CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of JP
Hearing date:	2 November – 6 November 2020
Date of findings:	27 November 2020
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death by hanging of an involuntary inpatient – assessment of risk for self harm – decision to discharge – nature and quality of nursing observations.
File number:	2017/317456
Representation:	Coronial Advocate assisting the inquest: G Denman of Counsel i/b Department of Communities and Justice, Legal. Hunter New England Local Health District: L Boyd, i/b NSW Crown Solicitor's Office Dr Dr Siddaiah: S McCarthy of Counsel i/b HWL Ebsworth Dr L Taylor: P Dwyer of Counsel i/b Avant Law. J Thompson: P Kava, New Law Solicitors Registered Nurses G Sharma, M Cormie, S Archbold and J John: P Robertson, NSW Nurses & Midwives Association.

Findings:

Identity
The person who died is JP.

Date of death:
JP died on 19 October 2017.

Place of death:
JP died at the Banksia Mental Health Unit, Tamworth.

Cause of death:
The cause of JP's death is hypoxic brain injury due to hanging.

Manner of death:
JP died when she hanged herself while an involuntary patient in a mental health unit. Her action was taken with the intention of ending her life.

Non Publication Orders

Pursuant to section 75 of *the Coroners Act 2009* [the Act], there is to be no publication of any matter that identifies the deceased person, the deceased person's relatives, and the deceased person's de facto partner.

Pursuant to section 74 of the Act, a non publication order in relation to other material has been made. A copy of the order may be found on the Registry file.

Section 81(1) of the *Coroners Act 2009* (NSW) [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of JP.

Introduction

1. On 19 October 2017 JP died in Tamworth Base Hospital. She was 46 years old, and was an involuntary patient at the hospital's mental health unit. On the morning of 16 October 2017 she had been found unconscious, hanging from the door of her hospital bedroom. She had used her own knitted jumper as a ligature.

2. Tragically JP had suffered severe hypoxic brain injury, and her condition did not improve over the next few days. On 19 October 2017 her life support was removed after consultation with her family, and she was pronounced deceased.

3. At autopsy the cause of JP's death was identified as hypoxic brain injury caused by hanging. A significant contributing condition was bronchopneumonia.

4. Since JP was an involuntary patient at the time of her death, an inquest is mandatory pursuant to sections 23 and 27 of the Act. JP's death raised questions about the adequacy of her care and treatment while in hospital.

5. The main areas for examination were the following:

- the assessment of JP's risk of self-harm
- the decision to discharge JP on 16 October 2017
- the nature and quality of JP's nursing observations on 16 October 2017.

6. The inquest heard evidence from nurses and doctors who had treated JP. The court was also assisted by expert reports and evidence in conclave from:

- Dr Giuffrida, forensic psychiatrist, formerly Director of Forensic Psychiatry for Western Sydney Local Health District.
- Dr Matthew Large, senior staff specialist psychiatrist, Clinical Director of the Eastern Suburbs Mental Health Service, and conjoint professor of psychiatry at the University of New South Wales.

The role of the Coroner

7. The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

8. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

JP's life

9. JP was of Maori background and was born in New Zealand. She moved to Australia in about 2002. Her sister and her father described her as a hard worker, and in the period before her death she was employed as an abattoir worker in Inverell, northern NSW. She had a de facto partner and she was the mother of two adult children.

10. JP's relationship with her partner was turbulent. On 11 October 2017 she was arrested after allegedly trying to run him over in her car.

11. As police had refused bail for JP, she was brought to court on 12 October 2017. The presiding magistrate made an order pursuant to section 33(1)(a) of the *Mental Health [Forensic Provisions] Act 1990* that she receive a mental health assessment. JP was taken that morning to Banksia Mental Health Unit [Banksia].

12. Banksia is a 25 bed psychiatric inpatient unit at Tamworth Hospital, for patients who need intensive treatment. Banksia is administered by the Hunter New England Local Health District [HNELHD]. It was here, four days later, that JP took the steps that led to her death.

