brian Machemedze and Charles Mabhena were alerted to an incident in the room of another (a third) patient. When they ran to investigate, they found Mr A attempting to strangle that patient from behind using a ligature.

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[25] IB page 319.
[26] This categorisation is used by Corrections Victoria for use in the custodial setting; it is not used by Forensicare: IB page 315 and Transcript page 84. Counterintuitively, the A1 – high security rating is the highest security rating used by Corrections Victoria to reflect the prisoner's level of risk and his/her needs. The ratings are, in descending order: A1(*) high security, A2 maximum security, B medium security, C restricted minimum security, C2 and C3 minimum security. A1* is a rating that can only be applied and removed by the Assistant Commissioner, Sentence Management Division: Corrections Victoria, Sentence Management Manual available at www.corrections.vic.gov.au/publications-mauals-and-statistics/sentence-management-manual-part-1.
[27] IB pages 323-324, Certificate of Psychiatrist pursuant to the MHA completed by Dr Clare McInerny on 19 December 2012.
[28] Mr A's initial assessment on return to MAP was P1 (Psychiatric – Serious psychiatric condition requiring intensive and/or immediate care) and S3 (Suicide/self-harm, potential risk of suicide or self-harm).
[29] IB page 317.

22. After Mr A was secured in the seclusion room, RN Machemedze recalled that Mr A and Mr Pham had spent quite an amount of time together the previous evening/night and went to Mr Pham's room to check on him. At about 6.55am, RN Machemedze found Mr Pham in his room, in bed and deceased.

23. It was uncontentious at inquest that Mr A caused Mr Pham's death, albeit Mr A was later charged with murder and found not guilty on the basis of mental impairment following a contested hearing in the Supreme Court of Victoria.[30]

INVESTIGATION AND SOURCES OF EVIDENCE

24. On 27 December 2012, LSC Sean Toohey was appointed Coroner's Investigator in this matter and compiled the coronial brief of evidence (coronial brief). The Court received the coronial brief on 29 July 2015, following conclusion of the criminal proceedings relating to Mr Pham's death. Following issues relating to the *Mental Health Act* 2014 amendments, the final matters relating to Mr A's criminal proceedings were settled in the second half of 2015. It was then that I was able to substantially progress the coronial investigation.

25. I received additional material through my assistant Leading Senior Constable Kelly Ramsey from the Police Coronial Support Unit and referred the matter to the Coroners Prevention Unit (**CPU**)[31] for a review of Mr Pham's and Mr A's management whilst at TEH. In summary, the CPU advised[32] that while no concerns arose from its review of Mr Pham's clinical management and care, there were some concerns about the clinical management and care provided to Mr A and these became the focus of the further coronial investigation and, ultimately, the inquest.

26. This finding is based on the totality of the material obtained in the coronial investigation of Mr Pham's death. That is, the original coronial brief prepared by LSC Toohey, the inquest brief compiled by LSC Ramsay, the statements, reports and testimony of those witnesses who testified at inquest and any documents tendered through them, and the final submissions of counsel. All of this material, together with

[30] Mentioned as part of my assistant's opening at transcript page 4.
[31] The CPU was established in 2008 to strengthen the prevention role of the Coroner. The CPU is staffed by experienced investigators as well as practising physicians and nurses who are independent of any health care professionals or institutions involved in a coronial investigation. Clinical staff of the CPU assist coroners by evaluating clinical management and care provided and identifying any areas of improvement so that similar deaths may be avoided in the future. The CPU also assists coroners to formulate prevention recommendations and comments, and monitors and evaluates their effectiveness once published.
[32] I received advice from the CPU in November 2015 and June 2016.

the inquest transcript, will remain on the coronial file.[33] In writing this finding, I do not purport to summarise all the material and evidence; rather, I will refer to the evidence only in such detail as is warranted by its forensic significance and the interests of narrative clarity.

## PURPOSE OF A CORONIAL INVESTIGATION

27. The purpose of a coronial investigation of a *reportable death*[34] is to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which the death occurred.[35] Mr Pham's death was reportable because of his status as a person placed in custody or care as he was a prisoner serving a sentence and therefore a person in the legal custody of the Secretary to the Department of Justice and/or was a patient in an approved mental health service within the meaning of the MHA 1986.[36]

28. The term 'cause of death' refers to the *medical* cause of death, incorporating where possible the mode or mechanism of death.

29. For coronial purposes, the term 'circumstances in which the death occurred' refers to the context or background and surrounding circumstances but is confined to those circumstances sufficiently proximate and causally relevant to the death, and not merely all circumstances which might form part of a narrative culminating in death.[37]

30. The broader purpose of any coronial investigations is to contribute to a reduction in the number of preventable deaths, through the findings of the investigation and the making of recommendations by coroners, generally referred to as the 'prevention role.'[38] Coroners are empowered to report to the Attorney-General in relation to a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health and safety or the administration of

[33] From the commencement of the *Coroners Act* 2008 (the Act), that is 1 November 2009, access to documents held by the Coroners Court of Victoria is governed by section 115 of the Act.
[34] The term is exhaustively defined in section 4 of the Act. Apart from a jurisdictional nexus with the State of Victoria (s 4(1)), reportable death includes "a death that appears to have been unexpected, unnatural of violent or to have resulted, directly or indirectly, from an accident or injury" (section 4(2)(a)).
[35] Section 67(1) of the Act.
[36] See section 3 of the Act for the definition of a "person placed in custody of care" and section 4 for the definition of "reportable death", especially section 4(2)(c), (d) and (e) and note amendments consequent to the passing of the MHA 2014.
[37] This is the effect of the authorities – see for example Harmsworth v The State Coroner [1989] VR 989; Clancy v West (Unreported 17/08/1994, Supreme Court of Victoria, Harper J).
[38] The 'prevention' role is now explicitly articulated in the Preamble and purposes of the Act, compared with the *Coroners Act* 1985 where this role was generally accepted as 'implicit'.

justice.[39] These are effectively the vehicles by which the Coroner's prevention role can be advanced.[40]

31. It is important to stress that coroners are not empowered to determine the civil or criminal liability arising from the investigation of a reportable death and are specifically prohibited from including in a finding or comment any statement that a person is, or may be, guilty of an offence.[41] However, a coroner may include a statement relating to a notification to the Director of Public Prosecutions if the coroner believes an indictable offence may have been committed in connection with the death.[42]

MEDICAL CAUSE OF DEATH

32. At about 10.30am on 27 December 2012, Forensic Pathologist Dr Linda Iles of the Victorian Institute of Forensic Medicine (**VIFM**), attended TEH and examined Mr Pham's body *in situ*. She observed him lying semi-supine in bed; his face was extremely congested and conjunctival haemorrhages were evident along with ligature marks about the neck. Rigor mortis was present and the extremities not in close proximity to the bed were cool.

33. The following day, Dr Iles reviewed the circumstances of Mr Pham's death as reported by police to the coroner,[43] post-mortem computerised tomography (**PMCT**) scanning of the whole body and performed an autopsy. Having done so, Dr Iles provided a twelve-page written report, dated 26 February 2013.[44]

34. Among Dr Iles' anatomical findings were multiple ligature abrasions about the neck, extensive haemorrhage within the strap muscles of the neck associated with a fracture of the thyroid cartilage, thymic, epicardial, facial and oral mucosal petechial haemorrhages, and an incidental finding of moderate single vessel coronary artery atherosclerosis.[45]

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[39] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.
[40] See also sections 73(1) and 72(5) of the Act which require publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation.
[41] Section 69(1) of the Act.
[42] Sections 69(2) and 49(1) of the Act.
[43] Police Report of Death to the Coroner (Police Form 83) prepared by Detective Senior Constable Kerry Glassner on 27 December 2012.
[44] Dr Iles' autopsy report is at IB pages 18-29 and includes her formal qualifications and experience.
[45] Ibid at IB page 29, Dr Iles made the following comment – "Post-mortem examination demonstrates moderate single vessel coronary artery atherosclerosis. No other significant natural disease was identified. This has not contributed directly to death."

