These findings have been written without the benefit of a transcript

STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of RR
Hearing dates:	3-5 December 2018
Date of findings:	19 December 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – self-inflicted death, death in acute care unit
File numbers:	2015/121417
Representation:	Mr J Harris, Counsel Assisting, instructed by Ms E Leung, Crown Solicitor's Office Mr T Hackett instructed by Mr D Indevar of O'Brien Solicitors, for the family of RR (JR, LR and AR) Mr R Gambi, instructed by Mr T Mineo of Avant Law, for Dr Russell Mr P Rooney, instructed by Mr L Sara of Hicksons for Western New South Wales Local Health District (WNSWLHD) Ms K Doust, solicitor, NSW Nurses and Midwives Association, for Nurses Cridland, Hove, O'Hara and Trevorrow

Findings:

The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity
The person who died was RR.

Date of death
She died on 21 April 2015.

Place of death
She died at Bloomfield Hospital, Orange NSW.

Cause of death
She died from neck compression.

Manner of death
RR's death was intentionally self-inflicted. She died after hanging herself with [redacted]

Non publication orders:

Pursuant to s. 75 of the *Coroners Act 2009*, the name and identity of RR may not be published.

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Introduction

1. RR died on 21 April 2015, at Bloomfield Hospital, Orange. She was 38 years of age. She had been admitted to that hospital on 12 April 2015, following an overdose. She was initially admitted on an involuntary basis but from 15 April 2015, she remained in hospital as a voluntary inpatient. On 21 April 2015, she was found in her room, hanging by [redacted].

2. RR was born in Canterbury Hospital and lived much of her early life in Sydney's inner west. She left Canterbury Girls' High School and commenced work with her mother as a nursing assistant. RR had her first child at 20 years of age. From that time she struggled with a number of relationship and other difficulties.

3. RR's death is a terrible tragedy that continues to cause enormous grief and distress to those who loved her. Her sister L spoke eloquently of the strong family bond she had with her siblings. Her mother JR came to the inquest, but her pain was so great, that she remained for the most part outside. I acknowledge the family's heartbreaking pain and profound loss.

The role of the coroner

4. The role of the coroner is to make findings as to the identity of a nominated person and in relation to the place and date of death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] The place and date of RR's death is known. For this reason the inquest focused on the circumstances surrounding her death and the care she received during her final hospitalisation at Bloomfield.

5. A coroner may also make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[2]

The evidence

6. The court took evidence over two days and heard final oral submissions from the parties on the third. The court also received extensive documentary material in four volumes. The material included witness statements, government policy documents, medical records, and photographs.

7. The court heard from medical staff involved in RR's care in the days prior to her death. It was also assisted by the expert testimony of Dr Kerri Eagle, a forensic psychiatrist with extensive experience in a range of mental health settings.

8. A list of issues was prepared before the proceedings commenced. The list included the following matters:

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[1] Section 81 *Coroners Act 2009* (NSW).
[2] Section 82 *Coroners Act 2009* (NSW).

- Was RR adequately assessed by Dr Russell on 13 and 15 April 2015?
- Was the frequency of psychiatric review thereafter appropriate?
- Was RR's suicide risk assessed, documented and managed appropriately?
- Was the information received from NSW Housing on 15 April 2015 adequately documented and considered?
- Was the decision to reclassify RR as a voluntary patient on 15 April 2015 appropriate?
- Would it have been appropriate, and practicable, to deny RR access to ligatures, including [redacted], in light of the information provided by NSW Housing and relevant policy?
- What care level was RR to receive from 16 April 2015, and was that appropriate?
- Were observations made by nursing staff in accordance with that care level?
- What problems were encountered during resuscitation?
- Is it necessary or desirable to make any recommendations in connection with any matter arising from the death?

Background

9. RR was the eldest of three siblings. She was extremely close to her siblings growing up. L told the court that she and her brother, AR, had been devastated by RR's death. They had spent their childhood together and even when things were sometimes hard, they always had each other's backs[3].

