IN THE CORONERS COURT
OF VICTORIA
AT LATROBE VALLEY

Court Reference: COR 2012 / 0400

FINDING INTO DEATH WITH INQUEST

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

Inquest into the Death of: SARAH LAVINIA SIMPSON

Delivered On:	11th December 2014
Delivered At:	Coroners Court of Victoria, 65 Kavanagh Street Southbank, Victoria 3006
Hearing Dates:	7th to 9th July 2014
Findings of:	JACINTA HEFFEY, CORONER
Representation:	Leading Senior Constable Kelly Ramsey – Police Coronial Support Unit Ms L Hunter, Solicitor - Acting for Latrobe Regional Hospital.

I, JACINTA HEFFEY, Coroner having investigated the death of SARAH LAVINIA SIMPSON

AND having held an inquest in relation to her death from 7th to the 9th July 2014
at LA TROBE VALLEY CORONERS COURT
find that the identity of the deceased was SARAH LAVINIA SIMPSON
born on 26th July, 1977
and the death occurred on 1st February 2012
on the railway track outside Latrobe Regional Hospital, Princes Highway Traralgon West
from:

1 (a) MULTIPLE INJURIES DUE TO IMPACT WITH A TRAIN

in the following circumstances:

1. Sarah Simpson left the Latrobe Regional Hospital shortly after she was last seen alive near the exit to the locked Flynn Unit of the hospital at 10.07 AM. She crossed the Princes Highway to the railway tracks that run adjacent to the highway. Peter Czalkowski was driving the V/Line train that departed Traralgon Railway Station some eight kilometres away at 10.15 AM in the direction of Melbourne. He saw the deceased standing between the tracks facing towards the on-coming train with her arms crossed over her chest. She was about 300 metres away when he first observed her and she made no attempt to move from the path of the train. He sounded the whistle and applied the brake in full service but was unable to avoid the collision. From the nature of her injuries, it is clear that Ms Simpson was killed instantly. At the time, the train was in a zone in which the maximum speed was 160 kph and Mr Czalkowski in a statement said that the train was travelling at about 150 kph. He was breath tested and returned a 0.0 result. There is no suggestion that Mr Czalkowski was in any way responsible for Sarah Simpson's death.

2. An inquest was conducted into the circumstances of the death, as immediately before hand, the deceased was an inpatient in a mental health facility. No issue arises as to her identity or cause of death.

Background

3. Sarah Simpson was aged 34 years at the time of her death. From her adolescent years she had struggled with mental health problems for which she had been treated. Her principal diagnosis appears to have been bi-polar affective disorder. Her parents are primary producers

and live at Meerlieu. Sarah moved to Melbourne about 10 years before her death and had been seeing a psychiatrist regularly. She was on a disability pension and had been living with a Simon Fair for about four years. Mr Fair was being treated for schizophrenia. On the 7th January 2012, Sarah had left him and travelled to Bairnsdale by train. She telephoned her parents at 10.30 PM from outside Bairnsdale Hospital asking to be picked up. She had a restless night at home and the next day was threatening to harm herself with a knife. She was taken to Sale Hospital by ambulance and from there to the Flynn Unit at La Trobe Regional Hospital.

4. She remained in the Flynn Unit as a voluntary patient until the 24th January when she was discharged home. At no stage during that penultimate admission had she been on an involuntary order and she was not discharged back into the community on a Community Treatment Order. A Case Manager had been appointed but had not yet met with her in that capacity. She had not been allowed unaccompanied leave during this stay. However she was granted accompanied leave to go with her parents to Melbourne for a medical appointment on the 17th January to do with her hepatitis problems. Dr Oladele Ojo had been her Consultant Psychiatrist during this and her later admission. He told the court that the reason for her not having leave during the admission 8th January to the 24th January had not been because of any perceived risk of self-harm. Rather, there was a concern that she would abscond.[1]

Circumstances of second admission

5. Sarah returned to her parents' property on the 24th January, 2012. Her mother had previously arranged to travel to Queensland on the 25th January for a two-week stay with another daughter who resides there. She had expressed concern to the hospital staff on the 23rd January that Sarah would be isolated on the farm as her father would be absent from the house for a lot of the time. On the 27th January, Sarah phoned her mother in Queensland very upset. On the 28th January, she phoned Mental Health Triage numerous times wanting transport to shops. She was reportedly pleasant on the phone.

