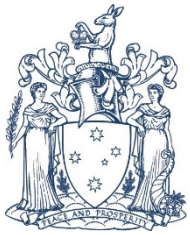

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2017 005602

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

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

Inquest into the Death of Kira Shae James

Delivered On:	15 December 2022
Delivered At:	Melbourne
Hearing Date:	7 November 2022
Findings of:	Coroner Leveasque Peterson
Police Coronial Support Unit:	Dani Lord, Leading Senior Constable
Keywords:	Mandatory inquest, in care, suicide, ligature

1. I, Coroner Leveasque Peterson, having investigated the death of Kira James, and having held an inquest in relation to this death on 7 November 2022 at Melbourne find that:

    a) the identity of the deceased was Kira Shae James born on 13 May 1996; and

    b) the death occurred on 5 November 2017 at Thomas Embling Hospital by neck compression.

2. I further find, under section 67(1)(c) of the ***Coroners Act 2008*** (‘**the Act’**) that the death occurred in the circumstances outlined below.

THE CORONIAL INVESTIGATION

3. Kira’s death constituted a ‘reportable death’ under the Act, as Kira was in care at the time of her death. I was therefore satisfied that an inquest into her death was required pursuant to section 52 of the Act.

4. In the circumstances, I considered it appropriate to hold a summary inquest which occurred on 7 November 2022. At the hearing, a summary of evidence was provided to the court by Coroner’s Assistant, Leading Senior Constable Dani Lord. The individual witnesses who had provided statements included in the Coronial Brief were not required to give evidence, as I was satisfied after considering all available evidence that there were no disputes on matters of fact.

5. The jurisdiction of the Coroners Court of Victoria is inquisitorial. The role of the Coroner is to independently investigate reportable deaths to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death occurred.

6. The role of the Coroner is to establish the facts. It is not the Coroner’s role to lay or apportion blame, to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

7. The expression “cause of death” refers to the medical cause of death, incorporating where possible, the mode or mechanism of death.

8. For coronial purposes, the phrase "circumstances in which death occurred," refers to the context or background and surrounding circumstances of the death. Rather than being a consideration of all circumstances which might form part of a narrative culminating in the death, it is confined to those circumstances which are sufficiently proximate and causally related to the death.

9. The broader purpose of coronial investigations is to contribute to a reduction in the number of preventable deaths, both through the observations made in the investigation findings, and by the making of recommendations by Coroners. This is generally referred to as the Court's "prevention" mandate.

10. Coroners are empowered:

    a) to report to the Attorney-General on a death;

    b) 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

    c) to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.

11. These powers are the means by which by which the Court's prevention role may be advanced.

12. This Finding draws on the totality of the material obtained in the coronial investigation of Kira's death, that is, the Court File, the Coronial Brief prepared by the Coroner's Investigator and further material obtained by the Court, together with a transcript of the Inquest hearing.

13. All coronial findings must be made based on proof of relevant facts on the balance of probabilities. The strength of evidence necessary to prove relevant facts varies according to the nature of the facts and the circumstances in which they are sought to be proved.

14. In determining these matters, I am guided by the principles enunciated in *Briginshaw v Briginshaw.* The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals or entities, unless the evidence provides a comfortable level of satisfaction that they caused or contributed to the death.

15. Proof of facts underpinning a finding that would, or may, have an extremely deleterious effect on a party's character, reputation or employment prospects demands a weight of evidence commensurate with the gravity of the facts sought to be proved. Facts should not be considered to have been proven on the balance of probabilities by inexact proofs, indefinite testimony or indirect inferences. Rather, such proof should be the result of clear, cogent or strict proof in the context of a presumption of innocence.

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

Identity

16. On 8 November 2017, Stewart James visually identified his daughter, Kira Shae James born 13 May 1996. Identity is not in dispute and requires no further investigation.

Medical Cause of Death

17. Forensic Pathologist Dr Heinrich Bouwer from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination on 6 November 2017 and provided a written report of his findings dated 17 January 2018.

