CITATION: *Inquest into the death of Sarah Rose Higgins NTMC 065 [2003]*

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
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FINDING OF:	Mr Greg Cavanagh SM
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REPRESENTATION:

Counsel:

Assisting:	Ms Elizabeth Morris Mr Michael Grant
Representing Territory Health Services:	Mr John Reeves QC Ms Sally Sievers

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IN THE CORONER'S COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No: D0056/2002

In the matter of an Inquest into the death of

SARAH ROSE HIGGINS ON 16 MARCH 2002 AT THE ROYAL DARWIN HOSPITAL IN THE NORTHERN TERRITORY OF AUSTRALIA

FINDINGS

(Delivered 19 December 2003)

Mr Cavanagh SM:

The nature and scope of the inquest

1. Sarah Rose Higgins ("the deceased") tragically hung herself in the Cowdy Ward at some time between 1330 hours and 1400 hours on 14 March 2002. She was placed on life-support and subsequently pronounced dead on 16 March 2002. At the time, the deceased was subject to an order made pursuant to the *Mental Health and Related Services Act*. As a result, she was a "person in care" within the meaning of s12 of the *Coroners Act*.

2. Section 34(1) of the Act details the matters that an investigating coroner is required to find during the course of an inquest into a death. The section provides:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
> (i) the identity of the deceased person;

(ii) the time and place of death;
(iii) the cause of death;
(iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*; and
(v) any relevant circumstances concerning the death; or

(b) a disaster shall, if possible, find –
(i) the cause and origin of the disaster; and
(ii) the circumstances in which the disaster occurred."

3. Section 34(2) of the Act operates to extend the Coroner's function as follows:

"(2) A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

4. The duties and discretions set out in subsections 34(1) and (2) are enlarged by s35 of the Act, which provides as follows:

"(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

"(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner."

5. The public Inquest in this matter was heard at the Darwin Magistrates Court between 8 and 11 September 2003. The matter was subsequently adjourned to 9 and 10 October 2003 for further evidence and submissions. Counsel assisting me over the course of the Inquest were Ms Elizabeth Morris and Mr Michael Grant. At the commencement of the inquest, Ms Sally Sievers sought leave to appear on behalf of Territory Health Services. I granted that leave pursuant to s40(3) of the Act. Ms Sievers appeared on behalf of Territory Health Services during the opening week

of the Inquest. At the resumption of the inquest, she was led by Mr John Reeves QC.

6. I was advised at the outset of the Inquest that the circumstances of the death have caused significant distress to the deceased's family. It was further submitted that any reporting of the matter which disclosed the deceased's name, and involved the publication of sensitive information in relation to the deceased's medical condition and family circumstances, would only serve to exacerbate the family's distress and that a suppression order was sought.

7. In matters of this nature of the Coroner's Court generally imposes certain restrictions on the publication of reports of the proceeding. The power to do so is found in s43 of the *Coroners Act*. That section provides: --

> **"43. Restriction on publication of reports**
>
> "(1) A coroner shall order that a report of an inquest or of part of the proceedings, or of evidence given at an inquest, shall not be published if the coroner reasonably believes that, to publish the report, would -
> (a) be likely to prejudice a person's fair trial;
> (b) be contrary to the administration of justice, national security or personal security; or
> (c) involve the disclosure of details of sensitive personal matters including, where the senior next of kin of the deceased have so requested, the name of the deceased.
>
> "(2) A person shall not publish a report in contravention of an order under subsection (1).
>
> "Penalty for an offence against this subsection: $10,000 or imprisonment for 2 years."

8. I considered that an order suppressing the publication of any information disclosing the deceased's medical condition was broader than required,

and would have been unduly restrictive in terms of permissible media coverage. In the circumstances, I made an order restricting the publication of any report of the matter which disclosed the deceased's name and the names of any of her family, including her parents. That order remains in place.

Formal findings

9. The mandatory findings pursuant to s34(1) of the Act are as follow.

(1) The identity of the deceased is Sarah Rose Higgins, who was born in Liverpool in the United Kingdom on 25 July 1982.