10. RR's early life was troubled, and she left home at 14 in the context of allegations of abuse. At 16 she made the first of a number of attempts at self-harm, cutting her wrists. She left school the following year, after completing Year 10, and commenced working as a nursing assistant.

11. Around this time, she met her partner J, with whom she formed a relationship and they remained together for about 19 years. They went on to have five children. Unfortunately, the relationship was marred by violence.

12. RR's poor mental health continued into her adult life. In August 2000, RR (aged 24) was admitted to Rozelle Hospital on a voluntary basis with depression and suicidal ideation. The context for this was that the family had recently become homeless, after J's mother took out an AVO against RR. RR received treatment at Rozelle, but she absconded from the hospital after a week.

[3] L's family statement, 5/12/18.

13. RR's poor mental health was exacerbated by drug use. She used amphetamines, including intravenously during the last year of her life at least, and she also smoked cannabis.

14. In 2010, RR's relationship with J ended, and she moved with the children to Orange. However, in August 2011, J took out an AVO against her and the children commenced living with their father.

15. After the separation, RR presented to the Emergency Department in crisis and she was referred for counselling. She also sought assistance from her GP, and in March 2012, she was prescribed antidepressants.

16. In early 2012, RR formed a new relationship with D. That relationship ended tragically in January 2013, when he drowned in the surf at Lake Tabourie. RR was with D when this happened, and it had a profound effect on her. Shortly afterwards, on 10 February 2013, she was admitted on a voluntary basis to Bloomfield Hospital with suicidal ideation. She remained there for about a month.

17. Following this admission, she commenced living at 5 Pimpala Place, Orange. Her son TP was also living with her at that time. She received further counselling and continued to take antidepressants until May 2013.

18. In the spring of 2013, RR met a man called F, to whom she became engaged. This relationship was also said to be violent. RR suffered a miscarriage at the end of 2013. Following this, she again became depressed and commenced taking antidepressants.

19. In early 2014, F received serious injuries in an accident, and RR spent a period as his carer. Their relationship ended in November 2014 when it is alleged that F assaulted RR and an AVO was taken out.

20. Following this, a man called C moved in with RR, although the nature of their relationship is somewhat unclear. It was again a problematic relationship for RR. Her son TP reports that drugs were being used in the home.

21. In January 2015, RR suffered a further miscarriage.

22. On 5 March 2015, RR travelled from Orange to Sydney. She left her two children, TP and JP, who had been living with her in Orange, in the care of her mother, and she then returned to Orange with C.

23. The next day she presented to Bloomfield Hospital with abdominal pain, possibly related to her earlier miscarriage. About a week later, C ended their relationship.

24. On 18 March 2015, police were called to Campbelltown train station. There they found RR, who said she had been threatened by another woman. RR told police that if she had the guts, she would hang herself. Police exercised their powers under s. 22 *Mental Health Act 2007* and took RR to Campbelltown Hospital.

25. She was admitted to Campbelltown on an involuntary basis for a week. The notes from that admission record that she had suicidal ideation with a clear plan to hang herself. She also admitted to recent intravenous ice use about four days prior to the admission, and told doctors that she had been using ice for the previous 12 months.

26. During this admission, a male patient sexually propositioned RR while she was in her room. She was transferred to the Psychiatric Emergency Care Centre and re-classified as a voluntary patient. She was then discharged home on 24 March 2015.

27. Late in March 2015, RR again visited her mother's home in Sydney. She collected belongings and left. Her sister, LR, sent RR a message after this, telling her to "*pull [her] head out of [her] butt*" and reminding her that her family loved her. In response, RR un-friended her sister on Facebook. That was the last contact RR had with her family.

28. At this point, RR was trying to leave Orange in order to move to Sydney, in part because she was fearful of her ex-partner, F, who was in the Orange area.