JP's mental health history

13. JP had a history of depression and cannabis dependence. She had an inpatient admission at Toowoomba Hospital in May 2014. Her GP had referred her there after becoming concerned at her voicing of homicidal thoughts. JP's condition resolved over her three days' stay and she was discharged *'in a stable condition'.*

14. Two years later JP was admitted to Armidale Hospital, this time for suicidal ideation and a reported attempt to take her own life. She told clinicians she had been planning to buy a rope to hang herself, or to overdose on methamphetamine. She had been in a relationship which she described as violent, and in addition she was stressed about upcoming criminal charges which had been laid against her.

15. In Armidale Hospital JP was diagnosed with adjustment disorder, cannabis dependency, and Cluster B personality disorder. A person with this type of disorder has difficulties regulating their emotions and behaviour. Typically this causes significant distress for the person and those around them and makes it difficult to maintain stable relationships.

16. According to the hospital notes, over the following two days JP's condition settled and she was discharged on 29 July 2016, with a plan for follow up psychological care in the community.

17. On 10 March 2017 JP was sentenced for the offences referred to in paragraph 14 above. She received two year jail sentences which were suspended. This meant that if she committed further offences during the following two year period, it was highly likely she would serve the remainder of her suspended sentence in prison.

18. Seven months after she was sentenced JP was charged with the offences described above, of driving her car in an attempt to cause bodily harm to her partner.

JP's first mental health assessment on 12 October 2017

19. Soon after her arrival at Banksia on 12 October 2017 JP was assessed by Dr Dayananda Siddaiah, a Senior Career Medical Officer. Dr Siddaiah has training in psychiatry and was working as a resident to consultant psychiatrist Dr Lauren Taylor.

20. Dr Siddaiah made quite detailed notes of his assessment. He found JP's risk of suicide to be *'high'*, based on his findings that she was severely emotionally dysregulated, had previously attempted self harm, had current thoughts of self harm, and was withdrawing from multiple substances. He recorded that she was distressed and crying at times, had feelings of hopelessness, and that she believed she would be going to jail because of the new charges.

21. Dr Siddaiah's diagnostic impression was that JP had a borderline and antisocial personality disorder and cannabis dependence. He concluded that she was a *'mentally disordered person'* and he directed that nursing staff give her 'close observations'. Although he did not specify the frequency of the observations, his direction was interpreted by nurses as requiring visual observations at fifteen minute intervals, which were to be documented. This is equivalent to what is known as 'Level 2 Observations'.

22. Dr Siddaiah's Treatment Plan also included that JP was to be reviewed by a consultant psychiatrist, following which a discharge plan

would be formed. In addition Dr Siddaiah documented that police were to be notified before JP was discharged. This is a requirement when a person is discharged from hospital after an assessment that has been directed under section 33(1)(a) of the *Mental Health [Forensic Provisions] Act 1990*.

23. In their conclave evidence at the inquest, Dr Giuffrida and Dr Large concurred that on 12 October Dr Siddaiah had performed a reasonable assessment of JP and had prepared an appropriate Treatment Plan. In their opinion, Dr Siddaiah's diagnostic impression of borderline and antisocial personality disorder and cannabis dependence was also reasonable. Dr Giuffrida however was of the view there was not a basis to exclude a diagnosis of a major depressive disorder or a psychosis. This will be discussed later in these findings.

24. During the remainder of the afternoon JP's allocated nurse, Registered Nurse Jayesh John, documented that JP was *'very anxious, expressing high levels of depression and suicidal ideation, kept on asking for rope to commit suicide'.*

JP's second mental health assessment on 13 October

25. The following day, a Friday, JP was assessed by consultant psychiatrist Dr Lauren Taylor in company with Dr Siddaiah and nursing staff.

26. Unfortunately Dr Taylor was not able to provide a statement or to give evidence at the inquest, for medical reasons. As a result the inquest did not have her evidence about her care and treatment of JP, in particular her mental health assessment. For this I am reliant on Dr Siddaiah's evidence and clinical notes.

27. Prior to the assessment however an incident occurred at 5.10am that morning. Registered Nurse Maddison Cormie saw JP trying to tie her jumper around her own neck. RN Cormie recorded that she told JP this was *'not acceptable behaviour'.* The jumper was the same garment which JP used as a ligature on 16 October. Photographs show it to be long-sleeved, with a loose knit.

28. Later that morning, Banksia social worker Louise Blanchard attempted to discuss with JP her many psychosocial issues. However JP became very agitated, climbing onto the table, screaming and waving her hands around. Since she was clearly too distressed to talk, Ms Blanchard resolved to try again later that day. She did not manage to do so and had a plan to see JP on Monday, after the weekend.