35. According to Dr Iles, there were multiple ligature marks about the neck, at least one of which was circumferential and that the thyroid cartilage fracture was consequent to the cartilage breaching its point of maximal flexibility due to the blunt force applied. The pathologist commented that she had been provided with photographs of two shoelaces tied together (found in Mr A's possession)[46] and that the ligature mark was consistent with being inflicted by the shoelaces or a ligature of similar width.[47]

36. Routine toxicological analysis of post-mortem specimens detected therapeutic levels of antipsychotic medications olanzapine (at ~0.2mg/L) and hydroxyrisperidone, a metabolite of risperidone[48] (at ~50ng/mL), and trace amounts of valproic acid metabolites. No alcohol or other commonly encountered drugs or poisons were detected. These results were consistent with Mr Pham's medication regime at the time of his death.[49]

37. Dr Iles concluded that the cause of Mr Pham's death was ligature strangulation.

38. I accept the cause of death proposed by Dr Iles and find that the cause of Mr Pham's death is ligature strangulation.

IDENTITY & NON-CONTENTIOUS FINDINGS AS TO CIRCUMSTANCES

39. Mr Pham's identity was not in issue. On 27 December 2012, Andrew John Jackson, Unit Manager and Psychiatric Nurse at the Argyle Unit of Thomas Embling Hospital, visually identified the deceased's body as being that of patient Thien Cong Pham, born 9 April 1985, and completed a Statement of Identification.[50]

40. Nor was there any contention around the date and place where Mr Pham died. Accordingly, I find, as a matter of formality, that Mr Pham died in the Argyle Unit at Thomas Embling Hospital, 201 Yarra Bend Road, Fairfield, Victoria on or about 27 December 2012.

[46] RN Machemedze refers to observing the shoelace ligature in Mr A's hand and removing it and leaving it on the floor outside the seclusion room before Mr A was placed inside: Exhibit B; IB Exhibit 1 (Photograph Booklet A), photographs 49, 50, 58-63 (and Statement of Crime Scene Photographer, SC Rachel Kingston-Lee, IB pages 174-178). Biological material located on the shoelaces was forensically examined with analyses providing extremely strong support for the proposition that the major component of the mixture of DNA in the sample originated from Mr Pham: Statement of Forensic Biologist Kate Outteridge at IB pages 183-193.
[47] IB pages 18-29 (Dr Iles' report).
[48] Also available as a drug in its own right, namely, 9-hydroxyrisperidone or paliperidone.
[49] IB pages 30-35 (Toxicologist's report).
[50] IB page 17.

FOCUS OF THE CORONIAL INVESTIGATION

41. As is often the case in this jurisdiction, the focus of the coronial investigation and inquest into Mr Pham's death was on aspects of the circumstances in which the death occurred.

42. As noted above and based on the advice of one of the CPU's Mental Health Investigators[51] who had reviewed Forensicare records pertaining to Mr Pham, in particular, since his admission to Argyle in April 2012, the clinical management and care provided to Mr Pham whilst at TEH did not appear wanting and was not a focus of the coronial investigation of his death.

43. In contrast, aspects of the clinical management and care provided to Mr A were the subject of further investigation and ultimately became the focus of the inquest, as they bore on Mr A's ability to cause Mr Pham's death without attracting the attention of the nursing staff caring for both of them on the evening of 26-27 December 2012.[52]

44. The focus of the inquest was twofold:

(a) Mr A's management at TEH between 21 and 27 December 2012 and in particular –

i. The appropriateness of the decision to cease his seclusion on 24 December 2012;

ii. The adequacy of arrangements to manage Mr A in Argyle's open ward;

iii. Management of Mr A overnight on 26-27 December 2012; and

(b) Improvements made by Forensicare/TEH after 2012.

While these issues are inter-related, I have endeavoured as far as possible to identify the evidence relevant to each issue under the appropriate heading in the paragraphs that follow.

PATIENT A's MANAGEMENT AT TEH

45. Mr A was transferred to TEH on 21 December 2012 at the request of Dr McInerney who had reviewed him at MAP on several occasions between 16 and 19 December 2012. Throughout his MAP admission, Mr A presented with notable irritability and

[51] Among the CPU's staff are Mental Health Investigators who are qualified and experienced in psychiatric nursing and psychology. They review medical records at the Coroner's request and provide preliminary advice about any issues raised by the Coroner or identified by them from the medical records.

[52] While the Coroner determines the witnesses to be called and the issues/scope of the inquest (section 64 of the Act), interested parties have a right to be heard as to the question of which witnesses should be called (section 66(1) of the Act. The parties were represented at two directions hearings (15 May and 17 July 2017) and were afforded the opportunity to make submissions about the witnesses to be called and the issues/scope of the inquest.

while he was superficially co-operative, he was resistant to discussing his mental state and clinical staff found it difficult to accurately assess it. He was perceived as 'somewhat menacing' at times and had a 'verbal outburst' following a misunderstanding with staff on 19 December 2012.[53]

46. Mr A's clozapine levels had been consistently subtherapeutic while at Barwon, though he denied medication non-compliance and there were no reports of observed non-compliance. Early transfer to TEH was considered necessary given the suspected relapse of schizophrenia and Mr A's history of IPV associated with deterioration of his mental health.[54]

47. Mr A was assessed in seclusion on arrival at Argyle on 21 December 2012. A risk assessment identified that he posed a high risk of interpersonal violence, substance abuse, weapon use, property damage, suicide or self-harm, non-compliance with medication and absconding.[55]

48. Notes made by nursing and clinical staff between 5 and 6pm on 21 December 2012 describe Mr A's 'odd demeanour'[56] and 'unusual'[57] presentation and that he provided one-word responses[58] during mental state examinations making him 'very difficult to assess'.[59] Dr Pandurangi nonetheless found Mr A's presentation to be 'highly indicative of deterioration in mental state'.[60] He formulated a plan 'given the high risk of IPV when he is unwell' that he continue to be nursed in seclusion over the following days with a gradual transition to the open ward after a testing period of access to the seclusion courtyard in the company of staff commencing that day.[61] Mr A was amenable to Dr Pandurangi's management plan.[62]

**Seclusion**

49. The use of seclusion in psychiatric care – confinement of person at any hour of the day or night in a room in which the doors and windows are locked from the outside – is authorised by the MHA only where necessary to protect the patient or another person

[53] IB page 329.
[54] Ibid.
[55] IB 334.
[56] IB page 333.
[57] IB page 332.
[58] IB page 332.
[59] IB page 335.
[60] IB page 338.
[61] IB page 338.
[62] IB page 338.

from an imminent risk to his/her health or safety, or to prevent absconding.[63] Seclusion must be authorised by a consultant psychiatrist or, in the case of an emergency, by the senior nurse on duty.

