IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2016 000185

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

*Section 67 of the **Coroners Act 2008***

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	BJ [1]
Date of birth:	11 March 1991
Date of death:	12 January 2016
Cause of death:	1(a) Hypoxic brain injury 1(b) Hanging
Place of death:	Dandenong Hospital, 105-135 David Street, Dandenong, Victoria, 3175

[1] the finding has been deidentified in accordance with the family's wishes

INTRODUCTION

1. On 12 January 2016, BJ was 24 years old when he died at Dandenong Hospital following an apparent suicide attempt. At the time, BJ did not have a fixed address.

2. BJ had a difficult childhood. His parents separated and in 2003 he was placed into foster care however he began to abscond and drink alcohol. Several years later, he began struggling with substance abuse.

3. When BJ was 13-years old, he was diagnosed with paranoid schizophrenia. This was later expanded to include substance abuse disorder and anti-social personality disorder. BJ was medicated for his conditions but was only intermittently compliant which resulted in several voluntary and (then) involuntary inpatient admissions, including at Bairnsdale Hospital, Traralgon Hospital, and Monash Medical Centre, with subsequent community follow-up. However, a feature of BJ's management was his poor engagement and compliance with these programs.

THE CORONIAL INVESTIGATION

4. BJ's death was reported to the Coroner as it fell within the definition of a reportable death in the Coroners Act 2008 (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding 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.

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

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of BJ's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

8. This finding draws on the totality of the coronial investigation into the death of BJ including evidence contained in the coronial brief. 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.[2]

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

Identity of the deceased

9. On 12 January 2016, BJ, born 11 March 1991, was identified by his father, who signed a formal Statement of Identification to this effect before a member of clinical staff at Monash Health.

10. Identity is not in dispute and requires no further investigation.

Medical cause of death

11. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an external examination of BJ's body in the mortuary on 15 January 2016 and provided a written report of his findings dated 31 March 2016.

12. The post-mortem examination revealed findings consistent with the stated circumstances. The whole of body post-mortem computed tomography (**CT**) scans performed at VIFM showed diffuse brain swelling and bi-basal lung consolidations.

13. Routine toxicological analysis of post-mortem samples detected the opioid fentanyl at a concentration of ~ 5 ng/mL, the anti-epileptic levetiracetam at ~ 19 mg/L, the benzodiazepines nordiazepam at ~ 0.04 mg/L, 7-aminoclonazepam at ~ 0.03 mg/L, midazolam at a concentration of ~ 0.3 mg/L, and paracetamol at trace levels.[3]

14. Dr Bouwer provided an opinion that it would be reasonable to attribute BJ's death to 1(a) *hypoxic brain injury (secondary to) 1(b)hanging*.

15. I accept Dr Bouwer's opinion.

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[2] 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.

[3] The presence of these drugs may likely be attributed to medical interventions performed during BJ's admission to Dandenong Hospital

Circumstances in which the death occurred

16. As he grew older, BJ began living an itinerant lifestyle, eventually moving to Melbourne where he lived in several locations with assistance from local missions and accommodation services. In December 2015, BJ moved into the Dandenong mental health catchment area however, despite attempts by the community mental health teams, BJ declined to engage, and his file was closed on 1 January 2016.

17. On 4 January 2016, BJ self-presented to the Dandenong Hospital Emergency Department (**ED**), stating that he had not had his medication for some time and was currently homeless. He presented as confused, agitated, and was found to be experiencing auditory hallucinations at the time. On admission, he was assessed as at low-medium risk of suicide and harm to others.

18. BJ was later voluntarily admitted to the Acute Psychiatric Unit (**APU**) where he was noted to have paranoid thoughts, auditory hallucinations, poor sleep, appetite and energy, persecutory delusions, poor insight and judgement, and was expressing suicidal ideation.

