IN THE CORONERS COURT COR 2019 002141

OF VICTORIA

AT MELBOURNE

IN THE MATTER OF THE DEATH OF CRAIG HARVEY

FINDING INTO DEATH FOLLOWING INQUEST

Delivered On:	20 April 2023
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Date:	16 March 2023
Findings of:	Coroner Catherine Fitzgerald
Counsel Assisting the Coroner:	Ms Jess Syrjanen
Solicitor for Naomi Harvey:	Ms Kelsey Wearden, Slater and Gordon
Counsel for Monash Health:	Ms Naomi Hodgson Instructed by Lander & Rogers

INTRODUCTION

1. On 28 April 2019, Craig Harvey was 50 years old when he was found deceased in his room in Ward E of Casey Hospital, Berwick, Victoria. This was an inpatient mental health ward. At the time of his death, Mr Harvey was a compulsory patient.

2. Mr Harvey had a significant history of mental health issues and was diagnosed with depression, opiate and alcohol abuse and antisocial personality disorder. He had a previous history of psychiatric inpatient admissions in 2015, 2016 and 2017, on a background of suicidal ideation. In 2016 he attempted suicide by hanging. He was known to use heroin, cannabis and "ice" and had relapsed despite attempts to cease use of drugs[1].

THE CORONIAL INVESTIGATION

3. Mr Harvey's death was reported to the Coroner as it fell within the definition of a reportable death pursuant to the *Coroners Act 2008* (Vic) (**the Act**), namely, it was the death of a person who immediately before death was a "person placed in custody or care"[2]. As Mr Harvey was a compulsory patient at Casey Hospital, he was a "person placed in custody or care" because he was "a patient detained in a designated mental health service within the meaning of the *Mental Health Act 2014* (Vic)" [3]. An inquest into Mr Harvey's death was therefore mandatory under the Act[4].

4. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and the circumstances in which the death occurred. The circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

5. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of

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1 Coronial Brief (**CB**), Monash Health records, 67.
2 Sections 4(1) and (2)(c) *Coroners Act 2008* (Vic).
3 Section 3 *Coroners Act 2008* (Vic).
4 Section 52(2)(c) *Coroners Act 2008* (Vic).

comments or recommendations in appropriate cases about any matter connected to the death under investigation.

6. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Harvey's death. The Coroner's Investigator conducted inquiries on the coroner's behalf and submitted a coronial brief of evidence. Further material was requested as part of the coronial investigation, including from Monash Health. An expert report was also submitted on behalf of Mr Harvey's daughter, Naomi Harvey, and included in the Inquest brief.

7. Following a mention hearing on 23 January 2023, I determined that a Summary Inquest be held. The Inquest was held on 16 March 2023, providing all the interested parties an opportunity to respond to the material gathered as part of the coronial investigation.

8. This finding draws on the totality of the coronial investigation and Inquest into the death of Craig Harvey. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[5]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

9. In January 2019, Mr Harvey was living with his daughter Naomi Harvey, and his mother in Berwick. In mid-January, Ms Harvey observed that her father's mental health was worsening when he began to suffer from paranoia and auditory hallucinations. This included: his belief that people were watching him, resulting in Mr Harvey living in the roof of his house; Mr Harvey setting up fishing line around the backyard to ensure that he would be notified if an intruder entered the backyard; Mr Harvey damaging the side fence to ensure that if anyone climbed onto it, the fence would collapse, and they would fall onto metal spikes that he had set up around the property[6]; a belief that he and his family were

[5] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

[6] CB, Statement of Naomi Harvey, 17.

being attacked; and, that pamphlets left in the letterbox were secret threats towards him from people who were after him[7].

10. On 28 March 2019, Ms Harvey was becoming increasingly concerned about her father's paranoia and asked him if she could take him to see a general practitioner or to a hospital, however he declined. Ms Harvey stated to Mr Harvey that she would call the Crisis and Treatment Team (**CATT**) if he did not "*sort himself out*"[8].