6. On Sunday 29th January, she phoned her mother and told her that she and her father were not getting along well. She phoned Paul Bromiley, a Community Mental Health Nurse at Sale Hospital asking for somebody to take her to the shops to buy cigarettes and wanting

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[1] See Transcript P 126. Dr Ojo told the court that there was a fear that she would abscond and go back to Melbourne and return to "this toxic, hostile relationship with her boyfriend". She had been agreeable to the restriction on her leave during her stay.

immediate accommodation. After she was told this was not possible, she called an ambulance at 6.37 PM and was taken to Sale Hospital. She phoned her mother from there to advise of this and asking her to tell her father that she was safe.

7. At 1.30 AM on the 30th January, she spoke to Paul Bromiley saying that she wanted to be admitted to the Flynn unit at La Trobe Regional Hospital and that she wanted admission to the Community Residential Care Units in Traralgon (CRCU). She acknowledged that she had been foolish to call an ambulance but had done so to bring attention to her need for alternate accommodation. She was told that this required planning. She offered to go home to her parents' place whilst this was done. Due to the late hour and the fact that nobody was answering the phone at her parents' home, she was put up at the Sale Motel. The plan was that the Case Manager would follow the matter up later that day.

8. She apparently left the Motel at 5 AM and was found by a passer-by wandering along the train track. An ambulance was called and she was taken to Sale Hospital.

9. There, she was reviewed by Emergency Physician, Dr. Howard Connor, who described her as agitated and expressing the delusion that she had killed someone five years before and needed to be punished. She said that she intended to end her life by going under the local train. He recommended her for involuntary admission to La Trobe Regional Hospital and she was transported there by ambulance. At Sale Hospital, she had also been assessed by Mental Health Nurse Aravind Sivom who wrote detailed notes for transmission to La Trobe Hospital. He ranked her suicide risk as "*high*" and a reasonable risk of absconding.

Admission to Flynn Unit, La Trobe Regional Hospital on 30th January

10. Sarah was admitted to the locked Flynn Unit at La Trobe Hospital as an involuntary patient under Section 10 Mental Health Act. The following day, 31st January, she was compulsorily assessed by Consultant Psychiatrist Dr Ojo in the presence also of Dr Thinza Moe, Hospital Medical Officer and Robert Kerr, Mental Health Nurse. Dr Ojo told the court that on that day, she was calm, co-operative and appropriate. He observed no psychotic features. She denied any suicidal ideation and reported feeling safe in Flynn Ward. She was insightful and identified lack of accommodation as her major issue. In view of this assessment, it was considered that she no longer met the criteria for an Intensive Treatment Order under the Mental Health Act and Dr Ojo discharged her therefrom. Dr Ojo told the court that he had developed a reasonable rapport with her during her previous admission. He decided to allow her one hour of unaccompanied leave that day. She apparently availed herself of this without

incident and left the hospital premises to go to the Service Station next door to buy cigarettes. The hospital documentation gives no clear indication of whether she exercised this entitlement or not. Her absence is not clear from the paperwork. Her mother, however, later found an invoice from the adjacent Service Station shop showing that she had been there at 11.15 AM on that day. (It is not possible to buy cigarettes on the hospital grounds.)

11. On the hospital file, it was noted that Sarah had been allowed unaccompanied leave for one hour on the 31st January. Several witnesses told the court that this was not giving permission to have one hour's leave for any day other than that day and any staff member picking up the file should have interpreted it that way. There would need to be a fresh assessment and risk assessment on the 1st February before Sarah's leave entitlement could be determined.

Events on the 1st February, 2012.

12. The 1st February being a Wednesday, a Critical Review Meeting was held in the morning at which the medical and senior nursing staff (Nurse Unit Manager) attend. This commences at about 9 AM. All files are removed from the Nurses Station and taken to the Macalister Video Conferencing Room.