29. Soon afterwards the mental health assessment of JP took place. Dr Siddaiah said that he and Dr Taylor had been made aware of JP's behaviour that morning of tying her jumper around her neck. In Dr Siddaiah's opinion however, the episode had not been *'a determined attempt at self harm'*, but more likely *'parasuicidal/manipulative type behaviour'*. At the inquest he explained that he had interpreted her action as an attempt to get release of her emotions, rather than an act performed with the intention of ending her life.

30. Dr Siddaiah told the court that during the assessment JP was *'engaging'* and showed willingness to get help for her mental health problems. She told himself and Dr Taylor the following:

- she had been depressed for two years but was now willing to try anti-depressant medication
- her relationships with partners had been violent and abusive
- she was *'sick of life'* and two months earlier had tried to hang herself with a rope but it had broken
- she had been cutting her arms because she felt *'angry'* and *'empty'*
- her job at the abattoir was the only thing that had kept her going.

31. It is evident from Dr Siddaiah's detailed notes that there was discussion with JP about her fears of going to prison. JP told them: *'I know that I will go to jail'* and *'I am looking at 7 to 10 years'*. In response Dr Taylor spoke to her about getting assistance from legal aid.

32. According to Dr Siddaiah's notes, Dr Taylor's diagnostic impression was that JP was suffering severe disturbance of mood, borderline personality disorder, cannabis dependence, trauma and dysthymia. Dysthymia is generally defined as a depressed mood sustained over a long period of time, and as having features in common with major depression. Dr Taylor concluded that JP was *'currently mentally ill with severe disturbance of mood [and] require[d] a brief period of inpatient treatment to initiate pharmacoptherapy'*. She directed that JP continue to receive *'close observations'*, that she be commenced on anti depressant medication, and that she be encouraged to seek legal assistance for her criminal charges.

33. Dr Taylor assessed the level of JP's risk to herself and others *'medium'*. As Dr Taylor was not able to give evidence, we do not have her clinical reasons for reducing JP's risk level from *'high'* to *'medium'*. However in his statement (confirmed in his evidence) Dr Siddaiah noted that during the assessment JP had been *'co-operative,engaging and forthcoming with Dr Taylor, was accepting of*

the care and treatment offered, and had no active suicidal or homicidal ideation when questioned'.

34. No change was directed to the level and frequency of JP's observations, which were maintained at 15 minute intervals. Dr Taylor played no further role in JP's care, and was not rostered for duty at any time before JP made her suicide attempt on Monday 16 October.

35. For the remainder of 13 October JP was recorded to be tearful, but compliant with her medication and not voicing any suicidal thoughts.

36. During the afternoon there was a multidisciplinary team meeting in which JP's case was discussed. Those who attended included Dr Siddaiah and Registered Nurse Linda Sutton. Here JP was considered for possible discharge, but according to Dr Siddaiah this was not intended to take place before the following week. There would be a review on the following Monday to assess whether JP's relationship crises had resolved and how she was responding to her medications.

14 and 15 October

37. On Saturday 14 October JP was very unsettled. During the morning she became angry and upturned a lounge and chairs in the communal dining area. At 11.45am she was again observed tying her jumper around her throat, the same garment she had used the previous morning. The knot she made was untied by a nurse and by Dr Peter Kenne who was on duty that morning. Dr Kenne is an on-call Career Medical Officer who provides psychiatric consultation at Banksia.

38. Dr Kenne immediately reviewed JP. He documented that JP *had 'ongoing suicidal ideation'* and that she had been *'seeing her deceased father who is telling her that it is time to join him'*. (In fact JP's father is not deceased). JP also voiced distress and anger at her partner who, she was convinced, would be the cause of her having to go to jail.

39. Dr Kenne told the court that although he believed JP's risk of self harm was still *'medium'*, this incident indicated it was at a level higher than it had been. For this reason he directed that she be moved to the Acute/Observation area of the Banksia unit. This is a physically smaller section of the unit. It has a nurses' station which is permanently staffed and provides direct line of sight of the area's four to five patients, except when they are in their bedrooms.