11. Later that day, between 3.00pm and 4.00pm, Mr Harvey informed his daughter that he was going to travel into the city to watch some live music. Ms Harvey thought this was unusual, as he did not often leave the house, but also knew that her father enjoyed watching live bands. She then spoke to her "Nan" (Mr Harvey's mother) who told her Mr Harvey said he was going to the shops. They were both concerned about Mr Harvey [9].

12. A few hours after Mr Harvey left, Ms Harvey found a handwritten note in her bedroom, next to her father's credit card and bank cards. The note stated "*Naomi. Gone to Richmond won't be back take card 1598 put on house. Love Dad. Take care I'll ring you."* Ms Harvey was immediately concerned by the note, although she knew that Mr Harvey often went missing for a week at a time and always returned home without incident[10].

13. Ms Harvey then located her father's mobile phone, which he rarely used. The battery was flat, so she charged it and checked his messages. She located a message from an unknown associate which stated that there were dealers outside the Richmond safe injecting rooms. Ms Harvey called her uncle to inform him of what she had found. Her uncle told her that it was not safe for her to drive around Richmond late at night on her own, and that she should wait for her father to call her[11].

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[7] Ibid.
[8] CB, Statement of Naomi Harvey, 18.
[9] Ibid.
[10] Ibid.
[11] Ibid.

14. At about 11.00am on 29 March 2019, Victoria Police were called to a welfare check at Regent Street, Richmond (near the North Richmond Railway Station) for a report of a man sitting near the train tracks on an overpass[12].

15. Police officers attended the location. They found Mr Harvey sitting near the railway tracks and spoke to him. Mr Harvey told the officers that he liked to use heroin near the train tracks because it was quiet and away from other people. The officers performed a pat down search of Mr Harvey and located a small white rock substance in his pockets. Mr Harvey admitted it was heroin and stated he was disappointed and upset as he had recently relapsed. Mr Harvey was arrested for an offence of Possessing a Drug of Dependence and conveyed to the Richmond Police Station. He was referred to the drug diversion program and released. An officer involved in his arrest stated that he did not appear to show any signs of self-harm and did not appear to be suicidal[13].

16. Later that day, at about 3.50pm, police officers were called back to the North Richmond Railway Station with a report that a male had walked in front of a train. The train driver was able to apply the emergency brakes and stop without hitting the person. The officers located Mr Harvey nearby and spoke with him. He informed them that he was feeling depressed because he had started using drugs again, and he had been arrested earlier in the day for drug possession. Police conveyed Mr Harvey under section 351 of the *Mental Health Act 2014* (Vic) to the Royal Melbourne Hospital (**RMH**) due to his suicidal ideation. He was assessed by mental health clinicians at the RMH and was subsequently released[14].

17. The next morning, from about 5.00am on 30 March 2019, Ms Harvey and her uncle extensively searched for Mr Harvey in and around the Richmond area but were unable to locate him. They had not heard from him either. Later that morning, Ms Harvey reported

[12] CB, Statement of Senior Constable (**S/C**) Andrew Tucker, 22.
[13] CB, Statement of S/C Tucker, 23-24.
[14] CB, Statement of First Constable Carl Robertson, 26-27.

Mr Harvey as missing to the Richmond Police Station and a missing person report was filed[15].

18. That afternoon, Victoria Police were called to attend a property in Brunswick due to a report that a man was on the roof of a building behaving erratically. When police officers arrived, the male identified himself as Craig Harvey and informed them that he was on the roof because people were chasing him. He was conveyed to RMH under section 351 of the *Mental Health Act 2014* (Vic)[16].

19. When Mr Harvey arrived at RMH, he was assessed by clinicians in the Emergency Department who determined that he needed to remain at the hospital as a compulsory patient under an Inpatient Assessment Order. Ms Harvey visited her father that night and spoke with a psychiatrist about Mr Harvey's history and paranoia. She observed that Mr Harvey was agitated. He told her that there were ultrasonic waves that were attempting to communicate with him, that she was not the real Naomi Harvey, and he could kill her. He also stated that he had tried to jump in front of a train. Whilst at RMH, Mr Harvey was placed on a Temporary Treatment Order (**TTO**) and then transferred to Sunshine Hospital on 4 April 2019[17].