29. On 10 April 2015, RR contacted Family and Community Housing Services (Housing) at Orange. She said she wanted to surrender her tenancy at 5 Pimpala Place and that Housing should dispose of her belongings. She said she was in Campbelltown at the time of this call.

30. It is apparent that she was actually in Orange, or at least she returned there soon after, and she continued to squat in her home for the next few days. She later admitted using ice and cannabis during this period.

31. By the time of RR's admission to Bloomfield Hospital on 12 April 2015, it would be observed that she was facing a variety of stressors. She had a chaotic lifestyle and was now facing homelessness; she had endured problematic and violent relationships; she had developed PTSD due to the death of her partner D; she had recently suffered a miscarriage; she was isolated, having separated from C and being estranged from her family, including her children; and she was using intravenous drugs. She also had certain personality traits that made her particularly vulnerable. It was in this context that she was admitted to Bloomfield Hospital.

Admission to Bloomfield Hospital

32. The circumstances that brought RR to Bloomfield Hospital are as follows. On 11 April 2015, RR took an overdose [redacted] She took these in four separate batches.

33. RR presented herself to the Emergency Department at Orange at 1.30am on Sunday 12 April 2015. She was assessed in the Emergency Department by Dr Lipski. The notes record that RR said she had a noose at home, which she planned to use. RR was assessed as at risk of suicide and was admitted on an involuntary basis (pursuant to s. 19(d) *Mental Health Act 2007*).

34. Various tests were performed and in due course she was medically cleared by the Emergency Department and referred for psychiatric review. The notes from RR's previous admission were obtained from Campbelltown Hospital, as were the notes from her admission to Bloomfield Hospital in 2013

Initial assessment

35. RR was initially assessed by psychiatric registrar Dr Fernando in the Mental Health Intensive Care Unit (MHICU) at about 1pm. Dr Fernando completed a Mental Health Assessment Form, in which he recorded her history, previous admissions, drug use and current stressors and then recorded a formal risk assessment. He considered her to be at "medium" risk of suicide in hospital. He also recorded that she had suicidal ideation, but no plans, and that she denied plans to self-harm in hospital.

36. Dr Fernando recorded a management plan to admit RR as a mentally disordered person (pursuant to s. 19(d) *Mental Health Act 2007*), move her to an acute ward, and continue her antidepressant medication. He requested a review by the psychiatrist the following day. He charted Seroquel or Quetiapine as a PRN or "as needed" medication. He also recorded that she should have no leave and should be monitored on "Care Level 3". That care level requires nursing staff to make observations every 30 minutes. That care level was recorded on a Leave document in RR's notes.

37. Dr Fernando was accompanied by RN Ferri. She completed a formal Mental Health Risk Assessment and completed progress notes. RN Ferri recorded that RR "*stated she took overdose and that if she was to leave the hospital she would hang herself*" although she "*guarantees her own safety while in hospital*".

Transfer to Lachlan Ward

38. At 3.40pm, RR was transferred to the Adult Acute Unit, the Lachlan Ward, where she was given Quetiapine at about 5pm for agitation.

39. At 9pm, RR was given [redacted] by an Enrolled Nurse. It became clear during the inquest that this was not [redacted] designed or formally issued by the Department of Health[4]. It appears most likely to have been [redacted] supplied from a store of second hand and charity items kept at the hospital to assist those in need. [redacted]

40. At the time there was a prohibited items list, which gave staff general guidance on this issue. Ligatures were not permitted in the MHICU, but patients in the Adult Acute Unit were permitted to have [redacted]. Accordingly, such items would only be removed if the treating team considered it appropriate. There is no evidence in the notes that the issue was ever specifically considered by her medical team or nursing staff.

[4] Evidence of Jason Crisp, 4/12/18

First review by Dr Russell

41. The following day, Monday 13 April 2015, RR was reviewed by Dr Andrew Russell, the Consultant Psychiatrist. At that time he was available for duty at the Lachlan Ward on Mondays and Wednesdays each week. He reviewed RR together with Career Medical Officer (CMO) Dr Reena Boquiren. This assessment was substantial, and Dr Boquiren documented the review in the progress notes. Dr Russell told the court that he estimated the interview would have taken about an hour, during which time RR was often tearful.