50. The MHA requires that individuals kept in seclusion be reviewed at intervals of not more than 15 minutes by a RN and must generally be examined by registered medical practitioner at intervals of not more than four hours.[64] While in seclusion and in accordance with the MHA, Mr A was reviewed every four hours by a consultant psychiatrist or psychiatric registrar and by nurses at 15-minute intervals.[65]

51. Mr A was generally co-operative with the four-hourly seclusion review protocol, except those occurring at 1am and 5am. Overnight, he ignored clinicians' requests to perform reviews and so they considered it unsafe to enter the room. Instead, clinicians noted that Mr A appeared to be actually sleeping or trying to sleep, and that he did not seem to be in any distress.[66]

52. During reviews successfully completed, Mr A was frequently described as being 'superficially co-operative',[67] 'guarded',[68] 'suspicious'[69] 'tense'[70] and 'unwilling to engage'[71] with clinicians or provide insight into his thoughts.[72] Clinicians were particularly mindful of Mr A's history of IPV given that his monosyllabic responses made his mental state difficult to assess.[73] Indeed, despite uneventful breaks in the seclusion and unit courtyards on 22 December 2012 accompanied by staff,[74] later the same day nursing staff refused to accompany Mr A for a smoke break because they did not feel safe.[75]

53. That said, the clinical notes do not disclose any signs that Mr A had shown verbal or physical aggression or violence to anyone.[76] Rather, Mr A was compliant with

[63] Section 82, MHA 1986 in force at the time of Mr Pham's death. Most episodes of seclusion at Forensicare relate to incidents of aggression or violence or immediate threats of harm to others: Exhibit D.
[64] Section 82 MHA 1986.
[65] IB 334-358 (Clinical Notes) and IB 290-312 (Approval/Authority for Seclusion and Seclusion Clinical Observations).
[66] IB pages 340, 348, 353 (Clinical Notes).
[67] IB pages 342, 344 and 347 for example.
[68] IB pages 345, 346 and 347.
[69] IB pages 345, 346 and 347.
[70] IB pages 345 and 346.
[71] IB pages 346 and 351 for example.
[72] IB pages 341, 343 and 347.
[73] IB pages 343, 344, 346 and 348.
[74] IB page 344.
[75] IB 347.
[76] See generally the Clinical Notes made during Mr A's period in seclusion: IB pages 332-358, and in particular notes made at about 2pm on 22 December and 9pm on 23 December 2012; c/f 'underlying hostility' noted around 1pm on 23 December 2012 in the context of a possible change to the seclusion plan.

prescribed medications including an increasing dose of clozapine, responsive to staff directions, had taken a number of breaks each day into the courtyards, and later, the garden, with staff – commenting on 23 December 2012 that he found these 'relaxing'[77] – and appeared to be eating and sleeping well.[78] He was noted to have a 'slightly warmer affect' on 23 December 2012, though he remained difficult to engage.[79]

THE DECISION TO CEASE PATIENT A's SECLUSION

54. Dr Pandurangi reviewed Mr A on the morning of 24 December 2012.[80] The psychiatrist noted that Mr A was 'cooperative' with the process but that his mental state was difficult to assess due to monosyllabic responses.[81] Mr A had poor eye contact, there was no rapport and he appeared 'mildly distracted'.[82] He was irritable when asked about clozapine compliance and the plan for ceasing seclusion.[83] Dr Pandurangi observed 'no overt' psychotic symptoms but considered Mr A's presentation as highly suggestive of their presence.[84]

55. Dr Pandurangi noted the 'difficult situation' presented by Mr A.[85] He considered it 'prudent' to trial Mr A in the unit courtyard with patients from the open ward to gauge his response and interactions with them before deciding to cease seclusion.[86] The psychiatrist noted that 'although a possible deterioration in mental state would significantly increase his risk of interpersonal violence, historically it ha[d] been difficult to predict these events'.[87]

56. Dr Pandurangi was unsure whether further seclusion would decrease Mr A's risk of IPV given that Mr A believed himself well and not in need of seclusion.[88] The psychiatrist directed that Mr A spend time in the unit courtyard with other patients and that if this went well, he would consider ceasing seclusion that day. RN McLoughlin was tasked to develop a management plan if seclusion was ceased.

57. A Nursing Entry in Mr A's medical record timed 1.45pm on 24 December 2012 noted that Mr A's mental state continued to be difficult to assess as he was 'dismissive and

[77] IB page 350.
[78] See generally the Clinical Notes made during Mr A's period in seclusion: IB pages 332-358.
[79] IB page 351.
[80] IB pages 354-357 (Clinical Notes).
[81] IB page 354.
[82] IB page 354.
[83] IB pages 354-355.
[84] IB pages 355-356.
[85] IB page 356.
[86] Ibid.
[87] IB page 356.
[88] Ibid.

guarded' when questioned, with some irritability evident.[89] He was provided with RN McLoughlin's management plan at 1pm and was 'agreeable' to it though 'did not appear to be listening much' or 'taking it in' when it was explained.[90] When escorted to the unit courtyard, Mr A spent his time doing laps and was dismissive of staff.

58. Although this note does not refer to any interactions with co-patients,[91] RN Lisa Carter recalled Mr Pham's efforts to renew his acquaintance with Mr A when the latter was first escorted into the unit courtyard. Mr Pham tried to shake hands with Mr A, who ignored him, and then attempted to strike up conversation but desisted when this too was rebuffed.[92] RN Carter thought Mr A's response 'very unusual' because the two men had been 'good friends' when previously co-patients at Argyle.[93]

59. Mr A's seclusion was ceased at about 1.15pm on 24 December 2012.

60. Dr Pandurangi, and Forensicare's Clinical Director, Dr Maurice Magner, gave evidence about the decision to cease Mr A's seclusion at inquest. Dr Pandurangi noted that when Mr A was transferred to TEH, there was no clear indication that Mr A was experiencing psychotic symptoms such as delusions or hallucinations, rather, that it was 'all about his demeanour … and low clozapine levels'; this gave rise to the suspicion that his mental state was deteriorating.[94]

61. Accordingly, Dr Pandurangi was mindful of the need to establish two things: whether Mr A's mental state had, in fact, deteriorated, and, whether he posed an imminent risk to himself or others.[95] He observed that the management for each is 'slightly different', with an increased dosage of medication the appropriate response to the former and seclusion for management of the latter.

62. Dr Pandurangi testified that Mr A's clozapine dose was increased on arrival at Argyle (and there was no report of non-compliance while in seclusion)[96] and, given his historical risk of IPV, he took the 'precautionary'[97] step of secluding Mr A 'for a few days' for further assessment, with gradual access to the unit.[98]

[89] IB page 358 (Clinical Note).
[90] IB page 358 (Clinical Note).
[91] Ibid.
[92] IB page 155.
[93] Ibid.
[94] Transcript page 132.
[95] Transcript page 134.
[96] Transcript page 134.
[97] Transcript pages 134 and 176.
[98] Transcript page 134.

63. Both Drs Pandurangi and Magner referred in their evidence to the MHA's stringent regulation of the use of seclusion. Dr Manger referred to the 'positive pressure' placed on psychiatrists by the MHA to cease seclusion as soon as possible[99] while Dr Pandurangi stated that he 'need[ed] to have some object[ive] evidence'[100] of imminent harm to justify the continuation of seclusion under the MHA.

64. During cross-examination, attempts were made to parse a material difference between 'no deterioration' and 'improvement' in Mr A's mental state in circumstances where he remained guarded and monosyllabic and so difficult to assess. In short, to identify what it was about Mr A's presentation that had changed during his seclusion to justify its cessation.

65. Dr Magner spoke of Mr A being 'enigmatic' and that it was 'difficult to evaluate change',[101] though he recalled nothing in the clinical notes to suggest Mr A 'shouldn't come out of seclusion'.[102]

66. For his part, Dr Pandurangi noted that in the six days prior to the cessation of seclusion (only three of these spent in seclusion), Mr A had been reviewed twice by three different psychiatrists.[103] The psychiatrist conceded that Mr A's mental state was difficult to assess,[104] including on 24 December 2012 when seclusion was ceased. He considered the 'change' in Mr A was that 'actually he was co-operative': he was compliant with all medical staff during reviews, compliant with medications, followed the directions of staff and when assessed by psychiatrists, though there was a lack of warmth and some irritability, he showed no signs of acute psychosis.

67. For these reasons, and in the absence of any aggression towards staff,[105] Dr Pandurangi considered that by 24 December 2012, there was no evidence that Mr A's seclusion should be continued[106] and rejected the proposition that he should have consulted with a more senior colleague before releasing Mr A from seclusion.[107]

[99] Transcript page 86.
[100] Transcript page 134.
[101] Transcript page 87.
[102] Transcript page 86.
[103] Transcript page 158.
[104] Transcript page 159.
[105] Transcript page 169.
[106] Transcript page 177.
[107] Transcript page 156.

68. A document entitled, 'Management Plan – [Mr A]' appears as Exhibit 12 of the inquest brief: it is unsigned and not dated but is likely to be the plan RN McLoughlin was tasked to prepare by Dr Pandurangi.