20. Mr Harvey remained at Sunshine Hospital for nine days. On admission, he reported a five-week history of hearing voices, he was afraid that he had infected his ex-girlfriend with hepatitis C and HIV, and that members of a bikie gang were after him. Clinicians thought the psychotic episode was likely triggered by a recent relationship breakdown. On 13 April 2019, he was transferred to Ward E at Casey Hospital, an inpatient metal health unit.[18]

21. On arrival at Casey Hospital, Mr Harvey was assessed by a consultant psychiatrist, who formed a likely diagnosis of psychotic depression with cluster B personality traits,

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[15] CB, Statement of Constable Nikita Powley, 30; CB, Statement of Naomi Harvey, 19. I note that Ms Harvey states that this occurred on 29 March, but by reference to her statement that Mr Harvey left his house on 28 March at 3 or 4 pm, the statements from police officers who interacted with Mr Harvey on 29 March, and the missing person report filed on 30 March, that date is incorrect.

[16] Summary of the Coronial Investigator, Leading Senior Constable (**LSC**) Patricia Halion, Police Coronial Brief, paragraph 17; CB, Monash Health records, 68.

[17] CB, Statement of Naomi Harvey, 19; CB, Monash Health records, 369 (Northwestern Mental Health Community Risk Assessment and Plan).

[18] CB, Statement of Dr Neeraj Sareen, 47.

polysubstance use disorder and a differential diagnosis of schizophrenia. He was assessed as being at high risk of suicide and was initially managed with 15-minute observations by nursing staff. He was not approved for day leave[19].

22. Casey Hospital held a family meeting with Mr Harvey, his daughter, and his mother on 18 April 2019. His family reported poor compliance with medication and a preference for him to be commenced on depot injections. Mr Harvey informed clinicians that he was well enough to return home and believed that he would be able to control his alcohol intake so that he could commence paliperidone depot injections. A plan was formulated to trial supervised leave and commence paliperidone depot injections. If Mr Harvey remained well, his visual observations would be reduced to hourly observations, he could also trial unsupervised leave, and the TTO would be converted to a Community Treatment Order[20].

23. On 18 April 2019, Mr Harvey utilised escorted day leave with his daughter[21]. He was also given his first paliperidone depot injection[22].

24. On 20 April 2019, Mr Harvey had his first instance of unescorted leave. He had further unescorted leave on 22 April 2019, as well as escorted day leave with his daughter[23].

25. When Mr Harvey was reviewed by clinicians on 23 April 2019, he denied thoughts of suicide and auditory hallucinations. However, Ms Harvey reported to staff that her father remained paranoid whilst on escorted leave with her[24]. Mr Harvey had his second paliperidone injection on this date[25].

26. Mr Harvey had escorted day leave on 25 April 2019 with Ms Harvey. The next day, on 26 April 2019, Mr Harvey was noted to be feeling unwell and irritable. His leave pass had expired, and he became increasingly irritable whilst this was followed up by nursing staff. When a phone call to his daughter was not answered, he reacted by punching a wall in the

[19] Ibid.
[20] CB, Statement of Dr Sareen, 47-48.
[21] CB, Monash medical records, 474.
[22] CB, Monash medical records, 476.
[23] CB, Monash medical records, 479.
[24] CB, Statement of Dr Sareen, 48.
[25] CB, Monash medical records, 481.

Inpatient Unit[26]. However, his leave was approved in the afternoon, and he went on unescorted leave twice without incident[27].

27. On 27 April 2019, Mr Harvey spent the day with Ms Harvey on escorted leave. He told his daughter that he was unwell with the flu and did not want to hug her as he did not want to infect her. He asked if he would be picked up on 28 April 2019 for leave, however Ms Harvey was unavailable on that day. She told him that she would pick him up again in a few days' time, which Mr Harvey appeared content with[28]. Mr Harvey returned to the ward earlier than expected on 27 April 2019 and informed staff that he was tired. He was noted to be slightly irritable, however this improved after he took a nap. Overnight, Mr Harvey was reported to be mostly awake with settled behaviour[29].