(2) The deceased died at the Royal Darwin Hospital on 16 March 2002.

(3) The cause of death was hypoxic encephalopathy as the result of attempted hanging.

(4) The particulars required to register the death are:

(i) the deceased was female;

(ii) the deceased was Caucasian;

(iii) a post-mortem examination was carried out and the cause of death was as detailed above;

(iv) the pathologist viewed the body after death;

(v) the pathologist was Dr Paull Botterill, a Locum Forensic Pathologist at the Royal Darwin Hospital;

(vi) the father of the deceased is Glen Lee Higgins;

(vii) the mother of the deceased is Rose Elizabeth Higgins;

(viii) at the time of her admission to Cowdy Ward, the deceased resided in a rented two bedroom flat in Reynolds Court, Coconut Grove; and

(ix) the deceased was not employed at the time of her death.

10. There is no suggestion that the deceased's hanging was not self-inflicted. Indeed, I am satisfied that the deceased intended to end of life by her actions.

Relevant circumstances concerning the death

I find on the evidence as follows;

11. The deceased was born in the United Kingdom on 25 July 1982. The deceased moved with her parents to Darwin when she was 11 years old and resided here up to the time of her death. She was 19 years of age at the time of her death. She was a single mother of a 22 month old son.

12. The deceased had a close relationship with her parents, who both attended during the course of the Inquest and gave evidence. The father of the deceased is a member of the Australian Defence Forces and the mother of the deceased was employed by the Northern Territory Police as a Forensic Technician. Both parents were entirely supportive of the deceased and maintained a close relationship with her and her son.

13. The deceased had a happy and unremarkable childhood and adolescence. She did well at school and completed year 11 at Casuarina Secondary College. The deceased was a mature adolescent who had weekend employment and babysitting jobs from a young age. During her school years the deceased was involved in athletics and swimming.

14. In 1998 the deceased entered into a de facto relationship with a local man employed by Paspaley Pearls. They maintained the relationship until January 2001. This was the deceased's first and only serious relationship. The relationship broke down and the couple became estranged prior to the deceased's death. He is the natural father of the deceased's son.

15. Various clinical notes made before her death indicate that the deceased was depressed about the termination of the relationship. Certain material tendered during the cause of the Inquest indicates that the deceased was a recreational user of marijuana and alcohol, and occasionally the drug known as “ecstasy”, and it would appear that her use of marijuana and alcohol increased following the breakdown of the relationship.

16. The deceased first described symptoms of mental disturbance to her general practitioner in or about January 2002. She reported that she was suffering from auditory hallucinations and paranoia. The deceased described herself as depressed, not coping, teary, lonely and isolated and having horrible dreams. She attended upon her general practitioner on 5 occasions in early January 2002. She was prescribed haloperidol, an anti-psychotic medication, without the benefit of an attendance upon any specialist mental health practitioner.

17. The deceased's mother became concerned at her lack of response to the medication and the lack of any specialist input. As a result, the mother of the deceased contacted the Tamarind Centre to arrange for the deceased's attendance there. The deceased first attended at the Tamarind Centre on 24 January 2002, and was subsequently admitted to the Cowdy Ward as a voluntary patient on 26 January 2002. She was well enough to take supervised leave with her mother on 27 February 2002.

18. On 1 March 2002, medical staff at the Cowdy Ward determined that the deceased should be detained as an involuntary patient. The deceased was apparently upset with that decision, but appeared to accept it.

19. On 6 March 2002, the Mental Health Review Tribunal made a seven day detention order. On that same day, the deceased was given unescorted leave on the hospital grounds, and was allowed supervised leave with her

parents. On 9 March 2002, the deceased had day leave with her parents. On 11 March 2002, the deceased had overnight leave with her father. Upon her return on 12 March 2002, the deceased's father expressed concern that she would be unable to cope if discharged at the expiry of the seven day order then in place.

20. On the evening of 12 March 2002, the deceased absconded from the Cowdy Ward. She was found and returned by her father in an intoxicated state.