**Management Plan**

69. The plan is expressed as being 'necessary for staff to feel confident and safe …' given Mr A's 'long history of violence and aggression'[108] and includes a warning that seclusion may be used if there is an imminent risk of violence towards others. Key components of the plan were that staff ensure Mr A's compliance with medication, conduct mental state examinations twice daily, search Mr A's room daily 'due to [his] history of weapon-making' and perform 15-minutely observations. The plan provides no guidance on addressing non-compliance with its requirements.

**Risk Assessment - DASA**

70. Not mentioned in the Management Plan is that Mr A was also made subject to daily Dynamic Appraisal of Situational Aggression (**DASA**) assessments when he came out of seclusion. The DASA is a risk assessment tool that predicts the likelihood of aggression over a very short time-period (24 hours).[109] Trained nursing staff assess and scale a patient's risk of aggression across seven measures: irritability, impulsivity, unwillingness to follow instructions, sensitivity to perceived provocation, ease to anger when requests are denied, negative attitudes and verbal threats.[110]

71. A DASA was completed for Mr A on 24, 25 and 26 December 2012. On each occasion, all scores were '0' with the overall prediction of situational aggression estimated as 'low'. Dr Magner observed that Mr A showed little evidence of his potential for violence during his December 2012 admission and while 'a review of his DASA ratings may have slightly changed the overall score, … it was unlikely to have indicated an imminent risk for severe violence'.[111] Moreover, although the DASA instrument has been well-validated and used in a variety of forensic and general

[108] IB Exhibit 12, page 249.
[109] Research shows that compared with similar tools it has a higher predictive validity. It measures irritability, impulsivity, and unwillingness to follow direction, a patient's sensitivity to perceived provocation, how easily a patient is angered when requests are denied, a patient's negative attitudes, and verbal threats.
[110] Forensicare Policy, 'Clinical Risk, Assessment and Management (Version 1, approved 26 April 2016)', Appendix 1, IB page 225.
[111] IB page 220. Dr Magner also commented that Mr A posed a 'chronically high' risk to relational security and was 'very difficult to read'. Accordingly, it was hard to anticipate when this risk was very high or just average: Transcript page 90.

mental health settings in Australia and overseas, according to Dr Magner, 'there is always a margin of error' when using such tools.[112]

**Mental State Examination**

72. Mental State Examination (**MSE**) is one of the core assessment tools specific to psychiatric specialists. The MSE is a snapshot of a patient's psychological functioning at a given point in time created by collating information about her/his physical, emotional and cognitive state systematically. The key components of the MSE are appearance, behaviours, mood, affect, speech, cognition, thoughts, perceptions, insight and judgement. MSEs are an important part of risk assessment and inform care and treatment planning.[113]

73. There was (and is) no policy or guideline at Forensicare about how an MSE is to be undertaken and documented.[114] However, Forensicare's Director of Nursing, Joanne Ryan, advised that all psychiatric nurses are trained and competent in conducting MSEs and are required to complete a Mental State Examination Competency.[115]

74. Ms Ryan indicated that to satisfy the requirement for an MSE she would expect nurses to assess a patient's presentation, including his/her thoughts perceptions, behaviour and mood and record findings relevant to their assessment of the patient's mental state in progress notes.[116] Assessment occurs through visual observation, direct questioning and listening but the method employed will depend on the staff member, the patient and their relationship.[117]

75. Given Mr A's Management Plan required MSEs twice daily, she expected that these would occur during the morning (7am-3.30pn) and afternoon (1.30pm-9.30pm) shifts.[118] Review of Mr A's medical records confirms that MSEs were undertaken and recorded twice on each of 24, 25 and 26 December 2012 in accordance with the Management Plan.[119] The notes continue to depict Mr A as monosyllabic and unwilling to engage in discussions about his mental state; largely isolative in

[112] IB page 220.
[113] Advice from the CPU November 2015.
[114] Exhibit H.
[115] Exhibit H and Transcript page 180. It is not clear whether competence is assessed once or on an ongoing basis.
[116] Exhibit H.
[117] Exhibit H, with which Dr Pandurangi's expectations for MSEs broadly align: Exhibit F.
[118] Exhibit H.
[119] Exhibits H and F.

behaviour, with little or no interaction with staff or co-patients[120] until about 5pm on 26 December 2012, after which time he and Mr Pham were 'inseparable'.[121]

**Medication Compliance**

76. Mr A's evening medication was clozapine.[122] At Argyle, medications were administered by nurses from the medication counter of the surgery with evening medications dispensed around 8pm.[123]

77. A Nursing Entry in Mr A's medical record timed 1.20pm on 25 December 2012 notes that the 'nursing team had a discussion regarding medication compliance last night … ?discussion with consultant re[garding] changing to liquid' form of Mr A's clozapine.[124] No reference to actual or suspected medication non-compliance appears in medical records dated 24 December 2012 but it can be inferred from the later note that the information was handed over.

78. Mr A's medical record contains no note suggesting actual or suspected medication non-compliance on 25 December 2012.

79. A Nursing Entry in Mr A's medical record (untimed)[125] on 26 December 2012 notes that Mr A took his medication with 'minimal water and [then] walk[ed] away'.[126] RN Dena Rehn, who dispensed Mr A's medication, thought it was 'quite clear that he had not swallowed the tablets'.[127] She challenged Mr A, saying, 'You haven't taken that'[128] and asked him to return to the counter twice, but Mr A did not respond. RN Rehn recalled that she 'backed off knowing there was another staff member standing near him [whom she] didn't want to put … in danger'.[129] She reported Mr A's 'non-compliance' to RN Blanka Pribylova, the medication supervisor for the shift, and later made a note in Mr A's medical record.[130]

80. RN Pribylova followed Mr A down the numbered corridor, asking him to turn around and talk to her so she could determine whether he had taken his medication. Mr A ignored her and continued walking towards his room. RN Pribylova followed him at a

[120] IB Exhibit 18, pages 358-363.
[121] IB page 156.
[122] IB page 364.
[123] IB pages 158-159 (Rehn) and 160-162 (Pribylova).
[124] IB page 360.
[125] But appearing after several notes, the earliest of which is timed 2pm, and before a night nursing entry timed 6am on 27 December 2012.
[126] IB page 363.
[127] IB Page 158.
[128] Ibid.
[129] Ibid.
[130] IB pages 159 and 363.

distance of about two metres, 'being very ready to react in case he turned to me'.[131] She spoke to him a couple more times and received no response. When she arrived at the door to Mr A's room, she observed him lying on his bed and looking up at the ceiling. RN Pribylova made further attempts to engage Mr A in conversation, which were ignored. Eventually, Mr A stood up, opened and closed his mouth twice, and then lay back down on his bed.

81. RN Pribylova reported her interaction to the Shift Leader, RN Tatenda Dangare.[132] RN Pribylova stated that concerns about Mr A's medication compliance were handed over to the night Shift Leader, RN Machemedze, though neither he nor RN Dangare had independent recollections of the content of the handover.[133]

82. In 2012, there was no uniform policy or guideline at Forensicare dictating what nursing staff should do when they suspect that a patient has not taken medication, or if they know that is the case.[134] The rationale for that position, according to Dr Magner, is that the 'appropriate response' to actual or suspected medication non-compliance will depend on the patient, the medication and the circumstances of the non-compliance, even among patients considered at high risk of IPV because the role of medication in mitigating that risk is not linear.[135]

83. Ms Ryan gave evidence about her expectations of nursing staff's response to actual or suspected medication non-compliance. These included that nurses engage with the patient at the time to ascertain whether or not medication had been taken (including by asking him/her to open his/her mouth), if it is clear that the medication had not been taken, to try to convince the patient to take it and, in either case, record the incident in progress notes and hand the information over to the next shift to ensure close monitoring and that the issue is raised with the treating doctor at the next multidisciplinary team meeting.[136]