40. Unbeknownst to Dr Kenne, later that day JP was moved from the Acute/Observation area back into the general area of the unit. The reasons for this are not documented. During the afternoon and evening JP was tearful and she experienced auditory hallucinations. She also

reported a visual hallucination of a *'woman in orange, sitting next to her and speaking with her'*, who sometimes comforted her and sometimes told her to hurt or kill herself.

41. The next day JP had occasional verbal outbursts. Dr Kenne was again on duty that morning, but he did not review JP as he said nursing staff had not raised any concerns about her. Her allocated nurse that afternoon was RN Gaurav Sharma. He spent some time with her, recalling that she was *'low at times and she appeared sad about the police case she was going through'.*

The events of 16 October

42. Endorsed Enrolled Nurse Jodie Thompson was allocated the care of JP on Monday 16 October, together with four or five other patients. Ms Thompson had not previously been involved in JP's care.

43. At about 7.00am Ms Thompson attended a handover from the outgoing shift of night nurses. She recalled being told that the plan was for JP to be discharged into police custody that morning.

44. Ms Thompson described the following events:

- sometime between 8.00 and 8.30am she took JP her morning medication, but JP was angry and refused to take it
- just before 8.30am her supervisor RN Linda Sutton told her to have JP ready for discharge at 10.00am.
- Dr Siddaiah was standing nearby. He told her that he had already faxed through to the hospital pharmacy, JP's medication prescriptions which were sufficient to cover one week. (I note that although Dr Siddaiah could not recall if he had done this, he told the court he has a practice of *'tentatively'* faxing prescriptions to the pharmacy in advance, so as to expedite discharge)
- at about 8.50am Ms Thompson collected discharge paperwork and went to see JP. She said to her: *'I'm preparing for your discharge, I have some papers'*. These included a document known as a Consumer Wellness Plan, which must be discussed with inpatients prior to their discharge.
- JP refused to complete the papers, saying *'I won't be here'* and *'I'm going'*. She then threw a pen in Ms Thompson's direction. Ms Thompson said she did not take JP to be indicating an intention to take her own life but rather, that she was aware she was leaving Banksia
- at about 9.00am Ms Thompson tried to take JP's vital signs observations, but JP would not let her do this. JP was then observed pacing and intermittently banging on her door.
- At about 9.25am Ms Thompson noticed JP walking towards the unit's courtyard.

45. This was the last time Ms Thompson saw JP before her suicide attempt. From the period 9.25am to 9.55am she did not carry out any observations of JP, and we do not know what JP was doing for much of this time. The reason why no observations were taken of JP during this period was because Ms Thompson had been asked to relieve RN Sharma in the nurses' station at the unit's Acute/Observation area. She was unable to find a colleague to cover her observation duties for her own patients, including JP.

46. Ms Thompson returned to her usual duties at 9.50am. She said that Dr Siddaiah told her he needed to see JP for *'a quick review before her discharge'*. Ms Thompson informed him that JP was agitated and had refused her morning medication. She then went in search of JP.

47. As she approached JP's room Ms Thompson saw that the door was closed and there was part of a knitted garment stuck in its upper corner. Ms Thompson immediately activated the duress alarm. With assistance she got the door open, to find JP slumped on the floor with her jumper tightly tied around her neck. JP was unresponsive and was not breathing. With the help of a colleague Ms Thompson immediately commenced chest compressions and mouth to mouth resuscitation.

48. JP was taken by ambulance to Tamworth Base Hospital. Tragically her condition did not improve, and she died three days later.

The assessment of JP's risk of self harm.

49. The focus of this inquest was upon the adequacy of JP's medical and nursing care while she was an inpatient at Banksia. Dr Giuffrida and Dr Large assisted the court with these issues, providing expert reports and giving oral evidence in conclave. The court also heard evidence about changes which have been made to Banksia's policies and procedures since JP's death. These are discussed later in the findings.

50. One of the issues for examination was whether JP's risk for self harm had been accurately assessed by her treating doctors. As noted, JP's suicide risk had been categorised as *'high'* on 12 October, and as *'medium'* on 13 October. Dr Giuffrida and Dr Large were asked their opinion on the appropriateness of these assessments.