21. On 13 March 2002, the Mental Health Review Tribunal made a further seven day detention order. Again, the deceased had sought discharge at hearing and was disappointed with the decision. She was of the opinion that the environment in the Cowdy Ward and her exposure to certain of the other patients was exacerbating her condition. That was a concern shared by the deceased's parents, although as stated they did not consider her condition was sufficiently stable to be released back into the community at that point in time.

22. Having regard to the mental condition of the deceased, the treatment regime ordered by the doctors included R15 observations, which required that she be sighted every 15 minutes and that her whereabouts be known at all times, and this was in place on 14 March 2002. She appears to have been last sighted at lunch at or about 1330 hours, although formal observations had not been taken for some time prior to that. She was found hanging in her room at or about 1400 hours. The immediate reason for that failure in observation was that the nurse charged with responsibility for conducting the observations was providing assistance with a difficult patient elsewhere on the Ward, with the unfortunate consequence that the deceased went unattended and unobserved.

23. A number of matters of concern in relation to public health were raised prior to and during the course of the Inquest. All health care professionals who played any significant role in the treatment of the deceased were called to give evidence during the course of the Inquest. During the course of the coronial investigation of the death by the Northern Territory Police, an independent expert review of the medical and outpatient files and relevant statements was commissioned by my office and undertaken by Dr Campbell, a Consultant Psychiatrist, and Brian O'Grady, a Clinical Psychologist. Dr Campbell is a Psychiatrist with 30 years experience who has held appointments as Director of Clinical Services at the Rozelle Hospital, as a member of the New South Wales Mental Health Review Tribunal, and various advisory and teaching appointments. Mr O'Grady is a Clinical Psychologist with extensive experience with serious mental illness who specialises in providing psychological assessment and treatment for patients with treatment-resistant positive symptoms of psychosis. I received evidence from both experts during the course of the Inquest. I should also note that the investigation undertaken by the coronial investigator viz. Acting Supt Jeanette Kerr was extensive and thorough in nature. Acting Supt Kerr's input into the investigative process was enhanced by the fact that she has certain qualifications in this field beyond that of the general police officer.

24. I will deal with each issue of concern in turn.

The treatment by the general practitioner

25. As stated, the deceased first recounted symptoms indicative of a psychosis to her general practitioner in early January 2002. She was not thereafter referred to specialist psychiatric care, and that was eventually done at the behest of the deceased's mother. Given the deceased's presentation, in my view she should have been referred earlier for

specialist psychiatric care. It is possible that had this been done, her condition may not have become so acute, however it is not possible to make any positive finding to that effect. It is to be noted that my view in this regard is with hindsight and I accept that the general practitioner was (and is) entitled to his considered view as to treatment.

26. In making these observations I also recognise the fact that the general practitioner involved has had significant experience over time treating patients with symptoms of psychiatric illness in the community given the shortage of psychiatric specialists in Darwin in years gone by. Times have now changed in Darwin and the early referral to psychiatric specialists is to be encouraged where the patient is manifesting florid symptoms of mental illness.

The failure to conduct observations

27. There is no dispute that the observations on the deceased were not conducted in accordance with the R15 observation regime. The deceased had been placed on R15 observation status because she was assessed as being at moderate risk of suicide or self-harm, or of absconding from the ward. Apart from the requirement of 15 minute observations, that observation status brought with it certain other requirements, and in particular:

(1) that the attending nurse be aware of the patient's whereabouts at all times; and
(2) that the attending nurse not be burdened with other duties during any period when he or she is responsible for conducting observations.

28. The evidence discloses that these requirements were not met in the subject case. The observation sheets tendered during the course of the

Inquest show that on the day of her hanging the deceased was not sighted at all between 1200 hours and 1300 hours, and again between 1330 hours and 1400 hours, when she was located hanging in her room.