42. RR said she was not psychotic but needed something for anxiety. Dr Russell's impression was that RR was in situational crisis, with a background of PTSD and substance abuse. She had some features of depression and possibly hypomania, no psychosis but possible withdrawal symptoms. He formulated a plan to refer her to a psychologist, arrange social work support regarding her accommodation, continue her medication and continue the involuntary admission.

43. Among other things, RR said she wanted unescorted ground leave in order to smoke. Dr Russell told the court that this is frequently a tension in patient care that involves balancing risk assessment with offering a patient a comfortable therapeutic environment. Smoking is a way of relieving tension for those who habitually smoke. Currently in NSW Health facilities it can only occur if a patient has unescorted ground leave, as smoking is not permitted on hospital grounds.

44. Dr Russell authorised unescorted ground leave as RR had requested. It was his understanding that unescorted ground leave was incompatible with maintaining RR on "Care Level 3". There is little doubt that her strong wish to smoke and the benefit Dr Russell thought that allowing her that privilege might bring, was factored into the decision to alter her care level.

45. Dr Boquiren recorded this decision in the Leave Type form, allocating RR to "Care Level 4". According to the relevant policy in force at the time, this level of care was appropriate where patients were not a foreseeable suicide or self-harm risk. Nursing staff were only required to check the patient every 2 hours. However, despite that determination, nursing staff continued to record in an Observation Record that they had checked RR every 30 minutes. These observations continued up until shortly prior to her death.

46. Following Dr Russell's assessment, he did not record a formal risk assessment, nor did he at any other stage during RR's admission. In a statement prepared for this inquest, Dr Russell stated that he assessed her to be at low-moderate suicide risk.

47. RR remained anxious on the Lachlan Ward, and received PRN medication that afternoon.

Housing workers discover a noose and suicide notes

48. The following day, Tuesday 14 April 2015, a significant discovery was made. Housing workers visited RR's home in order to assess it in light of her wish to surrender the tenancy. On arrival they discovered a noose hanging from the light fitting in the ceiling, and underneath a makeshift shrine, together with a suicide note and an informal will. They took photos of these items and reported them to their supervisor, Jacqueline Brooker. In turn, Ms Brooker contacted police and then Bloomfield Hospital, saying she would fax copies of the photos. She did so the following morning.

49. Meanwhile, RR was accessing a ceramics group at the hospital as part of her ground leave. This made her feel anxious about her ex-partner F, and as a result she had to leave a psychology group session in the afternoon in order to have more PRN medication.

Second review by Dr Russell

50. The next day, Wednesday 15 April 2015, at about 6.30pm Dr Russell and Dr Boquiren reviewed RR for a second time. Although the photos from Housing had by then been received and were documented earlier in the notes, Dr Russell made no reference to them in his review. Dr Russell told the court that he had not seen the documents until after RR's death. He agreed the documents were significant and would have been an important point of discussion with RR had he been made aware of them. He stated that he would have expected that a document of that significance would have been specifically brought to his attention. He expected his junior doctor to have reviewed the file. Dr Boquiren told the court that she did not remember having seen the documents before this review and that if they had seen it, it would have been discussed. This may indicate that the file was not adequately reviewed prior to the consultation or perhaps that the material had not yet made it to the file. Whatever the case, it was a serious gap in the information considered by the consultant psychiatrist, and in my view, is likely to have affected the care provided to RR at a crucial time.

51. During the consultation, Dr Russell noted RR's ongoing anxiety and that she had voiced concerns about a recent miscarriage. He recorded that she did not have a plan for suicide.