51. Dr Giuffrida endorsed Dr Siddaiah's assessment of JP's risk of harm to herself as *'high'*. He expressed surprise that her risk level had been altered to *'medium'* the following day, as the evidence indicated to him that JP's risk for suicide throughout her stay was *'both extreme and imminent in that it was continuous'* (at page 15 of his first report dated 19 September 2019). However he acknowledged the difficulty of a fair

evaluation of Dr Taylor's decision in the absence of direct evidence as to her clinical reasoning. I endorse this and for this reason, make no adverse comment of Dr Taylor on this issue.

52. In contrast with Dr Giuffrida, Dr Large declined to be critical of the reduction in the level of JP's risk for self harm, asserting that Dr Giuffrida's stance had been *'influenced by hindsight and outcome bias'*. Dr Large's position was based on his opinion, stated at page 21 of his report, that there is *'near unanimity in the peer- reviewed literature that the short-term prediction of suicide risk is not possible'*. There was, he stated, *'near universal lack of clarity'* about what the terms low, medium and high suicide risk actually mean.

53. It was evident from their reports and evidence that the two specialists differ in their opinion on the degree to which a person's suicide thoughts and behaviours may be relied upon to predict their risk for suicide. It is well beyond my expertise to conclude whether Dr Large's position on this issue is to be preferred to that of Dr Giuffrida. Nor is it necessary.

54. In my opinion, whether the suicide risk ascribed to JP was *'high'* or *'medium'* played little or no role in her tragic death. As it happened it made no practical difference to the actual care and treatment she received, in particular the level and frequency of her nursing observations. In my view other factors, which are examined later in these findings, were more significant contributors to her death.

55. Dr Giuffrida expressed the further criticism that when assessing JP's level of risk, her treating doctors had not given sufficient regard to her fear of being discharged to prison. In his opinion, she had clearly expressed these fears and they *'almost certainly exarcerbated her thoughts of suicide and almost certainly triggered her intention and a plan as to how she would take her life rather than returning to custody and facing a lengthy prison sentence'* (at page 20 of his first report).

56. The evidence supports Dr Giuffrida's assessment that JP's fear of returning to prison was persistent and prominent, and needed to factor strongly in the assessment of her risk of self harm. I accept Dr Large's opinion that both doctors appeared to be aware of this. JP's fears of a prison sentence are recorded in Dr Siddaiah's own assessment notes on 12 October and those he made of Dr Taylor's assessment on 13 October. In the latter document he notes that Dr Taylor spoke to JP about getting assistance from legal aid. This element also appears in the Treatment Plan documented at the end of the assessment.

57. These features indicate that Dr Taylor and Dr Siddaiah were aware that JP was very distressed by the near certainty that on discharge she

would be returning to custody. It appears they saw the need for JP to seek practical help with her legal problems, and that they encouraged her to do so.

58. In my view however the evidence gives rise to a question whether JP's fear of returning to custody received sufficient consideration the following day, when preparations were made for her to be discharged to police. This issue is now examined.

The decision to discharge JP on 16 October

59. On the evidence, there can be little doubt that the imminent prospect of a return to custody on the morning of 16 October was the immediate trigger for JP's desperate act. The inquest examined the steps that were taken by her treating team that morning, and whether a decision to discharge her was clinically appropriate.

60. A preliminary question was whether in fact a decision *had* been made to discharge JP on 16 October. The evidence presents a confusing picture.

61. On 12 October Dr Siddaiah documented a treatment plan which included that JP would be reviewed by a [consultant] psychiatrist, following which a discharge plan would be made and *'police to be notified before discharge from hospital'*. Notes made of the multidisciplinary meeting on the afternoon of 13 October recorded that JP was to remain as an inpatient until *'Monday'* and there would be a discharge to police custody.

62. However, on the morning of Monday 16 October the following took place:

- Ms Thompson was told by the outgoing nurse shift that JP *would* be discharged that morning. Soon afterwards RN Sutton told her to have JP ready for discharge at 10.00am
- although Dr Siddaiah was unable to recall whether he had done so, it is likely that he told Ms Thompson he had faxed JP's medication prescriptions to the hospital pharmacy that morning
- at about 8.50am Ms Thompson collected discharge paperwork, including a document called a Consumer Wellness Plan, and told JP she was preparing for her discharge
- about an hour later Dr Siddaiah asked Ms Thompson to bring JP for a review.