29. Ms Nooroa was responsible for and took the observations between 1030 hours and 1130 hours. Thereafter she handed responsibility to Mr Nolan. Mr Nolan made observations at 1130 hours, 1145 hours and 1200 hours. It is unclear who assumed responsibility for the deceased's observations after 1200 hours. None of the nurses or care staff on duty at the time admits having responsibility for the observations between 1200 hours and 1330 hours. During that period the deceased was seen by Ms Trenouth at 1300 hours. At that time Ms Trenouth was attending to a new patient on special observations. The deceased was seen by Mr Nolan at 1330 hours. That was a casual observation of the deceased walking from the dining area. Responsibility for the deceased's observations was assumed by Ms Mulherin at 1330 hours. There is some suggestion in the evidence that Ms Mulherin had responsibility for making the observations from 1300 hours, but was busy and unable to do so. Ms Mulherin's evidence was that she did not assume responsibility for the observations until 1330 hours. That is consistent with the general pattern that a staff member would assume responsibility for observations for a period of one hour commencing on the half hour.

30. During the period in which she was responsible for observing the deceased, Ms Mulherin was called to assist with another patient who was exhibiting some resistance to treatment by a male staff member. The responsibility for observing the deceased was not passed to any other staff member. Nobody undertook the scheduled R15 observations at 1330 hours and 1345 hours. The deceased was not seen again until found hanging in her room at or about 1400 hours. The deceased went for something in the order of two hours without appropriate observations.

The primary reason the deceased was involuntarily confined in the Cowdy Ward and not in the general community was so that she could be subject to a level of treatment and observation commensurate with her condition. The purpose of that involuntary detention was to ensure her safety. There was a failure of purpose.

31. The breakdown in the observation procedures is a matter of great concern in circumstances where in 1999 I conducted an inquiry into a death at the Cowdy Ward in circumstances where there was a similar delinquency in relation to the observation regime (Chung Wah deceased). At that time I noted that Territory Health Services had apparently made efforts towards tightening observation procedures and in educating staff to ensure a similar death did not happen again. Those efforts have been manifestly unsuccessful, at least in this case.

32. Institutions, including mental health institutions, are properly the subject of rigorous scrutiny in the course of the coronial process, especially where as in this case, citizens are kept against their will. In doing so, however, it is always necessary to make allowance for the fact that the coronial process is conducted with the benefit of hindsight. It is not appropriate to judge those individuals whose actions are the subject of scrutiny during the course of that process in accordance with the counsel of perfection. That, of course, does not detract from the requirement that the coronial process identify any institutional deficiencies with a view to making recommendations directed to the prevention of future deaths. The Coroner is required in these circumstances to find any relevant circumstances concerning the death, and to make relevant recommendations, if any, with respect to the prevention of future deaths in similar circumstances.

33. These duties reflect the fact that one of the primary purposes of the coronial jurisdiction is "to seek out and record as many of the facts surrounding the death as public interest requires": see *R v South London Coroner; Ex parte Thompson* (1982) 126 Sol J 625 at 628. This function finds voice in ss26 and 34(1)(a)(v) of the Act. It falls to the Coroner, inter alia, to draw together the investigation materials to see what can be learned and understood, and what may be done to avoid repetition of adverse events.

34. In this case, and notwithstanding the measures that were put in place in 1999, it would appear that staff were not altogether familiar with the detail or requirements of the observation policy. The policy has been subject to revision on three occasions from March 1999. Not all staff were aware which policy was current. I gleaned from the evidence that staff understanding of the requirements which governed the conduct of observations were derived from what was accepted in practice on the floor of the Ward, rather than from what was actually prescribed in the policy document. Familiarity with the policy document, and strict compliance with the procedures set out in that document, were not accorded the importance they should have been.

35. There was also a lack of consistency in the handover process. The requisite observation sheets were kept on the observation board. The evidence discloses that at handover time the board was sometimes transferred manually from one staff member to the next. In other circumstances, the board was simply picked up from the central office on the Ward without any formal handover. It was Ms Trenouth's evidence that although she was undertaking special observations on one particular patient, she was also attempting to conduct observations on the other patients at various stages of the day because nobody else was doing so.

That in itself should have alerted staff to the fact that observations were not being conducted appropriately.