28. From 18 April to 28 April 2019, the medical records evidence that Mr Harvey was compliant with medication and mostly polite with settled behaviour. He was compliant with nursing checks which reduced to hourly observations. He completed both escorted and unescorted leave without incident. He consistently denied thoughts of self-harm or suicide. He was regarded by the treating psychiatrist as being "low risk" throughout this period, and he therefore remained in a low dependency unit[30].

29. At breakfast time on 28 April 2019, Mr Harvey was observed to be asleep. He slept through most of the morning and then had lunch[31]. He denied thoughts of self-harm. His behaviour throughout the day was settled[32].

30. Mr Harvey was observed hourly throughout the day in accordance with the scheduled observations, up until 6.00pm[33]. Mr Harvey was offered dinner at that time, which he

[26] CB, Monash medical records, 487.
[27] Ibid.
[28] CB, Statement of Naomi Harvey, 20.
[29] CB, Statement of Dr Sareen, 48.
[30] CB, Statement of Professor David Clarke, 51.
[31] CB, Statement of Dr Sareen, 49.
[32] CB, Monash medical records, 490.
[33] CB, Statement of Jessika Woodhead, 43; CB, Monash medical records, 529.

declined[34]. The next visual observation was scheduled to occur an hour later, at about 7.00pm.

31. Enrolled Nurse (**EN**) Jessika Woodhead was asked to take over visual observations of all patients on the unit just before 7.00pm. This was to cover the meal break for anther nurse. Due to an incident with another patient at that time, EN Woodhead did not commence her visual observation checks until about 7.15pm[35]. EN Woodhead stated she checked on Mr Harvey at about 7.20pm[36]. When she approached the entrance to his room, she called out his name but did not receive a response. She stepped into the room and saw Mr Harvey's legs in a kneeling position, partially hidden behind the bathroom door. She rushed into the room and located Mr Harvey hanging from a shoelace, which was attached to the hinge of the wardrobe in Mr Harvey's room. She immediately called out for help, pressed the duress alarm, and attempted to loosen the shoelace, but was unable to. She ran out to the nurse's station to obtain a cut down tool and alerted staff that she needed urgent assistance. She returned to Mr Harvey's room along with other staff. Cardiopulmonary resuscitation was commenced, and a Code Blue was called[37].

32. The Code Blue team arrived within a few minutes and took over resuscitation. Mr Harvey was transferred to the Emergency Department, where resuscitation continued. Despite the efforts of staff, Mr Harvey was unable to be revived and was declared deceased at 8.15pm[38].

33. I note that there is a discrepancy in the evidence regarding the exact time that EN Woodhead went to complete the visual observation check and found Mr Harvey. According to EN Woodhead, who was responsible for making the scheduled observation at 7.00pm, it occurred at about 7.20pm[39]. However, an entry in the medical records regarding the response to the Code Blue indicates it may have been closer to 7.35pm. In my view it is unnecessary to seek to resolve this discrepancy. In either case the visual observation due

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[34] Ibid.
[35] CB, Statement of Jessika Woodhead,44.
[36] CB, Monash medical records, 497.
[37] Ibid; CB, Statement of Jessika Woodhead,43.
[38] CB, Monash medical records, 491.
[39] CB, Statement of Jessika Woodhead, 44 and CB, Monash medical records, 497. Cf CB, Monash medical records, 491 (entry by Anaesthetic Registrar who attended the Code Blue at 7.35pm).

to be made at 7.00 pm was late. At best it was 20 minutes late, or it was closer to 35 minutes late.

Identity

34. On 28 April 2019, Mr Harvey was visually identified by his daughter, Naomi Harvey. Identity is not in dispute and requires no further investigation.

Cause of death

35. On 29 April 2019 Forensic Pathologist Dr Gregory Young, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted a post-mortem examination and provided a written report of his findings dated 30 April 2019.

36. The post-mortem examination revealed findings consistent with the reported circumstances and no unexpected signs of trauma[40]. A post-mortem CT scan revealed rib fractures, consistent with resuscitation efforts[41].