52. Dr Russell again did not formally record a suicide risk assessment at that time. However, he did record changes to the management plan, principally that RR would be reclassified as a voluntary patient because she was not longer considered mentally disordered, although she would remain on the ward. Dr Russell increased the dose of antidepressant and changed the PRN medication to a slow-release version of the same drug. He also requested psychology input.

53. RR again received PRN medication that evening.

Third attendance by Dr Boquiren

54. The following day, 16 April 2015, RR was assessed again by Dr Boquiren. On this occasion, RR was concerned about her miscarriage. Dr Boquiren referred her for review by Obstetrics and Gynaecology, which occurred that afternoon.

55. This was the final occasion that Dr Boquiren reviewed RR during her admission. Accordingly, there was no attendance by either of the treating psychiatrists in the five days prior to RR's death. It was Dr Boquiren's evidence that she may have seen RR around the ward as she attended to other duties.

RR's progress during the admission

56. RR appeared to have an improved day on 16 April 2015. She accessed a gardening group and was socialising. She did not require PRN medication.

57. This situation remained for the next couple of days. According to nursing staff, she was bright and reactive, although she did need Temazepam on Saturday 18 April 2015 to help her sleep.

58. On Sunday 19 April 2015, the pattern continued, with RR accessing leave and socialising. However, that evening, she was teary about her circumstances and sought PRN medication.

59. There was a morning meeting the following day, Monday 20 April 2015. Dr Russell was present, and it is likely there would have been a discussion of RR's situation. However, due to needing to see newly admitted patients and discharging others, he did not review RR that day. Neither did Dr Boquiren. The nursing notes show that RR was reactive, settled and accessed leave in order to go to the clay works. However, she became restless in the evening and asked for a pregnancy test. She was given PRN medication and went to bed early.

Events of 21 April 2015

60. RR slept in the following morning. At some stage that day she accessed ground leave. In the afternoon, she had a brief discussion with the psychologist, Laura Nilon. She said she was concerned about pregnancy and her miscarriage. The psychologist made arrangements to see RR the following day.

61. Apart from this, the nursing notes for the day record that RR had a settled morning and no issues had arisen.

62. Nursing staff commenced the afternoon shift at about 3pm. The oncoming members of staff were RN Trevorrow, the nurse-in-charge, RN Hove and EN O'Hara. EN O'Hara was allocated five patients, including RR.

63. As with previous nursing staff, EN O'Hara commenced recording observations every 30 minutes throughout this shift. However, she told the court she became aware that, given RR was on "Care Level 4", her observations should only have been required every two hours. EN O'Hara told the court that from time to time, if things were busy, observations were marked off retrospectively. Thus if an observation was missed on the half hour, but completed on the hour, both were ticked retrospectively. It was her belief that others also saw to their observations in this manner.

64. The early part of the shift was unremarkable. Then, at about 8pm, there was an altercation between two male patients, which involved the attendance of security and required one patient to be sedated. RR voiced her concerns about this, and she asked EN O'Hara for some PRN medication. However, EN O'Hara declined, as in her view, RR did not appear elevated or agitated. Accordingly, she diverted RR to the dining room to listen to music, which she did. At one point she was asked to turn the music down. EN O'Hara told the court that she had checked the decision to defer PRN medication with her superior, who agreed it was an appropriate decision.

65. As a result of the altercation, supper came late at 9pm. RR was also seen in the kitchen around this time, where she asked RN Hove for another cup of Milo. She also picked up an apple and said it was "*for the morning*".

66. EN O'Hara last recorded observing RR at 9pm. However, she recalls that RR remained in the dining room until about 9.15pm, which is the last time she was seen by staff. After that point, RR returned to her room. EN O'Hara was then busy completing incident reports for the earlier altercation and also completing progress notes for her shift. At about 10.20pm she commenced RR's progress note.

67. At 10.22pm, RN Hove announced she would check all patients. When she approached RR's door, she saw something [redacted] She tried to open the door, but it was blocked. She pushed it open and discovered RR slumped against it, with [redacted] around her neck. She called a Rapid Response team at 10.26pm.