19. BJ was placed in the high-dependency Flexicare Area and was to have five minutely visual observations conducted as per his nursing care level (**NCL**) of 4. BJ's medical records indicate that these were completed from his admission until midnight, excluding an unexplained 25-minute gap between 9.10pm and 9.35pm.

20. BJ was recorded as being awake between 10.25pm and 12.15am and stating that he wanted to leave and that he did not believe that he required treatment. Nevertheless, he accepted medication and later slept through the remainder of the night. At the time, BJ did not have appear to have any perceptual or psychotic symptoms and denied any suicidal or homicidal thoughts. However clinical staff documented that he was suspicious, responding to stimuli, guarded and irritable.

21. On 5 January 2016 at 9.30am, BJ was assessed by consultant psychiatrist Dr Sharma, a psychiatric registrar, and hospital medical officer. He denied psychotic thoughts but complained of paranoia and disturbed sleep. A diagnosis of drug-induced psychosis was considered, and he was prescribed the anti-psychotic quetiapine. BJ's risk and suicidality levels were reassessed and recorded as 'very high' and 'high' respectively. His NCL remained at 4, with five minutely observations performed until 5.25pm.

22. BJ's mood was initially recorded as 'settled' but nursing notes made at 11.15am documented that BJ banged on the nurses' station window demanding the anti-psychotic zuclopenthixol acetate. He was given diazepam and paracetamol for his agitation after which he settled and slept.

23. That afternoon, at about 4.50pm, BJ became labile, hostile, angry, and paranoid about one of the nursing staff in the unit. He became aggressive and expressed homicidal thoughts towards the nurse and was given diazepam and the anti-psychotic quetiapine at 5.17pm.

24. Following this incident, BJ resumed banging on the nurses' station window and began demanding his possessions which was refused. He was last observed by nursing staff at 5.35pm when he returned to his room and slammed the door shut.

25. At 6.00pm a Code Blue[4] was activated after a knot sheet was observed over the door of BJ's room. Nursing staff immediately opened the door. As a result, BJ, who had constructed a ligature from his sheets, fell to the ground on the other side of the door. Staff immediately began cardiopulmonary resuscitation and at 6.02pm the Medical Emergency Team attended at which point return of spontaneous circulation was achieved. BJ was transferred to the Intensive Care Unit (**ICU**) at 6.50pm.

26. On 13 January 2016, BJ passed away from the sequelae of his attempt to hang himself using a bed sheet and the door and door jamb to his room.

FAMILY CONCERNS

27. In email correspondence directly with the Court, BJ's family raised a number of concerns about his death and other circumstances which they inferred were connected with the death. While I acknowledge the concerns raised, I could find no plausible causal connection between the concerns raised and BJ's death and have not investigated them as they appear to fall well outside the reasonable scope of a coronial investigation which is confined to those matter that are sufficiently proximate to and causally relevant to BJ's death.

[4] An alert signifying that a patient is experiencing a critical medical emergency.

CPU REVIEW

28. To assist with my investigation into the death of BJ, I requested the Coroners Prevention Unit (CPU)[5] to undertake a review of the adequacy of the care that BJ received during his time in the Flexicare Unit and whether any prevention-base opportunities could be identified.

29. Sources of evidence included the Coronial Brief, BJ's Monash Health medical records, Monash Health policy and procedures, and statements from Unit 2 Nurse Unit Manager Theresa Meiklem, consultant psychiatrist Dr Sujit Sharma, Mental Health Program Manager Professor David Clarke, and Director of Nursing Tracey Harmer.

30. From a broad overview standpoint, the decision to admit BJ into the Flexicare Unit on 4 January 2016 was appropriate, and the quality of assessment and treatment decisions are also in line with practice guidelines.

Observations on 5 January 2016

31. The CPU noted the discrepancy between the last time that BJ was last sighted by nursing staff (5.35pm), the discovery of BJ hanging from his door (exact time unknown), the activation of the Code Blue (6.00pm), and the attendance of the Medical Emergency Team (6.02pm).