84. Ms Ryan would not expect nurses to 'badger'[137] the patient about actual or suspected non-compliance; rather, to adopt an approach not likely to irritate or anger the patient

[131] IB page 161.
[132] IB page 161.
[133] See RN Pribylova's statement (IB Page 161), RN Dangare's statement (IB Page 164) and RN Machamedze's testimony at inquest (Transcript page 13). This is not to suggest that the information about actual or suspected medication non-compliance was not handed over to the night shift.
[134] Exhibits H and F.
[135] IB page 220.
[136] Exhibit H.
[137] Transcript page 186.

and assist longer term strategies to address non-compliance and the reasons for it.[138] She would not expect nurses to escalate concerns to a present or on-call consultant unless the patient presented an immediate risk of deterioration or violence.[139] Ms Ryan considered the nursing response to Mr A's 'suspected medication non-compliance' appropriate.[140]

85. Dr Pandurangi observed that the response to any instance of medication non-compliance by a patient was a clinical decision for the treatment team and would depend on the likely effect of non-compliance on the patient's presentation, and the characteristics of the medication.[141]

86. The psychiatrist noted the strict monitoring protocols surrounding the use of clozapine due its potentially serious side effects at initiation (myocarditis), from long term use (neutropenia and myocarditis) and abrupt cessation after prolonged use (rebound psychosis).[142] Dr Pandurangi also noted the requirement to recommence clozapine at the starting dose if more than 48 hours had elapsed since the last dose.[143]

87. Dr Pandurangi observed that 'in general terms', non-compliance with clozapine 'over a period of time' would have a detrimental effect on Mr A's mental state and would lead to deterioration of his illness and increased risk of IPV.[144] However, it was 'extremely difficult to comment' on whether missing a single dose of clozapine, 'on non-consecutive days', would have had an 'immediate and direct causal relationship with his risk of IPV.[145]

88. Dr Pandurangi testified that he would have expected actual non-compliance with clozapine to be reported by nurses to the on-call psychiatrist.[146] However, it was 'different' if non-compliance was suspected[147] rather than 'an absolute fact'.[148] The psychiatrist expected non-compliance to be reported to a medical registrar or psychiatrist immediately if nursing staff considered it 'urgent', for instance due to deterioration of mental state following medication non-compliance.[149] Dr Pandurangi

[138] Exhibit H.
[139] Exhibit H and Transcript page 186-187.
[140] Exhibit H.
[141] Exhibit F.
[142] Exhibit G.
[143] Exhibits F and G.
[144] Exhibit G.
[145] Exhibit G.
[146] Transcript page 162.
[147] Transcript page 162.
[148] Transcript page 164.
[149] Exhibit F.

observed that nothing in Mr A's medical record suggested any behavioural change or deterioration in mental state between 24 and 27 December 2012.[150]

**Searches**

89. Forensicare's 'Searches – Environmental and Personal' policy[151] is designed to ensure a safe and secure environment for patients, staff and visitors. The frequency of room searches depends on the patient and the unit.[152] Searches are intended to identify and remove any items of 'contraband' and provide insight into a patient's behaviour and mental state.[153]

90. 'Contraband' items are defined in a separate policy document. The definition includes 'weapons', including replicas and self-made items, however, what constitutes a weapon is not defined. The rationale for not defining what constitutes a weapon, according to Ms Ryan, is that 'anything can potentially be used to harm oneself or others'.[154] She noted that shoelaces were not normally considered a weapon and had not been identified as an 'item of risk' in relation to Mr A or otherwise.[155]

91. Somewhat in contrast to this comment, both Ms Ryan and Dr Magner reported that shoelaces (and shoes) are usually removed upon entering seclusion as a means of preventing self-harm,[156] suggesting some institutional consciousness of the potential for shoelaces to be used as ligatures.

92. Mr A's room was searched as part of his Management Plan on 25 and 26 December 2012. Nothing 'out of the ordinary' was located during either room search and Enrolled Nurse (EN) Evan Miller described Mr A as being 'very compliant' with the search of his room and his person on 26 December 2012.[157]

**15-Minutely or 'Close' Observations**

93. In December 2012, the observation system in place at TEH was a system of General Observations, Close Observations and Special Nurse Observations.[158] In broad terms,

[150] Exhibit G.
[151] Forensicare Searches – Environmental and Personal policy (approved 11 June 2012) at Tab 5 of Exhibit 20, IB pages 776-780.
[152] At Argyle, a minimum of two bedroom searches occur each day, at random: Forensicare Searches – Environmental and Personal policy (approved 11 June 2012) and Exhibit H.
[153] Exhibit H.
[154] Exhibit H.
[155] Exhibit H.
[156] Exhibits H and D.
[157] IB page 165. Coincidentally, Mr Pham's room was also searched on 26 December 2012 – randomly – and no contraband was located.
[158] IB page 216 and Victorian Institute of Forensic Mental Health Police 'Patient Specials and Close Observation' (Version 5) last reviewed in September 2011 prior to Mr Pham's death: IB Tab 5 of Exhibit 20.

General Observations required nursing staff to know a patient's general whereabouts at all times, Close Observations involved timed visual observations usually not more than 15 minutes apart and Special Nurse Observations – 1:1 nursing or 'specialling' – during which a nurse is required to remain with the patient, within sight and at arm's length, constantly.[159]

94. The nature of observations to which a patient is subject depends on his/her needs and risk factors as determined by the treatment team. However, a consultant psychiatrist, medical officer or the shift leader (the nurse in charge) could initiate specialling when a patient has indicated a potential or actual risk.[160]

95. The observation policy indicates that Close Observations are intended to involve a 'meaningful interaction' between staff and the patient to assist staff to become familiar with the patient's routine, risk elements and mental state and to begin the process of developing rapport. Close Observations, and interactions arising from this practice, are to be noted in the patient's clinical file. Nurse-initiated close observations could be ceased by nursing staff if the patient was assessed as no longer being at risk, otherwise a change to the frequency of observations was a decision of the treating team.[161]

96. Mr A was on Close Observations due to his 'historical risk of unpredictable and violence behaviour'.[162] At inquest, Dr Pandurangi confirmed that this was his rationale for initiating 15-minutely observations when Mr A entered the open ward on 24 December 2012,[163] a decision that would have been reviewed as a matter of course at the next multidisciplinary team meeting on 27 December 2012.

97. The psychiatrist noted that when Mr A's seclusion was ceased, there was no evidence to suggest a need for specialling, such as an imminent risk of suicide.[164] He also commented that specialling, because it is very intrusive, can heighten the risk to the physical safety of staff.[165] RN Machemedze agreed that 1:1 nursing could have 'made the situation worse' with Mr A and that 15-minutely observations were 'sufficient'

[159] IB Tab 5 of Exhibit 20.
[160] IB Tab 5 of Exhibit 20.
[161] IB Tab 5 of Exhibit 20.
[162] IB page 216.
[163] Transcript page 167.
[164] Transcript page 168.
[165] Transcript page 168.

given the information available.[166] He confirmed that had it been necessary, additional staff to provide specialling could have been arranged at short notice, even overnight.[167]

98. Dr Pandurangi testified that while subject to Close Observations, he expected that Mr A would actually be sighted by nursing staff every 15 minutes and, 'as far as possible, staff interact with him'.[168] The psychiatrist did not expect nurses to interact with patients on Close Observations every 15 minutes.[169]

99. RN Machemedze gave similar evidence: while conceding that Close Observations were about meaningful engagement, he emphasised the need to exercise clinical judgment depending on the risk posed by the individual.[170] He went on to say that with Mr A, if nurses tried to have meaningful engagement, 'we're more likely to have a negative outcome'.[171] Indeed, Mr A 'does not take interactions lightly … [it's] not always advisable [to] approach because he does not [like] authority always coming up to him'.[172] RN Machemedze also observed that simply sighting a patient has 'value' because it reduces the risk that s/he will become 'unnecessarily reactive … or irritated' and is 'meaningful' because 'you're not … unsettling the individual who is already settled'.[173]