Resuscitation efforts

68. The Rapid Response team arrived within minutes and resuscitation was attempted. Tragically, those efforts were unsuccessful and RR was declared deceased at 10.40pm.

69. It is apparent that equipment that should have been available to the Rapid Response team was either missing or inadequate. For example, the suction bag had a faulty valve and missing tubing; the automatic defibrillator was missing and one had to be obtained elsewhere. While the missing equipment impeded the resuscitation, there is no evidence that the absence of adequate equipment contributed to RR's death.

70. Following RR's death, notes were discovered in RR's room. On the bed there was a note apparently written by RR saying "*Sorry I just can't do this anymore*". She had

written a similar statement in a booklet nearby, and had also drawn a picture of a hangman with the words "*Only way out neck up girl!!!!*"

Cause and manner of death

71. An external examination confirmed that RR's death was consistent with hanging. The forensic pathologist recorded the cause of death as neck compression and confirmed that abrasions found on RR's neck were consistent with hanging by the [redacted]

72. There were no suspicious circumstances and the note found nearby offers cogent evidence that RR intended to take her own life. She was not intoxicated or affected by illicit drugs at the time of her death.

Expert review

73. An independent expert review of the care provided to RR was obtained by the coroner. Dr Kerri Eagle had the opportunity to review RR's recent medical records. Dr Eagle agreed that RR was a complex patient who had significant and long standing social and personality issues. She confirmed that RR may have had a major depressive disorder, but stated that it is unclear whether she was experiencing a depressive episode at the time of her death. She stated that RR had been previously diagnosed with Post Traumatic Stress Disorder, had a severe substance abuse disorder and had personality traits consistent with a borderline personality disorder, characterised by impulsivity and emotional dysregulation. She confirmed the difficulty in predicting suicide and the rarity of such events in mental health facilities.

74. Dr Eagle was not extremely critical of the care RR received. She accepted the possibility that consultants working in public mental health units are likely to be pressed for time and resources. Nevertheless, with the benefit of hindsight she was able to identify a number of missed opportunities in RR's care. Dr Russell's documentation of his risk assessment was inadequate and incomplete. No formal assessment by him was documented on the file. A structured tool is useful for both the practitioner who completes it and for those coming later. In retrospect Dr Russell identified RR's risk of suicide as low to moderate and apparently structured her care on that basis. What was missing was an appropriate and personalised documentary assessment of the particular risks she faced and an individualised plan to mitigate that risk.

75. Dr Eagle was of the view that the information from Housing, including photographs and copies of a recent suicide communication and informal will was important for RR's consultant to review. Perhaps if Dr Russell had been faced with the visual record of the noose RR had recently made, more specific consideration of the actual risk would have been undertaken and would have informed a specific risk management plan. Dr Russell could have spoken with her directly about the ligature discovered at her home. He accepted in evidence that it is likely that he would have asked her about the noose, if he had known about it. Other staff on the ward could have been alerted to the issue and safety strategies could have been developed, including removing

obvious ligatures from her immediate environment. Recording specific risk is also so important for medical, nursing and other staff who come into contact with a patient part way through their hospitalisation. The Mental Health Care Plan completed by RN Ian McNulty merely states "ensure a safe environment"[5]. A more effective strategy would have been to think through the specific risks that might exist and name them clearly. Here there was a very recent attempt at creating a noose, the risk that RR could try that again should have been specifically considered and documented.

76. When Dr Russell made changes to RR's legal status and management plan on 15 April 2015, her unescorted ground leave was continued. A care level was not formally documented on the file, however Dr Russell believed unescorted ground leave was incompatible with "Care Level 3", and accordingly he understood that RR would be at "Care Level 4". Dr Russell told the court that he was, in any event, content for RR's observations to be set at two hourly intervals. He told the court that RR appeared somewhat improved on the second consultation. Her responses were more ordered, she was more engaged and she was not irrational, crying or obviously distressed.