32. It is unlikely that nursing staff waited for up to 20 minutes prior to activating the Code Blue, and the most likely explanation is that BJ was not sighted by nursing staff between the last documented observation at 5.35pm and his discovery which, on the basis of the available evidence, most likely occurred at about 6.00pm when the Code Blue was activated.

33. It is reasonable to conclude that the five-minutely observations, as required by BJ's NCL, were not conducted between 5.35pm and 6.00pm. The CPU noted that a staff change over occurred at 5.40pm with some overlap of staffing on the unit which may have resulted in some confusion about who was responsible for conducting the observations during this time, in addition to a possible lack of understanding about the exact procedure of visual

[5] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health. In this instance the review was conducted by fully qualified and experienced psychiatric nurse who is also involved in the accreditation of public mental health services.

observations being taken every five minutes, and line of sight observations (taken from the nurses' station) not being sufficient to appreciate BJ's actions in constructing the ligature.

34. I note the statement received from Tracey Harmer, Director of Nursing with the Mental Health Program at Monash Health who stated that in 2018, Monash Health determined that five-minutely observations in the High Dependency Area (**HDA**) (formerly known as the Flexicare Area) were not feasible for the following reasons:

    a) If the nurse responsible for conducting observations was called away, they would be required to hand over the responsibility to another staff member. In practice, this may not always occur;

    b) The HDA can accommodate up to ten patients at a time. If all patients required five minutely observations, then this would become extremely difficult; and

    c) Due to an observable increase in acuity and individual patient needs since 2016, it was no longer considered practical to perform five minutely observations.

35. Ms Harmer further highlighted that, following the adoption of a new Enterprise Bargain Agreement in 2018, the ratio of staff to patients has greatly increased, allowing for a greater opportunity for staff to keep close observations of patients.

36. With the removal of the previous NCL levels, Monash Health has now adopted the following levels of nursing observation requirements. They are, in ascending acuity:

    a) 60-minute observations;

    b) 30-minute observations;

    c) 15-minute observations;

    d) Constant visual supervision in direct line of sight at all times; and

    e) Constant arms-length observation (1:1 nurse/patient ratio).

<u>Failure to escalate</u>

37. The CPU's investigation found that there was an inadequate response to and lack of reassessment of risk after BJ abruptly became aggressive and hostile towards one of the nursing staff at 11.15pm on 5 January 2016. Dr Sharma agreed that the change in BJ's

mental state should have been escalated to the psychiatric registrar and, preferably, to BJ's treating psychiatrist, in accordance with Monash Health's *Acute Behavioural Disturbance Clinical Guideline* (2016).

38. The guideline is evidence-based and should result in a more consistent approach to what pharmacological agents are prescribed and used and stipulates that earlier escalation should occur when initial pharmacological agents are assessed as ineffective.

Victoria Police investigation

39. Victoria Police members attended the Flexicare unit on 12 January 2016 to examine the scene of the attempted hanging as part of their investigation of BJ's death on behalf of the coroner. Staff were unable to locate the relevant observation records. The Coronial Investigator noted that due to the time that had passed since the attempted hanging, their investigation of the scene was confounded and, potentially, vital evidence was lost.

Monash Health internal review

40. An internal review was conducted by Monash Health following the death of BJ which identified several areas for improvement. Changes that have been made or planned as result of that review include:

    a) The installation of glass windows in the bedroom doors of high dependency bedrooms;

    b) A redesign of the HAD unit to improve line-of-sight monitoring by staff;

    c) Installation of pressure-sensitive pads on the top of bedroom doors and education of staff regarding their use;

    d) The implementation of new procedures relating to the management of a high dependency area;

    e) Meetings with clinicians on duty at the time of BJ's death to outline their obligations in contemporaneous clinical recording;

    f) The provision of alcohol and drug training to staff; and

    g) Youth Drug and Alcohol specialists now attend the unit's case discussion on a fortnightly basis.