MANAGEMENT OVERNIGHT 26-27 DECEMBER 2012

100. Overnight on 26-27 December 2012, RNs Machemedze, Mabhena and Stephen Fan were the 9pm until 7am nightshift staff at Argyle, with RN Machemedze the nurse in charge. All beds were occupied and there were 15 patients in the open ward.[174]

101. Neither of the nurses who testified at inquest had an independent recollection of the content of the handover received from the afternoon shift's RN Dangare.[175] While RN Machemedze thought that the requirement to perform Close Observations of Mr A to manage his IPV risk was handed over,[176] he was unsure whether suspicions about Mr A's compliance with medication[177] had been communicated. To the best of his recollection, RN Machemedze testified that nothing handed over triggered the need to

[166] Transcript page 47.
[167] Transcript pages 47-48.
[168] Transcript page 138.
[169] Transcript page 138.
[170] Transcript page 17.
[171] Transcript page 17.
[172] Transcript pages 16-17.
[173] Transcript page 49.
[174] Exhibit C.
[175] Transcript pages 10 (Machemedze) and 200-201 (Mabhena).
[176] Transcript pages 11-12.
[177] Transcript page 11.

alter the treatment plan outside the multidisciplinary team meeting due to occur the following morning.[178]

102. Both RNs Machemedze and Mabhena had nursed Mr A previously at TEH.[179] They were aware of his diagnosis, that 'within institutions' he had 'issues with authority [figures]', his history of unpredictable IPV and concealing weapons.[180] RN Machemedze recalled at times 'feeling threatened' by Mr A's demeanour but felt he had the skills to manage such encounters appropriately.[181] RN Mabhena recalled that Mr A was a patient whom nurses generally feared because of the risk he posed to others.[182] RN Fan reported spending some time during the early part of the shift reviewing the patient files because he did not usually work at Argyle.[183]

103. RN Machemedze divided the shift into three-hour blocks during which the nurses would take turns to undertake Close Observations of Mr A, and complete the patient (presence) checklist hourly.[184] He assigned himself 9pm-midnight, allocated midnight-3am to RN Mabhena and 3am-7am to RN Fan. The 'Argyle Patient Check List' (**Patient Checklist**)[185] and Mr A's 'Close Observation Checklist' (**Checklist**) were kept on separate clipboards.[186]

104. The evidence of the nightshift nurses suggests that they spent much of the shift in the staff station, except when checking on all patients hourly.[187] RN Machemedze stated that his 'primary location' was in the staff station, in a position from which he could see 'most of the unit', though he would 'stand up and do other things'.[188] He conceded that while there was good visibility from the staff station down the numbered corridor and of some communal areas, one had to 'put your head up … you need to be looking'.[189] Nurses had to leave the staff station to see the lettered corridor.[190]

[178] Transcript page 21.
[179] Transcript pages 19 (Machemedze) and 200 (Mabhena).
[180] Transcript page 18.
[181] Transcript pages 16 and 33.
[182] Transcript page 200.
[183] IB page 144.
[184] Exhibits A and B.
[185] Exhibit C.
[186] Transcript page 54.
[187] Transcript pages 36 and 51 and Exhibit A (Machemedze), Transcript page 205 (Mahbena) and IB page 144 (Fan).
[188] Transcript page 36.
[189] Transcript page 51.
[190] Transcript page 51.

105. RN Machemedze recalled that between 9-10pm, Mr A moved frequently between several of the communal areas which were highly visible to staff,[191] spending some of the time with Mr Pham.[192]

106. RN Machemedze commented that when performing 15-minutely observations, a nurse may actually sight the patient several times and/or in different locations within the interval between observations. Accordingly, a location noted on the Checklist would not necessarily mean that the patient spent 15 minutes in one place, only that when the timed observation was made the patient was in the noted location.[193]

107. Just before RN Machemedze checked on all patients at 10pm, he saw Mr Pham and Mr A walk past the staff station together. After completing his check of patients in the lettered corridor, RN Machemedze started checks in the numbered corridor whereupon he saw that Mr A was in Mr Pham's room with him. When asked to leave Mr Pham's room because it was 'against hospital rules' for a patient to be in another's room, Mr A said that they were 'just listening to music'.[194] RN Machemedze reiterated his request that Mr A leave Mr Pham's room and Mr A complied, sitting instead in the corridor outside Mr Pham's room, talking and listening to music.[195]

108. Shortly before 11pm, Mr Pham asked for and was given some noodles. After he had eaten them, Mr A took the container they had been in, washed it, and returned it to Mr Pham. RNs Machmedze[196] and Mahbena[197] observed this and that, generally, the two men were 'hanging around together and being very social'.[198] Although on the look-out for bullying or harassment, RN Machemedze observed that co-patients were encouraged to socialise: 'these are guys who don't easily make friends'.[199] He thought that Mr Pham and Mr A 'looked very relaxed in each other's company'.[200] Similarly, RN Mahbena testified that the men 'seemed to be … emotionally supporting each other' and that there was 'nothing of concern' in their interactions.[201] In contrast, RN

[191] Exhibit B.
[192] Transcript page 206.
[193] Transcript pages 56-57.
[194] Exhibit B.
[195] Ibid.
[196] Exhibit B.
[197] Transcript page 206.
[198] Exhibit B.
[199] Ibid.
[200] Ibid.
[201] Transcript page 206.

Fan ‘didn’t notice any interaction’ between Mr Pham and Mr A throughout the night.[202]

109. At 11pm, RN Machmedze commenced his hourly check, starting in the lettered corridor. When he conducted his check of the numbered corridor, he found Mr A in Mr Pham’s room again.[203] This time when he asked Mr A to leave Mr Pham’s room, Mr A ‘looked at [the nurse] in a very hostile, threatening and aggressive manner’.[204] Rather than reiterate his request immediately and risk ‘escalating’[205] the situation, RN Machmedze continued with his check and returned to Mr Pham’s room a few minutes later. Mr A had remained in Mr Pham’s room but left when the request to leave was repeated, perhaps with some input from Mr Pham.[206] RN Machemedze warned Mr Pham not to allow anyone into his room.

110. Over the next hour, Mr A and Mr Pham remained in each other’s company. They were seen by nurses in the staff station walking back and forth between the numbered corridor and the smokers’ lounge. During RN Machemedze’s midnight check, Mr A was in the corridor outside Mr Pham’s room.[207]

111. At an unspecified time, but prior to RN Mabhena commencing his observation period, RN Mabhena discussed with RN Machemedze his concern about Mr A being in the corridor given that it was time for ‘lights out’ (between 11pm-midnight).[208] At inquest, RN Machemedze testified that he had not ‘ignored’ Mr A’s presence in the corridor, rather that he was being ‘patient’ with him ‘because [I] knew what we were dealing with’[209] and because it was not unusual for a patient to ‘stay awake and talking to a mate until they are exhausted and go to sleep’.[210]

112. While RN Machemedze stated that the fact that Mr A spent so much time over night in the corridor was only concerning because sleep was encouraged,[211] RN Mahbena was concerned because it was ‘against the rules’ and ‘dangerous’.[212] RN Machmedze told his colleague that provided Close Observations of Mr A were performed, he remained outside Mr Pham’s room and Mr Pham remained happy to talk with Mr A, ‘that should

[202] IB page 144.
[203] Exhibit B.
[204] Exhibit B and Transcript page 33.
[205] Transcript page 33 and Exhibit B.
[206] Transcript page 33 and Exhibit B.
[207] Exhibits B and Checklist.
[208] Transcript page 235.
[209] Transcript page 51.
[210] Transcript page 52.
[211] Transcript page 52.
[212] Transcript pages 234-235.

be fine'. RN Mahbena discussed this management strategy with Mr Pham and Mr A, both of whom were content with it.[213]