13. From all accounts, Sarah had not presented with any problems in the preceding 24 hours. The only intervention had been some medication to help her sleep on the evening of the 31st January.

14. On the 1st February, she was allocated to Francine Riley, a State Enrolled Nurse. The court heard that Ms Riley's role was to meet with Sarah early in the morning, take her vital signs and engage with her to assess if she had any problems. This, Ms Riley did, chatting with Sarah over breakfast. She described her as being "bright and reactive' and looking forward to Rudi Grassecker (Welfare Officer) finding her accommodation. Sarah asked Ms Riley if she could go to the canteen (which is located outside the locked ward but within the hospital). Ms Riley went to the office to check Sarah's leave status from the whiteboard and had asked Sarah to accompany her there. She made the check and (wrongly) interpreted it as allowing leave. However, when she went to press the exit button to open the external door, Sarah had disappeared. This occurred at about 9.30 AM. Assuming that she must have changed her mind, Ms Riley crossed out the entry she had made on the whiteboard and went about her other duties.

15. At 10.07 AM, Sarah was sighted by Registered Nurse Anthony Wenzell standing in front of the Flynn Office. (The locked exit door is directly opposite, a few steps away). As he had

been assigned the job of recording observation levels for all the clients that hour, he noted on the observation chart that he had sighted Sarah at this time. He did not otherwise engage with her.

16. Notwithstanding internal enquiries and Root Cause Analysis following Sarah's death, no information has come to light to explain how she managed to exit the Unit shortly after 10.07 AM.

17. There are two mechanisms to unlock the exit door. It can be done by pressing a button in the Office or by a staff member sliding his/her card into electronic slot beside the door. At this time, the door was able to be opened from outside by cleaners and other staff members. It remains a mystery as to how Sarah got out. Her absence was not noticed until police arrived at the unit after 11 AM, having found identifying items on the railway track.

18. Without this vital information, it is difficult to level specific criticism at the hospital. A number of deficiencies became apparent in the course of the inquest, but without specifically knowing how Sarah managed to leave the Unit unnoticed, it is not possible to identify what role, if any, these deficiencies may have played.

Systemic Deficiencies

A. Confusion as to how to determine leave entitlements.

19. As I have stated, Sarah did not exit the unit as a result of Ms Riley's enquiries as to whether she was entitled to leave and with her consent.

20. However, what did come to light in the course of the inquest, was an apparent misunderstanding as to how leave entitlements are ascertained. Ms Riley went to the whiteboard in the Office and wrongly interpreted what she read there. Her first mistake was to rely on the whiteboard for this information. She wrongly believed that the whiteboard was updated by night staff to inform nursing staff as to leave entitlements. In fact, the whiteboard is not the correct source. The correct source is the file itself. Notwithstanding that Sarah's file would have been taken into the meeting room for the Critical Review meeting, the court heard that there was no impediment to staff members either going to that room to access the file or to phoning through to the meeting room.

21. The whiteboard is more a record of actual movements. So, if on accessing the file, it is discovered that a client is entitled to an hour off the ward on a particular day, the whiteboard provides the information as to whether that hour has already been used.

B. Failure to record leave actually taken.

22. As stated above, it is unclear from the documentation as to whether Sarah actually exercised her right to take an hour's leave off the ward on the 31st January. This is a significant failing in that it is likely that the permission to leave the unit unaccompanied was part of the on-going risk assessment process. The court heard that Sarah had not had unaccompanied leave during her recent past admission as she was considered an absconding risk. Just how she had managed to conduct herself on her leave on the 31st January would no doubt have been at least one feature bearing on the minds of medical staff in determining whether such leave was to be allowed the following day.

C. The number of people able to open the exit door

23. As stated above, cleaners and other La Trobe Regional Hospital staff members had clearance to use their access cards to enter the locked ward. Sarah was dressed in warm clothing. Somebody unfamiliar with her could have believed her to be visiting from outside and moved aside to let her exit as they came in. This is, of course, speculation, but a number of witnesses told of incidents like this occurring when nobody was present in the Office or staff there were otherwise pre-occupied.