36. At the relevant time the observation policy did not provide for regular observations to be handed over to another nurse in the event that the responsible nurse was called away to an emergency. It is pleasing to see that the policy has since been amended to rectify that situation, although commonsense and sound clinical practice should have dictated the adoption of such a measure even in the absence of some express formulation in the policy.

37. It is possible that if the observations had been conducted appropriately the death could have been averted. The evidence of the forensic pathologist was that only a relatively short time need elapse between the application of the ligature and terminal injury. In this case the deceased obviously took some time to prepare herself. She lit a candle. She wrote a note. She changed into her best clothes. I consider it likely that had the deceased been sighted every 15 minutes, as prescribed, she would have been interrupted in those preparations.

38. Despite the various uncertainties alluded to above in relation to the precise detail of the policy and the handover processes, there can be no doubt that all staff were aware that a patient on R15 observations is required to be sighted every 15 minutes. There is also no doubt that staff are aware that at any given time one member of staff must be responsible for those observation duties. The failure to implement and comply with those procedures in this case was due to human error. I cannot emphasise too strongly the fact that if the treating medical practitioner has formed the view that a mentally ill patient requires observation and has allocated an observation status for that reason, psychiatric nurses and care staff must act in accordance with that direction.

39. It is very difficult to frame a recommendation directed to ensuring that this takes place. There is an observation policy in place and it is plainly the corporate responsibility of supervisors and administrators to ensure that there is compliance with that policy, and the individual responsibility of nurses and care staff to ensure that they comply with the policy. It became apparent during the course of the Inquest that there was a significant degree of angst among staff after this death. That is to be expected. It was also apparent to me that staff within Mental Health Services are hard-working, dedicated and well-qualified. In the aftermath of the death there were a number of reviews, one effect of which would have been to reinforce the importance of compliance with the observation policy in the minds of all staff. I cannot see that there is any comment or recommendation that might be made in this forum which would operate to further heighten awareness of the importance of complying with the policy.

40. There is, however, one matter relevant to the observation policy that is amenable to recommendation. When the policy was revised in March 1999, there was a requirement for regular category observations in the following terms:

> "… that the attending nurse keep the patient within visual range whilst the patient is in general ward areas, to enable observation of the patient's general behaviour and interaction."

41. I note that the Inquest into the earlier death to which I have adverted above was conducted in April 1999. The March 1999 policy was presented during the course of that Inquest as a policy document revised in response to the death, and was endorsed as appropriate during the course of the Inquest. The findings in that Inquest were delivered in June 1999. In June 1999, I can only assume coincidentally, the policy was revised and the requirement that patients be kept within visual range

whilst in general ward areas was removed. That requirement remained excised from the policy following a review in April 2002. There was some evidence given by Ms Bradley during the course of the inquest to the effect that such a requirement is too restrictive, and that the configuration of the Ward is such that all patients on observations would need to be kept in the one area.

42. I do not accept those reasons. It may well be the case that best practice standards call for psychiatric patients to be cared for in the least restrictive environment possible. I accept that in the general course. However, in circumstances where a patient has been placed on observations because there is some concern about a risk of self-harm there is necessarily a restriction imposed. It is appropriate in those circumstances that the patient be kept within visual range when in the general ward area. That does not mean, as counsel for Territory Health Services sought to submit, that all patients on observations would have to attend the toilet at the same time.

43. It is my formal recommendation that the observation policy be amended to require for regular category observations that the attending nurse keep the patient within visual range whilst the patient is in general ward areas, to enable observation of the patient's general behaviour and interaction. That was apparently considered appropriate by Territory Health Services following the death of Chun Huang. The requirement was subsequently removed. There has now been another death in similar circumstances. The amendment would serve to reinforce in the minds of staff the seriousness that attends the allocation of observation status, and would ensure as far as possible that any aberrant or unusual behaviour is identified.