77. Nevertheless there was clearly ongoing confusion around how often RR should be observed. EN O'Hara stated that in her final shift at least, observations were not done every half hour as indicated. EN O'Hara noted that although there was a half hourly observation sheet attached to RR's file, she discovered over the course of her shift that the handover sheet recorded that RR was at "Care Level 4". EN O'Hara described a troubling practice where she and perhaps other nurses, might miss observations if they were busy and retrospectively tick the box when they completed a later observation. It is thus difficult to know with any certainty how often RR was being observed. In Dr Eagle's view, while one cannot be sure it would have made a difference, RR should have been observed at half hourly intervals.

78. While there is no ideal frequency of psychiatric review, Dr Eagle considered it would have been reasonable for Dr Russell or Dr Boquiren to review RR on Monday 20 April 2015, the day prior to her death. Dr Eagle made it clear that Dr Russell could have appropriately relied upon a more junior doctor, CMO or resident to examine RR, but someone should have seen her. When Dr Russell last saw RR on 15 April 2015, he believed he saw a discernible improvement in her condition. Nothing further was brought to his attention which would have necessitated him seeing her again personally, especially if he was busy with new patients, but it was still only days after her admission. Someone should have been charged with this task.

79. By the day of her death, although RR had seen Dr Boquiren in relation to the gynaecological issues, she had not had a psychiatric review since 15 April 2015, six days prior. Dr Eagle stated that a further review may not have altered RR's management plan, but it would certainly have been best practice. I accept her opinion.

80. Dr Eagle was clear about the real difficulties which exist in predicting suicide in any patient. The decision can be sudden and impulsive. It is important to remember that there were times during her last few days when RR was agitated, but according to the

[5] Bloomfield Hospital records – 12 to 21 April 2015. Exhibit 1, Volume 2, Tab 26, page 112.

contemporaneous nursing notes there were other times when she apparently appeared cheerful, bright and co-operative. No risk prevention strategy is guaranteed, but in my view staff were not placed on adequate alert for the real risks still involved in RR's care.

Changes made by Western NSW Local Health District (WNSWLHD) since RR's death

81. Following RR's death, WNSWLHD undertook a detailed investigation "to ascertain whether there were any systems failures in the care provided."[6] A number of issues were identified about the flow of patient information between practitioners and between departments. As a result, further training was conducted in relation to using the eMR and in streamlining referral procedures. Staff in the Mental Health Acute Inpatient Unit were also educated on the importance of escalating high risk issues of clinical concern to guard against a situation where critical information was not brought to the attention of relevant medical staff in a timely manner, as in RR's case. Changes were made to the conduct of daily morning meetings to ensure they met the need to adequately review and plan care for every patient.

82. Following a review of RR's death there was some recognition that changes to the relevant leave policies were also desirable. The need for unescorted ground leave is now considered somewhat separately to the consideration of care levels and how regularly observations should take place. There is some recognition that even those on 30 minute observations may be eligible for unescorted ground leave.

83. A significant change has been brought about by state wide policy changes to observations in inpatient mental health wards. The new policy, issued by NSW Health, has been implemented at the Local Health District. The policy changes provide an emphasis on engagement with the patient in the observation process, with the objective of making purposeful observations to assist in responding to a patient's needs. Jason Crisp, the Director of Integrated Mental Health and Drug and Alcohol Services at WNSWLHD gave evidence of new forms and procedures brought in at WNSWLHD to implement the NSW Health policy directive. Patient activity is now to be documented in the forms used for recording observations,[7] as opposed to a "tick a box" record. Audits undertaken by the campus nurse manager at Bloomfield Hospital from July 2017 to October 2018 demonstrate general compliance with the new forms and procedures, although auditors did not always observe a round of observation activity in the Adult Acute Unit during the audits.[8] Mr Crisp told the court that although there was initial feedback from nursing staff that the new observations procedures involving more documentation were time consuming and increased their workload, patient engagement improved. Mr Crisp told the court that overall the response was positive and that there was an improvement despite the difficulties with the additional administrative burden.