113. Over the next three hours, during the period RN Mahbena was performing Close Observations, Mr A was noted as being in the numbered corridor.[214] At each of the 1-3am patient checks, RN Mahbena saw that Mr Pham was in his room and that Mr A was in the corridor outside it. When asked if he was alright, Mr A said he was and that he was talking to Mr Pham.[215] RN Mahbena's entries on the Patient Checklist reflect his observations that both Mr Pham and Mr A were awake at 1am and 2am, but that only Mr A was awake at 3am.[216]

114. RN Mahbena could not recall whether, when he last checked on Mr Pham at 3am, the door to Mr Pham's bedroom was closed.[217] The doors of patient bedrooms lock when fully closed and can only be re-opened from the inside or, from the outside, by a staff member using a key.[218] It was Forensicare's policy that patient bedroom doors be kept shut at night.[219] However, RN Mabhena testified that although staff encouraged patients to keep their doors shut for their own safety, ultimately it was the patient's choice whether or not to do so – 'what can we do?'[220] Some patients preferred their door to be left ajar or open for 'fresh air' or because they wanted to let in some light from the corridor.[221] RN Mabhena recalled having a conversation with Mr Pham overnight on 26-27 December 2012 about closing his door but he was content for it to remain open because he could not sleep and was talking with Mr A.[222]

115. RN Fan was responsible for performing Close Observations of Mr A between 3.15am and 7am, though between 4.15am and 5am, RN Mabhena made 15-minutely observations as his colleague was required elsewhere.[223] RN Mahbena recalled that Mr Pham's bedroom door was shut when he performed the 5am patient check.[224] All entries made on the Checklist between 3.15am and 5.45am record Mr A as being either in his room or in bed.

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[213] Transcript page 236.
[214] Checklist.
[215] Exhibit I.
[216] Exhibit C and Transcript pages 206-207.
[217] Transcript pages 227-228.
[218] Transcript page 227.
[219] Transcript pages 100-101 and 227.
[220] Transcript page 232.
[221] Transcript page 232.
[222] Transcript page 232. RN Machemedze stated that Mr Pham preferred his door open: Exhibit B.
[223] Exhibits C and A.
[224] Transcript page 228-229.

116. Around 6am, RN Mahbena had started writing nursing notes in each patient's clinical file for the overnight shift when Mr A presented at the staff station to request toiletries which were provided. RN Fan recorded on the Checklist that Mr A was in the bathroom at 6am. Mr A returned the toiletries to RN Machemedze in the staff station around 6.10am.[225]

117. A few minutes later, RNs Machemedze and Mahbena were alerted by a patient to an incident in room A in the eastern, lettered corridor. Upon arriving, they saw Mr A with his hands around a patient's neck. Both nurses activated their duress alarms at 6.16am.[226] The nurses physically removed Mr A's grip from the other patient. RN Machemedze confiscated shoelaces from Mr A and then remained with the assaulted patient in room A while RN Mabhena escorted Mr A to the smokers' lounge and monitored him. A medical emergency message was received by the TEH control centre at 6.18am.[227]

118. Upon arrival of additional staff, RN Machemedze asked Mr A to come out of the smokers' lounge, which he did, and he was escorted to seclusion without incident.[228]

119. Around this time, the morning shift nurses had arrived. RN Machemedze performed a handover and, while doing so, recalled that Mr A had spent a lot of time with Mr Pham overnight and went to check on him.[229]

120. RN Machemedze noticed that, unusually, the door to Mr Pham's room was closed.[230] Looking through the glass panel in the door, he saw Mr Pham lying in bed facing the wall. RN Machemedze knocked, but there was no response from Mr Pham. He unlocked the door, calling out to Mr Pham and then shaking him when there was no response. RN Machemedze pulled Mr Pham's shoulder towards him, disturbing the blanket and revealing a ligature mark around Mr Pham's neck. Mr Pham was not breathing and pulseless.[231] RN Machemedze's duress alarm was activated for a second time at 6.55am.[232]

[225] Exhibit A.
[226] Exhibit A.
[227] Exhibit A.
[228] Exhibit A.
[229] Exhibits A and B.
[230] Exhibit B and Transcript page 228 (RN Mahbena recalled that his colleague had to unlock Mr Pham's door).
[231] Exhibit B.
[232] Exhibit A.

121. Both RNs Machemedze and Mahbena gave evidence that prior to finding Mr A assaulting a co-patient, the shift had been 'normal and non-eventful',[233] and that there had been 'nothing obvious'[234] to suggest Mr A was contemplating violence.

122. However, RN Mahbena believed that had there been more than a 'skeleton staff' overnight,[235] there would have been more options for Mr A's management, he could have been specialled or staff could have been 'more assertive' in removing him from the corridor.[236]

123. In contrast, RN Machemedze testified that there was nothing to suggest a clinical need to escalate to a psychiatrist or that more intensive observations would have mitigated Mr A's risk of IPV.[237] He observed that a patient's mental state and a risk of IPV might change suddenly, siting Mr A's activities between 6am and 6.15am as an example.[238]

124. Throughout the six o'clock hour, RN Fan purportedly continued to make Close Observations of Mr A. However, the entries he made on the Checklist between 6.15am and 6.45am show clear evidence of overwriting. Overwriting – necessitated by RN Fan having pre-filled "observations" in advance – was characterised by Dr Magner as falsification of those records and a serious breach of policy that was 'unacceptable'.[239] RN Fan later admitted to Forensicare management that he had falsified the above-mentioned entries on the Checklist and chose to resign in the face of likely disciplinary action by Forensicare.[240] In my view, a pall of uncertainty is therefore cast over the accuracy of all Close Observations of Mr A made by RN Fan on 27 December 2012.[241]

125. When asked at inquest, RNs Machemedze and Mahbena and Dr Magner denied that there was a 'culture' of falsifying observation records or non-adherence to patient observations policy at Forensicare.[242] Both RN Mahbena and Dr Magner referred to retrospective note-taking[243] due to the 'pressures of the clinical environment' – that is,

[233] Exhibit B.
[234] Transcript page 242.
[235] Transcript page 239.
[236] Transcript page 240.
[237] Transcript page 46.
[238] Transcript pages 42-43.
[239] Transcript pages 102-103.
[240] Exhibit E.
[241] I note the concession made by Forensicare in its submission dated 24 November 2017 that doubt was cast over the accuracy of RN Fan's observations on 27 December 2012.
[242] Transcript pages 40-41 (Machemedze), 216-217 (Mahbena) and 103, 108 (Magner).
[243] Transcript page 217 (Mahbena).

completing written records of observations actually taken after the fact – but that 'deliberately falsifying in advance is something else'.[244]

IMPROVEMENTS AT FORENSICARE SINCE DECEMBER 2012

126. I note Dr Magner's evidence that since TEH was designed during the 1990s, the demand for mental health treatment for very ill individuals with very high needs in the custodial setting has increased exponentially.[245] The Clinical Director observed that Mr A is an 'unusually difficult individual'[246] even within the small subset of mentally unwell prisoners who require very high levels of security[247] because his risk of IPV seems to be chronically high and it is difficult to anticipate when this risk is very high or 'just average'.[248]

127. Dr Magner also drew an important distinction between risk management practices in a custodial setting – where high security prisoners could be managed long term in conditions of 23-hour per day lockdown – and the tools available under and compatible with the "least restrictive intervention" principles that underpin the MHA.[249] He opined that notwithstanding that TEH's facilities were limited (to seclusion and the open ward) and management options to some degree constrained by the therapeutic paradigm of the MHA, Mr A was 'adequately managed' at Argyle in December 2012 but could have been better-managed if there was an additional high security facility.[250]

128. Dr Magner gave evidence about the internal review and the Office of the Chief Psychiatrist's review of clinical practice and safety conducted following Mr Pham's death, and about Forensicare's responses to the recommendations arising from them.[251] A synopsis of the key developments appear in the paragraphs that follow.