Staffing levels

44. Following the death of the deceased the Top End Mental Health Services Executive commissioned an internal review into the death. That review was undertaken by Ms Pat Bradley, the Acting Executive Director of Nursing with Top End Mental Health Services. She was assisted by Mr Peter Mals, a senior allied health professional. The findings of the review were delivered on 2 April 2002. Those findings identified the "immediate cause" of the death as a "breakdown of regular observations system" and "failure to secure continuity of monitoring". The review went on to identify certain "underlying causes", including "excess bed numbers", "demand on nursing staff" and "overcrowded environment".

45. In order to understand the basis for those conclusions, it is necessary to give some consideration to the situation which presented in the Cowdy Ward at the time of the death. The Ward is designed to accommodate 12 patients. It is possible to accommodate 18 patients on the Ward if some are roomed together. In the 12 months prior to March 2002 there had been occasional spikes in occupancy where patient numbers on the Ward had increased to in excess of 20. From some time shortly prior to the death of the deceased, the Ward experienced a sustained occupancy rate above 20 patients. The chart annexed to Mr Rowe's statement at exhibit 15 indicates that this sustained increase dated from in or about mid-March 2002. Ms Bradley's report indicates that the sustained increase dated from mid-February 2002. Whatever date is adopted, the increase was practically contemporaneous with the death.

46. In order to accommodate any increase in patient numbers beyond the capacity of the Cowdy Ward proper, it was necessary to open the Joan Ridley Unit, which is the high security Ward within Mental Health Services.

47. The Cowdy Ward was funded for 21 patients. In other words, the budgetary allocation assumed that there would be a mean occupancy of 21 and provided funding to allow for, inter alia, the engagement of sufficient numbers of nursing and ancillary care staff to cater for that patient load. During some periods the patient load would be higher, requiring staffing levels beyond the notional budgetary allocation. During other periods the patient load would be lower, allowing for some saving. It was the responsibility of the clinical nurse consultant in charge of the Ward to ensure that there were sufficient numbers of staff to cater for the number of patients on the Ward at any given time. This was done using the staff on permanent roster, supplemented by a pool of casuals.

48. There is a shortage of trained and experienced psychiatric care staff in Darwin. That shortage meant that staff numbers on the Cowdy Ward were often made up by casuals who had already worked a shift elsewhere. The Cowdy Ward is an entirely reactive care facility, in that it is impossible to plan for the precise numbers on Ward at any given time. The Ward is bound to accept all acute admissions. A number of unexpected admissions in short order will have a significant impact on the staff to patient ratio. For obvious logistical reasons, it is not possible to address any staff shortage immediately. The patient profile includes rural and remote patients, mothers with babies, patients whose first language is something other than English, and patients in the grip of psychosis or hypomania. For periods leading up to the death of the deceased there were frequently more than 20 patients in the unit, and on occasion in excess of 25. It is against that background that the review identified excess bed numbers, demand on nursing staff and overcrowded environment as underlying causes of the death.

49. It has been submitted by counsel for Territory Health Services that the scope of this Inquest is limited. It is conceded by counsel that to the

extent the failure to conduct observations on the deceased was caused by inadequate staffing levels, the staffing levels and any matters directly related thereto fall within the purview of the Inquest. Conversely, it is submitted that the general management of Mental Health Services, the budgetary/funding arrangements for the Cowdy Ward, and the general management, clinical practices and policies adopted or used within Top End Mental Health Services fall outside the jurisdiction of the Coroner.

50. I have previously given some consideration to the ambit of the coroner's jurisdiction in relation to findings, comments and recommendations in the matter of an Inquest into the Death of Kanisha Turner (unreported, Coroners Court, Mr Cavanagh SM, 18 August 2000). As stated there, I am of the opinion that s34 of the Act does not limit the Coroner to an examination of factors causative of the death. Paragraph 34(1)(a)(iii) requires the Coroner to find, if possible, the cause of death. As earlier detailed, paragraph 34(1)(a)(v) goes on to provide that in addition to finding the cause of death, the Coroner must also find the relevant circumstances concerning the death. That clause expands the function of the Coroner beyond an examination of circumstances bearing some direct causal nexus to the death. If that were not the case, paragraph (v) would be otiose.