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[6] For a full discussion of this procedure see the statement of Jason Crisp, Director of Integrated Mental Health and Drug and Alcohol Services. Exhibit 1, Volume 1, Tab 22.
[7] Forms to be used for recording observations. Exhibit 2, Tab 4.
[8] Audits. Exhibit 2, Tab 11.

84. WNSWLHD was also mindful of the inadequacies discovered with the resuscitation trolley. It has also brought in a new resuscitation trolley, introduced new training and competency assessment in this area and has reviewed the governance of the staff who oversee resuscitation equipment.

85. Mr Crisp also told the court that there has been a change to communication of the patient care levels to the medical team. Mr Crisp told the court that patient care levels are now shown on boards on the walls of the wards for all medical staff to view and check, and that the boards are updated via a clinical review process.

The need for recommendations

86. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focusses on the specific lessons that may be learnt from the particular death.

87. Changes already made or contemplated by WNSWLHD have reduced the need for more comprehensive recommendations. It was pleasing that Jason Crisp, on behalf of WNSWLHD, made it clear that WNSWLHD was keen to capture any further learning that may arise out of the inquest.

88. As is so often the case, it is necessary to acknowledge the budgetary considerations that face WNSWLHD. It is possible that RR may have been suited to a Higher Dependency Unit (HDU), at the time of her admission so that her progress could be monitored more closely. However, at this stage there are no immediate plans for a HDU in WNSWLHD and unfortunately consideration of this issue is well beyond the scope of this inquest.

89. During the course of the evidence it became clear that a simple policy change should be considered which would reduce the likelihood of easily obtaining a ligature that could be used on an impulsive basis. The court was supplied with the list of currently prohibited items in the Adult Acute ward.[9] This includes: aerosols, steel cap boots, glass bottles and mirrors. The list could be altered to include [redacted]

90. The court also considered whether there are technological solutions or strategies which might usefully assist staff with monitoring patients at risk of harm. For this reason Dr Eagle was also asked to consider other methods of patient observation. There is a current study by the Black Dog Institute and Hunter New England Local Health District regarding back-to-base pulse oximetry in acute inpatient settings. This involves wearing a bracelet which monitors pulse and oxygen readings and alerts staff where readings deviate. Both Dr Eagle and Jason Crisp were cautious about over-

[9] Orange Health Service, Operational Procedure: Prohibited Items List – Adult Acute Services, Version 3, dated 21 June 2011. Exhibit 1, Tab 35

reliance on such technology. Nevertheless, I intend to recommend that WNSWLHD review the trial results when they become available.

Findings

91. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was RR.

Date of death

She died on 21 April 2015.

Place of death

She died at Bloomfield Hospital, Orange, NSW.

Cause of death

She died from neck compression.

Manner of death

RR's death was intentionally self-inflicted. She died after hanging herself with [redacted]

Recommendations pursuant to section 82 Coroners Act 2009

92. For reasons stated above, I make the following recommendations to Western New South Wales Local Health District:

- WNSWLHD give consideration to extending the prohibited items list in the Adult Acute Unit to include [redacted] in line with the restrictions currently in place in the Mental Health Intensive Care Unit (MHICU).
- WNSWLHD give full consideration to the results of the Back to Base Oximetry Trial currently being undertaken by the Black Dog Institute and Hunter New England Local Health District when they become available, with a view to assessing whether the technology would be useful at Bloomfield Hospital.

Conclusion

93. Finally, I once again express my sincere condolences to RR's family. Their loss is profound and ongoing.

94. I thank RR's family for their participation in this inquest. They have been motivated to improve the health system for others and I commend their efforts in this regard. I thank

them for the generosity they have shown in sharing memories of their much loved family member.

95. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
19 December 2018
NSW State Coroner's Court, Glebe