63. These events strongly suggest that JP's treating team expected her to be discharged that morning. In his statement Dr Siddaiah acknowledged that on 16 October discharge was certainly contemplated. He amplified this in his evidence at inquest, stating that after JP's assessment on 13 October he had felt confident she would be

suitable for discharge the following Monday. However he was clear that discharge was contingent upon a review *'to assess whether [her] situational crisis had resolved, assess any response to medication, and to consider whether there had been any developments of concern'.*

64. It can be assumed that when Dr Siddaiah spoke of a review, he was referring to the requirement that a consultant review be undertaken within 24-48 hours prior to the transfer of care of a mentally ill inpatient. This is mandated in NSW Health's policy directive *Transfer of Care from Mental Health Inpatient Services*, current at that time. The requirement for a consultant review is found at Stage 4: 'Confirming Readiness for Transfer of Care (within 24-48 hours of transfer)'. Reassessment of a patient's suicide risk is an essential element of the review.

65. This policy directive is designed to promote safe and effective transfer of patients from their inpatient units, by way of discharge into the community or to another inpatient setting. It does not specifically deal with the situation of inpatients who are to be discharged into custody, but I have assumed that the key elements remain applicable to their situation. That is, that such patients require a planned approach to their transfer, so as to ensure that they are clinically appropriate for transfer and that there will be continuity in their mental health care.

66. The staged approach set out in the policy directive contemplates that the consultant review referred to in paragraph 64 above will take place prior to discussions with the patient about transfer arrangements, including completion of the Consumer Wellness Plan. Yet in JP's case her treating team appears to have set about performing these tasks in circumstances where the psychiatric review had not yet been conducted.

67. I have concluded that although a formal decision had not been made on 16 October to discharge JP from hospital, the actions taken by those involved in her care reflected an assumption that this would be the case. This was despite her treating team being aware of her highly unsettled and disturbing behaviour throughout her stay, and despite the fact that no psychiatric review had been performed. It is safe to assume that JP herself was convinced that she was to be discharged that morning.

68. Dr Giuffrida was strongly of the view that it was not appropriate to have considered discharging JP on 16 October. He commented at page 20 of his first report that she was *'still in the acute phase of her illness and would require a lengthy period of treatment in hospital before she was likely to enjoy any significant relief of any of her symptoms of anxiety or depression and any significant reduction of her suicidal self harm risk'.*

69. In his report Dr Large disagreed that JP's treating team should not have considered her for an early discharge. However he tempered this opinion with his oral evidence at inquest. Commenting that by Monday JP remained very distressed, disorganised and vulnerable, Dr Large thought it likely that Dr Siddaiah would have concluded, in his assessment that morning, that JP was *not* ready for discharge. It may be inferred from these comments that Dr Large would have agreed with such an assessment.

70. The consensus therefore is that it would not have been clinically appropriate for JP to have been discharged on the morning of 16 October.

Communications with JP on 16 October

71. As noted, it is highly likely that JP's conviction that she was to be returned to custody precipitated her desperate act to hang herself. This raises a question as to the appropriateness of the communications she received that morning.

72. At the inquest there was consensus between Dr Giuffrida, Dr Large and Dr Siddaiah that there is a need to communicate in a sensitive manner the news to a person in JP's circumstances that she is being considered for a discharge into custody.

73. In Dr Large's opinion the decision to discharge needed to be communicated in a private space by the primary nurse, following the psychiatric review. In the period prior to that, although it was important for nursing staff to deal honestly with anxious patients, it was preferable that the likelihood of a discharge to custody not receive too much foreshadowing. Dr Giuffrida concurred with this approach. He added that in JP's circumstances there needed to be a discussion with her about her fears of custody and what arrangements would be made for her proper care in prison. Given the difficulties that staff had experienced engaging with JP, it would have been appropriate to involve the multidisciplinary team in these discussions, in particular social work staff.

74. It cannot be said that the communications with JP on 16 October conformed with these recommended practices. They also appear to be inconsistent in important ways with the staged approach described in the *Transfer of Care* policy directive. JP was simply told at 8.50am that preparations were underway for her discharge that morning. There had been no medical review that day of her risk for suicide or her readiness for discharge, no discussion about her fears of custody, no attempts to reassure her about her care arrangements, and no involvement by

social work staff. It is little wonder that JP was left with a sense of desperation and hopelessness.