129. Dr Danny Sullivan, Assistant Clinical Director of Forensicare, conducted a review of security at TEH, particularly in the male acute units, using Security Needs Assessment Profile (SNAP) and other validated tools. Upon completion of the review in November 2013, Dr Sullivan reported that there are small number of patients who cannot be managed safely in the existing male acute units. He recommended that a

[244] Transcript page 103 (Magner).
[245] Transcript page 97.
[246] Transcript page 89.
[247] Transcript page 83.
[248] Transcript page 90.
[249] See generally, Transcript pages 87 and 89.
[250] Transcript page 85.
[251] Transcript pages 99-102.

high security unit be developed to provide for the assessment, stabilisation and short-term management of some acute admissions, and potentially for the longer-term management of patients who continue to pose a serious risk of IPV. The security review's findings were shared with the Department of Health.[252]

130. A formal meeting structure between Forensicare, Corrections Victoria and Justice Health was established through which to improve communication and to identify, plan and communicate the transfer of mentally ill prisoners identified as at extreme risk of IPV.[253]

131. A High-Risk Panel was established, first operating in June 2013, to consider strategies for managing security risks posed by the 'highest' risk patients. The Panel comprises of the Operations Manager, Security and Emergency Manager, Unit Manager, Consultant Psychiatrist and is chaired by the Assistant Clinical Director of Inpatient Operations. The Panel must consider all prison hospital transfers of prisoners who have a 'V1' rating under the Corrections Victoria classification system, one assigned to prisoners posing an 'immediate threat' or having 'any previous history' of IPV. The Panel may consider transfers of prisoners without a 'V1' classification but whose prison history are otherwise 'of concern'. The Panel is now regularly used and, according to Dr Manger, is 'functioning effectively' though no formal evaluation of it had occurred as of the date of the inquest.[254]

132. On 4 January 2013, Forensicare implemented a policy of requiring nursing staff to close patients' doors on every hourly overnight check from the start of the nightshift.[255]

133. Duress alarms were installed in the bedrooms of all units along with corridor alarms in acute units which trigger in the staff station to alert staff of patient movements.[256]

134. Forensicare has consulted with the Departments of Health and Human Services and Justice and Community Safety to assist current and future service needs planning. The Department of Health and Human Services has committed to establishing a High Dependency Unit to provide a higher level of treatment for high risk patients for short periods.[257]

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[252] IB pages 213-218 (Dr Magner's statement dated 8 March 2016).
[253] Ibid.
[254] IB pages 213-218 (Dr Magner's statement dated 8 March 2016) and Exhibit D. It is uncontroversial that Mr A was such a patient and would have been managed by reference to this regime had it been in place at the time.
[255] IB pages 213-218 (Dr Magner's statement dated 8 March 2016).
[256] Ibid.
[257] Ibid.

135. In response to the absence of a differentiated care environment at TEH between seclusion and the open ward, the Acute Male Unit Clinical Governance Team undertook a review to address the absence of an intermediate care zone for the management of high risk patients. De-escalation areas have since been introduced in all acute units within TEH.[258]

136. In late 2013, Forensicare created a working party to review its risk assessment tools. In early 2014, a new Risk Assessment Framework was established to standardise the tools used for common clinical risks and specific risks, including those for violence. A new tool was introduced, the Short Term Assessment of Risk and Treatability (**START**), to complement the DASA and Historical Clinical Risk Management tools already in use. By August 2016, more than 90% of Forensicare's nursing staff had been trained in the use of the START tool.[259]

137. In May 2013, Forensicare established the Nursing Working Group (**NOWG**) to review nursing observation procedures within TEH. A new observation policy – Patient Observation and Engagement Policy - was developed and implemented in February 2014 (and was reviewed in August 2015). The new policy has a greater focus on using observation to engage with patients rather than simply observing their movements and behaviours. Timed observations have been abandoned in favour of system of General, Constant and Special Observations. All patients remain under General Observation at all times, with higher levels of observation prescribed by the Consultant Psychiatrist in light of factors including clinical need, assessed risk, patient behaviour, state of mind and environmental issues, and the need for Constant or Special Observation is reviewed daily.[260]

138. The nurse in charge is responsible for ensuring that the appropriate level of observation for each patient is provided at all times. Constant and special observation of a patient occurs by a designated clinician for a period of up to two hours, during which the clinician must report any changes to the patient's mental state and behaviour immediately to the nurse in charge and document specified matters[261] in the clinical record at the end of that period.[262]

[258] Ibid.
[259] Ibid.
[260] IB pages 213-218 (Dr Magner's statement dated 8 March 2016).
[261] The patient's state of mind, changes to the assessed level of risk, description of levels of engagement and rapport and a description of activities and rest periods.
[262] IB pages 213-218 (Dr Magner's statement dated 8 March 2016).

139. I commend the improvements to systems, policy and practice implemented by Forensicare following Mr Pham's death.

FINDINGS/CONCLUSIONS

140. The standard of proof for coronial findings of fact is the civil standard of proof on the balance of probabilities, with the *Briginshaw* gloss or explications.[263] The effect of the authorities is that Coroners should not make adverse comments or findings against individuals unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death and in the case of individuals acting in their professional capacity, only where there was a material departure from the standards of their profession.

141. It is axiomatic that the assessment of any departure from norms or standards must be judged strictly without the benefit of hindsight. The trajectory that leads to a death of one patient at the hand of another may well be obvious after the event. Patterns or causal connections that can be traced from the privileged position of knowing the tragic outcome, may not have been obvious or even appreciable before the event. This is particularly so with individuals who have a recognised chronic risk of interpersonal violence as well as a presentation that is difficult to read.

142. Having applied the applicable standard of proof to the available evidence, I find that:

    a) Mr Pham's clinical management during his April 2012 admission to TEH was reasonable and appropriate;

    b) When seen in the context of the *Mental Health Act 1986* which governed the clinical management and care provided to Mr A at TEH, the decision to cease Mr A's seclusion on the afternoon of 24 December 2012 was a reasonable response to his modest clinical improvement;

    c) The Management Plan in place upon Mr A's transfer to Argyle's open ward was reasonable in its inception;

    d) Mr A's management by 15-minutely observations was appropriate in the circumstances;

[263] *Briginshaw v Briginshaw* (1938) 60 C.L.R. 336, especially at 362-363. "*The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issues had been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences…*"

e) The nursing response to incidents of suspected medication non-compliance by Mr A on 24 and 26 December 2012 was reasonable in the circumstances and would likely have been addressed at the next scheduled ward round on the morning of 27 December 2012;

f) No good excuse was proffered for the failure to enforce Forensicare's policy that patient bedroom doors remain closed overnight and this aspect of the clinical management and care provide both to Mr Pham and Mr A was suboptimal;

g) That said, had the policy been enforced and Mr Pham's door closed, Mr Pham would still have been able to open the door himself from the inside and could have left his room or allowed Mr A to enter, without necessarily coming to the attention of nursing staff immediately;

h) Without the benefit of hindsight, it is not possible to find that Mr A's interest in and social interaction with Mr Pham overnight on 26-27 December 2012, was suspicious or such as should have raised concerns in the nursing staff about his safety in the company of Mr A;

i) Close Observations of Mr A purportedly conducted by RN Fan on the morning of 27 December 2012 are unreliable and his falsification of observation records between 6.15am and 6.45am on that date falls well below the standards expected of Registered Nurses at THE and in any other context where observations are ordered;

j) I am consequently unable to determine the time on 27 December 2012 when Mr Pham died, though I am satisfied that his death occurred sometime after 2am and prior to 6.55am;

k) The changes to systems, policy and practices at TEH implemented by Forensicare since Mr Pham's death are likely to reduce the risk of deaths occurring in similar circumstances in the future.

PUBLICATION OF FINDING

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

DISTRIBUTION OF FINDING

144. I direct that a copy of this finding be provided to:

Pham Le, Thien Pham's mother

Forensicare

Mr A c/o Victoria Legal Aid

The Office of the Chief Psychiatrist

Corrections Victoria

LSC Sean Toohey, Coroner's Investigator

Signature:


Paresa Antoniadis Spanos
Coroner
Date: 26 November 2019

Cc: Manager, Coroners Prevention Unit