18. Dr Bouwer provided an opinion that the cause of Kira's death was 1(a) *Neck compression.*

19. I accept Dr Bouwer's opinion.

Circumstances in which the death occurred

Background

1. Kira Shae James was born on 13 May 1996 to Stewart and Jodie James.

2. Early in her life, Kira's parents divorced, with each pursuing new relationships and having children with new partners. Following the divorce, Kira initially lived in New South Wales with her mother.

3. Kira was only four years old when Jodie took her life, and Kira returned to live with her father in Victoria.

4. Kira was a pleasant, studious child who participated in calisthenics, and was popular amongst her teachers and peers. As her school years progressed however, Kira became quite insular. Kira's father, Stewart, noted Kira received counselling, however he observed that she would become withdrawn whenever the topic of her mother was raised.

5. At 16 years old, Kira experienced her first episode of self harm. She took an overdose of medication, and while hospitalised, the then-Department of Human Services became involved with the family, sharing the concerns her family had that Kira was becoming more withdrawn.

6. A year later, Kira called "000" saying she had started a fire in the family home. After the fire was put out, she was taken by Ambulance to the Banksia Unit at the Royal Children's Hospital.

7. A few weeks later, police were again called when Kira threatened to burn the house down with her father and his partner inside. This time she stated she would kill herself as well, and these incidents led to intervention orders being sought for Stewart and his partner.

8. After her release from the Banksia Unit, Kira had returned to school, however her mental health caused her to leave school before the end of Year 11.

9. From August 2013 to August 2014, Kira was subject to 25 mental health transfers where police members were called to assist.

10. In February 2014, Kira told her youth worker she wanted to end her life by hanging herself. This incident was reported to police who were able to locate her before any incident occurred. From this point, Kira's behaviour escalated rapidly with incidents of unprovoked violence against members of the public and staff during the times she was in care.

11. In May 2014, Kira attempted to stab an 81-year-old man in the neck with a knife as he walked past in the street, telling him she needed to kill him. Police members described Kira's behaviour when arrested as 'psychotic' and reported that she had indicated that voices in her head had told her she needed to kill four people that day.

12. That same year, Kira assaulted a female in an unprovoked attack armed with a Stanley knife.

13. Over the next three years Kira's behaviour resulted in numerous charges for assault, weapons offences, theft and making threats to kill. These episodes of offending led to Kira being incarcerated.

14. In September 2014, whilst on remand at the Dame Phyliss Frost Centre, Kira attempted to strangle another inmate who she was having a conversation with. There were also several recorded incidents of violence against staff.

15. During her period of remand, Kira spent time in the facility's mental health unit and engaged in repeated acts of self-harm during her custodial sentence.

16. By October 2015, Kira's mental health had deteriorated and she was transferred to Thomas Embling Hospital (**Thomas Embling**) in Fairfield under a Secure Treatment Order.

17. After completing her custodial sentence, Kira remained at Thomas Embling as an Involuntary Patient on an Inpatient Treatment Order under the *Mental Health Act 2014*. She remained at the facility until her death.

Circumstances in which the death occurred

18. Kira was subject to repeated independent reviews by the Mental Health Tribunal while at Thomas Embling. Repeated aggressive behaviour meant that Kira continued to present a high level of risk to the treating team. As such, a less restrictive placement could not be implemented and Thomas Embling remained the most appropriate placement for Kira.

19. Efforts to assess Kira with a view to transitioning her to a lower acuity facility also triggered anxiety and Kira expressed a view that she was not ready nor capable of moving from the

Barossa Unit. The assessments corresponded with increased aggression towards staff and other patients. Once the plan for transition was withdrawn, Kira's anxiety and incidents with staff also receded.

20. Kira's consultant forensic psychiatrist Dr Fiona Toal described Kira as suffering from psychosis, an eating disorder and borderline personality disorder (**BPD**) with prominent antisocial personality traits. Dr Toal indicated that Kira's history was suggestive of a genetic vulnerability to mental health problems, and the loss of her mother at an early age saw Kira develop a profound fear of abandonment.

21. Seclusion and constant observation gave Kira increased feelings of persecution by staff and this acted as a trigger to more violent episodes toward staff.

22. During her time at Thomas Embling, Kira was involved in thirty-nine documented episodes of self-harm. A majority of these incidents involved the use of ligature.