37. Toxicological analysis of post-mortem blood samples identified the presence of diazepam and its metabolite nordiazepam[42], temazepam, hydroxyrisperidone[43], olanzapine[44], and mirtazapine[45], but did not identify alcohol or any other commonly encountered drugs or poisons[46].

38. Toxicological analysis of post-mortem urine samples identified the presence of morphine and its metabolite codeine[47], diazepam and its metabolite nordiazepam, temazepam and its

[40] CB, Medical Examiner's Report (**MER**), 4.
[41] Ibid.
[42] Diazepam is a benzodiazepine derivative indicated for anxiety, muscle relaxation and seizures.
[43] Risperidone is an atypical (second-generation) antipsychotic drug effective against the positive and negative symptoms of schizophrenia.
[44] Olanzapine is an atypical (second-generation) antipsychotic drug with a similar structure to clozapine.
[45] Mirtazapine is indicated for the treatment of depression.
[46] CB, Victorian Institute of Forensic Medicine (**VIFM**) Toxicology Report, 7.
[47] Morphine is a narcotic analgesic used for the treatment of moderate to severe pain. Morphine is the primary constituent of crude opium and also a metabolite of codeine, ethylmorphine, heroin and pholcodine.

metabolite oxazepam, hydroxyrisperidone, olanzapine, mirtazapine, and paracetamol[48] but did not identify any alcohol or other commonly encountered drugs or poisons[49].

39. Dr Young provided an opinion that the medical cause of death was "*1(a) Hanging*"[50].

40. I accept Dr Young's opinion.

EXPERT EVIDENCE

41. An expert report by Associate Professor (**A/Prof**) Jonathan Phillips was submitted to the Court by the legal representatives acting on behalf of Ms Harvey. Monash Health did not take issue with the report[51].

42. I have considered the entirety of the report by A/Prof Phillips. By way of summary, A/Prof Phillips provided opinions as follows:

    a. The internal review conducted by Monash Health following the death of Mr Harvey was "*comprehensive*"[52].

    b. Mr Harvey "*Suffered both chronic and acute psychopathology and was a person at risk of longer-term self-destructive behaviours and had a variable risk for short-term self-destructive behaviour*"[53].

    c. Mr Harvey had a "*complex diagnosis*". Each diagnosed disorder brought with it "*an increased risk for self-harm/suicide*". The combination of diagnoses meant he had a significantly increased risk for self-harm/suicide, both over the long term and in the period immediately preceding his death[54].

[48] Paracetamol is an analgesic drug available in many proprietary products either by itself or in combination with other drugs such as codeine and propoxyphene.
[49] CB, VIFM Toxicology Report, 7.
[50] CB, MER, 4.
[51] Transcript of mentions hearing 31 January/ 2023 at P8, L4-12.
[52] CB, Report by A/Prof Phillips, 65.
[53] CB, Report by A/Prof Phillips, 67, para 26.
[54] CB, Report by A/Prof Phillips, 67, para 27.

d. Mr Harvey "*had a high chronic suicide risk, made worse at times of exacerbation of his various mental disorders*"[55].

e. A/Prof Phillips was "*not critical of the major part of Mr Harvey's care by Monash Health in April 2019, beyond the service having failed to provide him with a safe hospital environment*"[56].

f. It is "*well understood by health systems and individual hospitals*" that disturbed persons in a hospital setting will use the means available to them in an attempt to die, and hanging is an obvious method. Wardrobes are known as obvious hanging points, and this is not a new understanding. Accommodation should be free of possible hanging points[57].

g. Placing Mr Harvey on a depot anti-psychotic agent "*probably would have allowed forward movement in his medical care and also attend to his long-term addictive behaviour*". There was a "*reasonable prospect…that he would have made slow but useful gains, with a proper reduction in his chronic and acute risk for suicide*"[58].

h. The identification of wardrobe hinges by the audit team in 2016 and 2017 as a "*medium risk ligature point*" was correct[59].

i. It was "*unreasonable*" that the ligature point was not removed, given more than two years had passed since the initial identification[60].