41. The review also noted the Victorian Chief Psychiatrist Direction 2016/01 which states that observing patients from a staff base (such as the nurses' station) is not an acceptable level of service provision and staff must be in the area where the patient is when they make their observations. Professor Clarke noted that the Flexicare unit now meets this requirement.

42. The non-compliance with documentation of NCL observations was identified during the review with staff on the unit at the time of BJ's death, suggesting that multiple contemporaneous activities required of staff led to non-compliance with documentation, rather than the actual observations not taking place. It was conceded, however, that this was not acceptable practice and does not comply with the relevant procedures.

FINDINGS AND CONCLUSION

43. 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.[6]

44. Adverse findings or comments against individuals in their professional capacity, or against institutions, are not to be made with the benefit of hindsight but only on the basis of what was known or should reasonably have been known or done at the time, and only where the evidence supports a finding that they departed materially from the standards of their profession and, in so doing, caused or contributed to the death under investigation.

45. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was BJ, born 11 March 1991;

    b) the death occurred on 12 January 2016 at Dandenong Hospital, 105-135 David Street, Dandenong, Victoria, 3175;

    c) the cause of BJ's death was *hypoxic brain injury secondary to hanging*; and

    d) the death occurred in the circumstances described above; and

[6] *Briginshaw v Briginshaw* (1938) 60 CLR 336 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 available evidence supports a finding that BJ intentionally took his own life and the possibility that he did so while his judgement was impaired by his mental illness remains open.

46. The weight of the evidence supports a finding that the five-minutely observations, as required by BJ's NCL, were not undertaken in accordance with the relevant procedures from 5.35pm onwards, during the shift change over on 5 January 2016.

47. The practice of requiring five-minutely observations posed logistical difficulties which have since been recognised and the practice abandoned by Monash Health.

48. Since BJs' death and following an internal review of the circumstances in which he died, Monash Health have implemented a number of changes to their practice which should improve patient safety in the future and Monash Health are to be commended for doing so.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments on a matter connected with the death, including matters relating to public health and safety or the administration of justice:

1. It is vital that appropriate and contemporaneous reporting take place following any serious incident to allow for a proper investigation to take place and, where necessary, for identified deficiencies to be recognised and rectified. This includes the completion of both internal and external reporting responsibilities.

2. It is trite to say that BJ's resuscitation and transfer to the Intensive Care Unit was the paramount consideration at the time. It is also the case that beds in inpatient psychiatric units are a valuable commodity and that beds and bedrooms cannot be quarantined indefinitely while police make observations, take photographs and otherwise investigate the scene.

3. This case highlights once again, the effect on a coronial (and potentially criminal) investigation following a death in an inpatient unit where there is successful resuscitation of the patient and a delay between the actions that ultimately cause the death and the death of the patient.

4. Strictly speaking, the coronial jurisdiction is not invoked until a death has occurred. I have previously identified the issue of delayed scene investigation by Victoria Police in my finding into the death of TK7 also a hanging in an inpatient psychiatric unit, in which I made a similar recommendation to that which follows.

RECOMMENDATION

Pursuant to section 72(2) of the Act, I make the following recommendation on a matter connected with the death, including recommendations relating to public health and safety or the administration of justice:

1. That Monash Health develop a procedure that addresses the need for scene preservation and/or recording, in circumstances where a serious suicide attempt has taken place in an inpatient facility, in anticipation of a foreseeable coronial investigation. Such a procedure could also assist the health service to undertake its own internal review or root cause analysis (whether mandate or otherwise) and to comply, more broadly, with its duty of care obligations.

[7] COR 2009 4252.

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

The family of BJ

Peter Ryan, Monash Health

Dr Neil Coventry, Office of the Chief Psychiatrist

Landers & Rogers, on behalf of Monash Health

Senior Constable Joanne Cockerell, Victoria Police, Coroner's Investigator

Signature:

Paresa Antoniadis Spanos

Coroner

Date: 30 March 2022

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 investigation. 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.