75. It is possible that the above steps would have been taken during or following the planned psychiatric review of JP. If so however I am unclear why Ms Thompson was left to communicate a decision to discharge *prior* to that review having taken place.

76. I do not at all suggest that Ms Thompson was responsible for these deficiencies in communication. First, it is entirely unclear why she was tasked to tell JP she was to be discharged, in circumstances where the psychiatric review had not yet taken place. She was directed to do this by others in the treating team. Secondly, JP's distress levels on receipt of this news almost certainly precluded Ms Thompson from engaging with her in any meaningful way. This however underlines the need for a careful and considered approach to communicating such information to a person in JP's situation.

77. Following Ms Thompson's unsuccessful attempt at 9.00am to take JP's vital signs, there is no record of any further communication with JP. Convinced that she was returning to prison, it was during this period that she took action to end her life. It is possible (but of course not certain) that the outcome would have been different had a more considered approach been taken that morning to the task of communicating with JP about a possible discharge.

78. Having carefully considered the evidence regarding staff interactions with JP on the morning of 16 October I conclude that they were sub optimal, in the respects described above.

79. I have considered whether there is a need to recommend any changes to policies and procedures in this area. The conclusion I reach is that there is not. The *Transfer of Care* policy appears to make comprehensive and sound arrangements. These are designed to ensure careful decisions about discharge, and to promote clear and considerate communications with patients about them.

80. I have found there were shortcomings in the way in which JP's treating team implemented this policy, in particular in the lack of consideration given to how these difficult discussions with JP were to be held. However it is to be hoped that a recent policy reforming the nature of patient engagement has brought improvements in this area. In July 2017 NSW Health released a new policy directive *Engagement and Observation in Mental Health Inpatients Units*. The purpose is to emphasise the performance of therapeutic observations of mental health patients, as opposed to mere visual observations. Clinical staff are encouraged to develop rapport with their patients, and by these means to make a better assessment of their risk of harm and contribute to their recovery.

81. By 2019 all Banksia staff had received training in the new policy. The policy change was commended by Dr Giuffrida and Dr Large as introducing a genuine cultural shift in the care of mentally ill people. Engagement with patients that is informed by these principles is a very positive change, and encourages the more sensitive approach that JP required on the morning of 16 October.

The hiatus in nursing observations on 16 October

82. The third area for examination is the critical period on the morning of 16 October when no observations of JP were performed. At the inquest Ms Thompson told the court that she carried out JP's required 15 minute nursing observations that morning up until 9.25am. This was when she was directed to relieve a colleague in the Acute/Observation area who had gone onto his rostered tea break. No one was available to cover nursing observations of Ms Thompson's allocated patients from this time until Ms Thompson returned to her usual duties at 9.50am. It was about five minutes later that she discovered JP unconscious in her room.

83. Thus for the period 9.25am onwards JP was unobserved and uninterrupted by anyone, giving her the opportunity to attempt to hang herself.

84. Level 2 nursing observations do not require that a patient be monitored at all times. For this reason it is not suggested that if the required observations had been performed JP would *not* have had the opportunity to take her own life. Nevertheless the observations regime is important for the safety and welfare of vulnerable patients, being designed to mitigate the risk they will attempt such action.

85. At the inquest the court heard that since JP died, the HNELHD has taken steps to ensure that the duties of relieving nurses will always be covered by a colleague. A roster is now in place to ensure that the relieving nurse's duties, including observations of their patients, is transferred to a nominated colleague. This system change is welcome.

86. Before leaving the issue of observations, a missing document needs to be noted. Within hours of JP's suicide attempt, the Level 2 Observation Sheet documenting her 15 minute nursing observations for 16 October was unable to be found. It has never been located. An investigation was conducted by the LHD's Human Resources but it failed to discover what happened to the missing document.

87. Banksia and other health facilities within the HNELHD still use paper files for medical and nursing records. With such a system it is almost inevitable that documents will be misplaced from time to time. However

the court heard that over the next three to five years, health facilities within the LHD will transfer to an electronic records system. According to Dr Brendan Flynn, the Executive Director of Mental Health for the HNELHD, all records of mental health patients will be documented electronically including their nursing observations. I expect this will reduce the incidence of records going missing.