43. I accept these opinions from Associate Professor Phillips.

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[55] CB, Report by A/Prof Phillips, 67, para 29.
[56] CB, Report by A/Prof Phillips, 68, para 31.
[57] CB, Report by A/Prof Phillips, 68, para 32.
[58] CB, Report by A/Prof Phillips, 68, para 38.
[59] CB, Report by A/Prof Phillips, 69.
[60] Ibid.

ISSUES ARISING IN RELATION TO THE DEATH

i) The ligature point and ligature audit process

44. Following Mr Harvey's death, Monash Health conducted an internal review of the incident and submitted it to Safer Care Victoria[61]. On behalf of Monash Health, a statement was made by Professor David Clarke, Program Director of Mental Health, regarding the review findings and response by Monash Health, to assist the coronial investigation[62].

45. It is clear that Mr Harvey ended his own life by utilising a shoelace and the wardrobe door hinge in his room. The internal review noted that the wardrobe door was a known ligature point in the unit where Mr Harvey was held, having been identified by Monash Health during ligature audits conducted in 2016 and 2017. Those audits identified the wardrobe doors as being "*medium risk*," but "*the removal of all wardrobe doors was not prioritised*" and did not occur following those audits[63]. A subsequent ligature audit in 2018 did not identify the wardrobe doors and hinges as ligature points, nor did it reference the prior two audits conducted in 2016 and 2017[64]. There was therefore no consideration given to the risk posed by the wardrobe doors/hinges following the completion of the ligature audit in 2018.

46. Professor Clarke confirmed that all wardrobe doors and hinges were removed from the Inpatient Unit on 30 April 2019[65]. I note that this was just two days after the death of Mr Harvey, and prior to the internal review being completed.

47. The internal review concluded that that the presence of a ligature point in Mr Harvey's room was a main factor contributing to the incident. So too, were identified issues with the ligature audit process, being "*an inadequate staff mix and training for those managing ligature audits; and inadequate procedure for follow-up of ligature audits*"[66].

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[61] CB, Statement of Professor David Clarke, 50.
[62] CB, Statement of Prof Clarke, 50-53.
[63] CB, Statement of Prof Clarke, 52.
[64] Ibid.
[65] Ibid.
[66] CB, Statement of Prof Clarke, 50.

48. As a result of the internal review findings, changes were made to the ligature audit process. They are now conducted annually, by two or three people, and ordinarily involve a nurse manager from a different ward, a staff member from the Quality Unit and a representative from the Occupational Health and Safety Engineering team[67]. A new "*Mental Health Inpatient Ligature Point Assessment and Management Procedure*" has been developed by Monash Health[68]. There is also a central oversight of ligature audits to ensure consistency of approach across all sites[69]. Importantly, there is now a "*Mental Health Program Recommendations Log which tracks recommendations and action/closure from incident reviews*"[70].

49. Mr Harvey was a compulsory patient at Casey Hospital, and he was known to be a suicide risk. I am satisfied that the presence of the known ligature point in the room he was allocated provided him with the opportunity to take his own life. The wardrobe door and hinges were visible and identifiable as a ligature point. The presence of this ligature point in the room, previously assessed by Monash Health as being "*medium risk*", was inherently unsafe having regard to Mr Harvey's known risk of suicide.

50. The removal of these ligature points from the Inpatient Unit was clearly not a difficult or time-consuming task, as it was completed within two days of Mr Harvey's death. Yet this was not completed following the audits in 2016 and 2017, and there was no scheduled time for removal. Having regard to all the available evidence, I have concluded that no satisfactory explanation has been provided for the failure to remove the known ligature points following either the 2016 or 2017 audit, and prior to Mr Harvey's death. As such, it was not reasonable that they were still present in the room occupied by Mr Harvey. In arriving at that conclusion, I have specifically had regard to the ease with which the ligature points were removed, the period of time that passed since they were first identified in 2016, and the acceptance by Monash Health of the conclusions in A/Prof Phillips' report.