D. Action taken since Sarah's death

24. The Court heard from Cathryn Hoppner, the Director of Mental Health Services that, as Sarah's death was what is known as a "*Sentinel Event*", it was required that there be an after-the-event analysis, known as Root Cause Analysis. I do not propose to go into all the technical detail about forms and protocols that have emerged as a result of this analysis, suffice to say that the new process, which was due to be implemented in June this year, is designed to improve management of risk through a collaborative approach between nursing and medical staff. There should no longer be any confusion about how to access the most recent risk assessment, particularly as it impacts on issues such as leave. With mandatory workshops, staff will now be aware of how to access recent and up to date information about leave entitlements. Furthermore, access to the Flynn Unit has been significantly curtailed to limit access, as of right, to the Unit to staff actually attached to the unit. So, general hospital staff and cleaning staff, for example, no longer have automatic access with swipe cards.

Other family concerns

A. Discharge Planning upon admission

25. On first impressions, it seemed strange that shortly after Sarah's admission to the Flynn Unit, there was communication with Sale Hospital, and in particular with Sarah's recently appointed Case Manager, to commence the process of discharge planning. I am satisfied, however, that this process is purely an administrative one and has no significance in terms of suggesting any imminent decision to discharge a client soon after admission.

B. Discharge from Involuntary Treatment Order within 24 hours

26. As Dr Ojo explained, under the provisions of the Mental Health Act, a patient cannot be mandatorily detained under Section 10 beyond 24 hours unless five different criteria are met. In his professional opinion, during the risk assessment at which Dr Thinza, HMO and the experienced mental health nurse Robert Kerr were present, Sarah did not satisfy all of these criteria. Indeed, their joint assessment of her on that day was encouraging in that she identified her main problem to be accommodation. Dr Ojo was obliged, in line with the prevailing philosophical basis underlying treatment of mental illness, to manage Sarah in the least restrictive way.

27. It was known, by the three professionals who attended that meeting, that Sarah had been sighted the day before walking along a train track. It was known that she had been acutely suicidal. However, that she ultimately chose this way to die does not support a version that she was prospectively and/or necessarily at risk of attempting to do this again. As the court heard, once in a locked environment, it was not unusual for clients to feel safer and re-assured and, therefore, to present very differently after a few hours. Furthermore, Sarah had identified a solution to her difficulties, as she perceived them, namely the need for independent accommodation. As far as she was aware, this was going to be the focus of her stay there and she was looking forward to working this out, as she told Nurse Riley on the morning of the 1st February.

28. In all likelihood, had it not been for the meeting intervening and had there been the routine risk assessment on that Wednesday morning, and had Sarah been able to give a good account of her leave the day before, leave would probably have been granted on the 1st February as well. But this would only have been after a risk assessment had been conducted. That this process is now emphasised as part of the training, that engaging with clients by nursing staff and collaboration between staff members are now part of the emerging hospital culture and,

finally, now that there are amendments to the Mental Health Act that encourage greater access to family members nominated by the client, all these things may mean that in future, a death of this nature might be avoided.

29. However, I do not believe that it can be known what drove Sarah to take her life at the time that she did. She left no suicide note. She was not demonstrating despair on the morning of her death, rather the opposite.

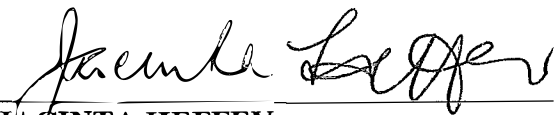
30. This court is engaged on a daily basis with unwitnessed suicides, particularly of people with mental illness. Sarah was clearly raised in a loving home with supportive parents and siblings. She was, however, cursed with an illness for which she could find no lasting cure and, ultimately, chose to end her life to free herself from the pain of it. As we frequently see, mental illness rarely takes a predictable course. It is ever shifting and dynamic. Its course and momentum are frequently elusive even to the most practiced eye.

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

The Family of Sarah Simpson

Lucy Hunter, Corporate Counsel, La Trobe Regional Hospital

Signature:



JACINTA HEFFEY
CORONER
Date: 11 December 2014