88. I will now address some remaining issues for examination.

Diagnosis of JP's mental health condition

89. I have noted there was disagreement between Dr Giuffirda and Dr Large as to whether JP ought to be have been diagnosed with a major depressive disorder or psychosis. In Dr Large's view the evidence supported a diagnosis of the depressive condition dysthymia, but fell short of supporting a diagnosis of major depression. Dr Giuffrida disagreed. However for similar reasons to those set out in paragraph 54 above, I have concluded this is an issue which had little influence on the care and treatment actually provided to JP, or on the preventability of her death.

90. Both witnesses agreed that while in Banksia JP had been prescribed appropriate medication.

Hanging points

91. At the inquest the court heard evidence about what steps Banksia has taken to reduce ligature hanging points in its furniture and furnishings. The LHD provided evidence that on 23 July 2018, works commenced at Banksia to install ligature-free door handles. Viewing windows and 'kitten doors' (which enable staff to enter a patient room in an emergency) have also been installed.

92. It was noted however that on 16 October JP did not use a hanging point. She managed to fashion a ligature by attaching her jumper over the top of her bedroom door. I acknowledge that despite efforts to reduce self harm opportunities in mental health hospitals and prisons, it will never be feasible to eradicate all such risks. While mental health units need to be safe places, they also need to offer a comfortable and humane environment in the interests of promoting patient recovery.

93. A related issue was whether JP's nurses ought to have removed JP's jumper after she had been observed on two occasions tying it around her neck. The court heard that Banksia policy is to remove items such as shoelaces, belts and cords from patients. Dr Giuffrida agreed with Dr Large that it can be a difficult decision to remove personal items from a patient, given the need to maintain a humane environment. He agreed further that numerous personal items can offer opportunities for self harm. Nevertheless in Dr Giuffrida's opinion, since this specific

garment had been used by JP in this specific manner on two occasions, removal of it would have been warranted. It is hard to disagree with this conclusion.

Patient capacity

94. There was evidence at the inquest that on the morning JP made her suicide attempt, Banksia was six patients over its capacity. There is no direct evidence that this was a factor in JP's death; nevertheless the court heard that since then the LHD has introduced a procedural change to Banksia admissions. There is now in operation a Patient Flow Escalation Process, whereby patients are not directly transferred to Banksia but are taken to Tamworth Base Hospital's Emergency Department for triaging. From there the Emergency Department liaises with Banksia regarding bed availability. If Banksia is at capacity, arrangements will be made for the patient to be taken to another mental health unit within the LHD.

95. In his evidence Dr Flynn provided information that in the twelve months previous to June 2020 it had rarely been the case that Banksia had not had the capacity to admit a new patient.

A new Banksia Inpatient Unit

96. Planning has commenced for the building of a new Banksia Mental Health Unit, to completely replace the existing one. The project is still in its early stages. The court heard that the new unit will have capacity for eight additional beds. It is also intended that it will create better spaces for categories of patients with distinct needs, such as elderly patients and young persons. Furniture and furnishings will be designed to reduce as far as is feasible the availability of hanging points.

97. It is welcome news that there will soon be additional capacity to help address the growing need for mental health services.

Question of recommendations

98. Since JP's tragic death, Banksia has introduced a number of changes which obviate the need for recommendations to be considered. These include the changes referred to in paragraphs 80, 85 and 91 above, as well as the planned transition to electronic records. For this reason I do not intend to put forward any recommendations for consideration.

99. It was evident that JP's very sad death has had a painful impact on many people, foremost of course her family and those close to her. Other people affected include those who treated her in hospital, some of whom at inquest expressed their regret at her death and their sympathy for her family. It was commendable that the LHD's Executive Director of Mental Health attended each day of the inquest to hear the

evidence and to provide his own, in order to assist with the questions raised by JP's death.

Conclusion

100. I will close by expressing my sincere sympathy to all those who loved JP. I wish also to thank Counsel Assisting the inquest, the representatives of the interested parties, and the Officer in Charge of the coronial investigation, for their valuable assistance in the matter.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity

The person who died is JP.

Date of death

JP died on 19 October 2017.

Place of death

JP died at the Banksia Mental Health Unit, Tamworth.

Cause of death

The cause of JP's death is hypoxic brain injury due to hanging.

Manner of death

JP died when she hanged herself while an involuntary patient in a mental health unit. Her action was taken with the intention of ending her life.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

Date
27 November 2020