23. Kira was clearly a highly complex individual and her treatment required clinicians to implement a delicate balance of tools in order to maintain her wellbeing. Kira's treatment and management plan at Thomas Embling appropriately emphasised her choice and personal responsibility, whilst also attempting to achieve a balance between extreme restrictions intended to minimise risks, and less restrictive techniques intended to lower her distress. The adoption of a less restrictive approach, involving staff engagement, regular assessment and Kira utilising self-management tools to lower her distress, meant there was always a residual risk of both harm to self and others.

24. SPECTRUM, an agency specialising in personality disorder and complex trauma, also provided specialist input to Kira's treatment. Generally, the service provided personal sessions and assistance to Kira's clinicians. However, Kira had chosen to disengage with the service prior to her death.

25. Part of Kira's self-management plan was to activate her room duress alarm when she had the urge to self-harm, or if she felt unsafe, and she was said to have frequently activated that alarm, either before or shortly after self-harm behaviour. Kira was noted to be at a high and enduring risk of harming herself and others.

26. In the months before her death, Kira was reported to have had an escalation in episodes of aggression towards staff, requiring restrictive intervention and seclusion. Seclusion periods ranged from a few hours to periods of more than a week and were punctuated by assaults on staff and fashioning ligature items from bedding. Kira reportedly expressed an ambivalence towards her treatment and rehabilitation and incidents of self-harm frequently included attempts at self-strangulation followed by activation of her duress button.

27. Between September 2017 and November 2017, staff notes recorded Kira as fluctuating between being 'bright and jovial' to having tearful episodes where she expressed self-loathing and anger towards herself, thoughts of self-harm or an urge to hurt others. These instances were often linked to her preoccupation with weight and her perception of personal weight gain. Kira alternated between periods of engagement and intense effort to work with nursing staff and psychologists, to periods of withdrawal, annoyance and violence towards staff and other patients.

28. In these last months of her life, there were four recorded attempts of self-harm, several episodes of self-imposed and staff enforced seclusion, and occasions where Kira refused to eat or drink for periods of time. Kira's daily Dynamic Appraisal of Situational Aggression (**DASA**) fluctuated daily between 'Low' and 'High', and staff continued to engage Kira and to assist her when she found herself heightened, aggravated, or distressed.

29. The week of her death, Kira was due to reengage with a SPECTRUM psychologist and according to staff, had been able to utilise her personal strategies successfully when she had had thoughts of self-harm and harm to others. On 4 November 2017, Kira's DASA score was assessed as 'low', and she denied any ongoing suicidal thoughts.

30. On 5 November 2017, staff on duty that morning described Kira as "settled in manner and mood". Between 8.00am and 8.30am Kira was seen by several staff, walking up and down the hallway listening to her iPod, in what they described as her usual exercise routine. Kira collected her medication at 8.00am and had multiple interactions with staff who described her as smiling, laughing and joking, bright and happy, and displaying a positive outlook.

31. A short time later, at 8.36am, CCTV from the unit shows Kira leaving her room and walking to the 'Quiet Lounge' to utilise exercise equipment. After a few minutes use, Kira left and returned to her room at 8.42am. This was the last time that Kira was seen alive.

32. At 8.56am, a male staff member is observed on CCTV attending the door of Kira's room to conduct the required hourly security check of patients. This check requires staff to sight each patient to confirm they are in the facility and then complete a checklist of confirmed sightings of each patient.

33. The staff member attending Kira's room, found the door closed and described hearing noises inside which were "typical of someone getting changed and were not noises that gave me reason to be concerned". The staff member decided they should not disturb Kira to maintain her privacy and did not open the curtain on the observation window to sight Kira or speak to her. Kira was signed off as being present on the security check list. The staff member then returned to his duties, relieving other staff who were monitoring other patients.

34. At 9.30am, Kira did not attend breakfast which was not unusual for her eating habits, and staff believed that she was resting in her room.

35. At 9.58am, staff member Registered Nurse (**RN**) Shepley attended Kira's room to check on her and opened the curtain on the observation window to her room. Initially unable to see Kira, RN Shepley looked down and saw Kira laying on the floor in front of the door. Entering the room, she found Kira with a pair of black leggings pulled tightly around her neck 2-3 times and tied in a knot at the front of her neck. She observed Kira's skin to be purple and that she was not breathing.