[67] CB, Statement of Prof Clarke, 52.
[68] CB, Mental Health Inpatient Ligature Point Assessment and Management Procedure, 54-58.
[69] Ibid.
[70] CB, Statement of Prof Clarke, 52.

51. I have also concluded that the ligature audit process which was in place was inadequate. Firstly, the ligature points which were previously identified in 2016 and 2017 were not referenced in the 2018 audit, meaning that there was no adequate process to ensure that previously identified ligature points were re-visited in subsequent audits. Secondly, the 2018 ligature audit was deficient because it failed to identify the ligature point at all, and should have done so, even in the absence of reference to the earlier audits. As a result, there was no consideration of whether removal of the known ligature point could, or could not, be completed due to these deficiencies in the audit process. It was also not reasonable that the ligature point remained in Mr Harvey's room in circumstances where there had been a failure to recognise it, and consider removal, following the 2018 audit.

52. Having regarded to all the available evidence, I am satisfied that Mr Harvey's death was preventable. It cannot be known whether Mr Harvey would have found some other means to take his own life at this time, had the known ligature point not been available to him, but he would not have had the opportunity to take his life in the way he did, had the known ligature point been removed.

53. I am also satisfied that the response of Monash Health following Mr Harvey's death, and the internal review process, has adequately addressed these identified issues[71].

ii) The delayed 7.00pm visual observation

54. At the time of his death, Mr Harvey was meant to be observed hourly. The last observation prior to his death was at 6.00pm, and there was nothing of concern noted about his demeanour or behaviour. The next observation should have occurred at 7.00pm. I accept the evidence of EN Woodhead that the observation did not occur at that time due to available staffing levels, and the need for her to attend to another patient in the unit.

55. One of the factors which affected the timeliness of the hourly observation may have been the allocation of staff during meal breaks. I note that the internal review found this was a main factor contributing to the incident, "*leaving a small number of nurses on the ward at*

[71] CB, Statement of Prof David Clarke, 50-53.

the time of the incident"[72]. This has subsequently been addressed by Monash Health through a review of the process of allocation of meal breaks[73].

56. The available evidence does not enable me to determine what time Mr Harvey took steps to take his own life. It was sometime between the last observation at 6.00pm, and before he was discovered by EN Woodhead. I therefore cannot make any comment about whether an observation at 7.00pm would have averted his death by either interrupting his decision making in relation to taking his own life or providing an earlier opportunity for medical intervention. I also note that Mr Harvey would have been aware of the hourly observation regime, and it cannot be known whether, having determined to take his own life, he timed his actions so that he would not be seen by nursing staff prior to the scheduled observation which was meant to occur at 7.00pm.

iii) Clinical care

57. During a mention hearing held on 31 January 2023, the legal representative appearing on behalf of Ms Harvey confirmed that there was no criticism of the clinical care provided to Mr Harvey at Casey Hospital[74]. This is consistent with the expert opinion A/Prof Phillips, who was not critical of the clinical management of Mr Harvey at Casey Hospital.

58. Having regard to all the available evidence, I am satisfied that no issues arise in relation to the clinical care provided to Mr Harvey.

FINDINGS AND CONCLUSION

59. Having investigated the death of Craig Harvey, and having held an inquest in relation to this death on 16 March 2023 at Melbourne, I find that:

a) the identity of the deceased was Craig Harvey, born on 19 June 1968;

[72] CB, statement of Prof David Clarke, 50.
[73] CB, statement of Prof David Clarke, 55.
[74] Transcript of mentions hearing 31 January 2023 P11, L23-25.

b) the death occurred on 28 April 2019 at Casey Hospital, 62-70 Kangan Drive, Berwick, Victoria and the cause of death was 1a: Hanging; and

c) the death occurred in the circumstances described above.

60. Having considered all the circumstances, I am satisfied that Mr Harvey intentionally took his own life.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Naomi Harvey, Senior Next of Kin (Care of Slater and Gordon Lawyers)

Monash Health (Care of Lander & Rogers)

Leading Senior Constable Patricia Halion, Victoria Police, Coroner's Investigator

Signature:

Coroner Catherine Fitzgerald

Date: 20 April 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.