36. RN Shepley sounded the duress alarm and staff immediately attended to assist and Ambulance was called. Strenuous efforts were made to revive Kira however these were unsuccessful, and she was pronounced dead at 10.45am.

INTERNAL INVESTIGATION BY THOMAS EMBLING

37. Following Kira's death, Forensicare and Thomas Embling conducted a Root Cause Analysis (**RCA**) on 9 February 2018.

38. The Court obtained a statement on behalf of Thomas Embling from Ms Joanna Ryan, Director of Nursing at time of incident. In that statement, Ms Ryan detailed the outcomes of the internal investigation into Kira's death, provided a summary of the RCA, and set out the resulting recommendations.

39. Ms Ryan indicated that although not formally set out in the policy, convention at the workplace required that in circumstances where an hourly check could not be conducted at the required time, there was an allowance for a 15-minute variance. If the allocated clinician could not complete the check, or sight the patient, this should be escalated to the Associate Nursing Unit Manager on duty so that the task could be reallocated.

40. In this case, Kira was not sighted at the hourly check however she was nonetheless marked off as being present, and there was no escalation or request for a recheck on Kira.

41. Briefly, the RCA identified issues relating to:

    a) the helplessness and frustration Kira felt, and the impact of her BPD diagnosis as a long-term inpatient;

    b) Kira's levels of distress and fixation with weight loss and a lack of detail about this in her management plans;

    c) lack of access to management plans in a central location to inform day to day care;

    d) the mixture of acute and sub-acute patients creating additional challenges for staff;

    e) varied levels of staff experience with BPD and eating disorders when the hospital focus is psychosis;

    f) the ongoing challenge for staff of managing chronic self-harm, suicidal ideation, and aggression; and

g) the non-adherence to the patient count procedure.

42. Other contributing factors identified included staff inattention and distraction, staff knowledge and skills, Kira's medical and social history, the patient count policy not being followed, and workforce factors of skill mix of staff and adequacy of training.

43. As a result of the RCA, eight recommendations have been implemented or progressed since Kira's death. In summary they included:

a) The development of an accessible care plan in a central location in electronic record to inform current day to day care and management needs.

b) Updating the Intensive Case Review document and related care documents to ensure items identified are actioned with staff accountabilities and timelines clearly identified.

c) Implementing enhanced reflective practice arrangements for staff dealing with complex and challenging patients.

d) Providing additional training to staff to enhance skill in management of BPD and eating disorders.

e) Updating the patient count procedure in conjunction with the patient observation and engagement procedure.

f) Updating the Patient Safety Plan Proforma and linking it to the Care Pathway Plan

g) Incorporating the ISBAR tool (Identity, Situation, Background, Assessment and Recommendation) at handover that will be reviewed and audited on a regular basis.

h) The development of specialist family therapist expertise in partnership with a family therapy training provider, and implementation of targeted training for staff.

44. I commend Forensicare and Thomas Embling for the comprehensive review and recommendations that followed Kira's death. I am confident that future patients will have an enhanced level of care and improved outcomes as a result.

RECOMMENDATIONS

45. I have determined to make an additional recommendation directed to Forensicare in connection with the death of Kira Shae James under section 72(2) of the Act, namely:

    a) That Forensicare amend its policy on Patient Counts to include an escalation process that is applicable in circumstances where the clinician allocated to conduct the count is unable to complete it within the required timeframe. This escalation process should enable the task to be reallocated to an available clinician.

ORDERS

46. I order that this finding be published on the Internet.

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

    a) Stewart James, Senior Next of Kin
    b) Dr Margaret Grigg, Chief Executive Officer, Forensicare
    c) Melissa Iskov, Forensicare and Thomas Embling Hospital
    d) Senior Constable Belinda Thomas, Coroner's Investigator
    e) Leading Senior Constable Dani Lord, Coroner's Assistant

I convey my sincere condolences to Kira's family for their loss and acknowledge the tragic circumstances of her death.

Signature:

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CORONER LEVEASQUE PETERSON

Date: 21 December 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 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.