51. Similarly, sections 34(2) and 35 of the Act allow the Coroner to make comment and recommendations in relation to matters "connected" with the death. That term is capable of describing a spectrum of relationships ranging from the direct and immediate to the tenuous and remote, depending upon the range and purpose of the legislation under consideration: see *Collector of Customs v Pozzolanic* (1993) 115 ALR 1. The nature and purpose of the modern coronial jurisdiction requires that a broad construction be afforded to the phrase "connected with the death".

52. This is not to say, of course, that there are not limitations on the breadth of any inquiry by the Coroner. There must always be the relevant nexus. As was observed in *Harmsworth v The State Coroner* [1989] VR 989, the inquiry must be relevant to the death or disaster in question and the Coroner may not inquire for the sole reason of making comment or recommendation. There is nothing in that decision to indicate that the Coroner's avenues of inquiry are limited to those matters which have a direct causal nexus to the death. Thus, the availability or non-availability of appropriate firefighting equipment was a pertinent and relevant line of investigation in the circumstances of that case, regardless whether there was a finding to the effect that the deaths would have been averted had such equipment been available.

53. I also note the decision of this Court in the Inquest into the Death of Robert James Jones (unreported, Coroners Court, Mr Lowndes SM, 22 August 1997). There, the presiding coroner observed that *Harmsworth* was best viewed as a decision based on the particular wording of s19 (1) of the Victorian *Coroners Act*. That provision obliges and empowers the Victorian Coroner to find "how death occurred". It is a narrower formulation than the obligation "to find any relevant circumstances concerning the death".

54. It is clear from the most cursory examination of the materials and exposure to the evidence heard during the course of the Inquest that staffing levels and overcrowding are matters relevant to the death, even if the ultimate finding is that they were not directly causative of the death. So much is immediately apparent from the internal review commissioned by the Top End Mental Health Services Executive. That necessarily includes inquiry into whether the staff shortages and overcrowding were due to funding constraints and/or other management or clinical determinations. It is also apparent from what has already fallen that the

policies and practices in relation to observations are relevant to the death. Accordingly, I am of the opinion that this Inquest may properly inquire and make findings in relation to staffing levels and allocations within the Cowdy Ward at the time of the death, the management of Mental Health Services insofar as it relates to staffing and patient numbers, the budgetary/funding arrangements for the Cowdy Ward insofar as they relate to or impact upon staffing, and the general practices and policies adopted or used within Top End Mental Health Services insofar as they relate to staffing, patient numbers and observation policy.

55. The practice at the time of the death was, and remains, that the number of nursing staff required for a given patient load was determined by the application of a formula. That formula varied between the early shift, late shift and nightshift in accordance with the different patient requirements on each shift. The period relevant to the death of the deceased was the early shift. The formula for early shift was:

$$W = S + \frac{(BN - S)}{3}$$

Where:
W = requisite workforce
BN = number of patients
S = number of patients on special observations

56. Mr Siermans was the clinical nurse consultant in charge of the Ward at the relevant time. It was his responsibility to ensure that staffing levels were adequate. Mr Siermans gave evidence during the course of the inquest. I considered him to be a professional, frank, caring and impressive witness. He made the concession in cross-examination that staffing numbers at the time of the death were inadequate. That concession notwithstanding, I accept the submission of Counsel for Territory Health Services that the cross-examination proceeded on the basis that there were 26 patients on

the Cowdy Ward at the time. A subsequent analysis of the patient numbers indicated that they varied over the course of the day as patients were variously admitted, discharged, and released on or returned from leave.

57. The analysis of patient numbers shows that in the hour leading up to the death of the deceased, there were 21 patients on the Ward, of whom three were subject to special observations status. In the period up to 1300 hours on the day there were seven staff on duty plus the clinical nurse consultant. I do not accept the submission that the clinical nurse consultant is appropriately taken into account in assessing requisite staff numbers. That person has various managerial obligations and cannot be considered as part of the routine complement of nurses for the purpose of the formula. So much is apparent from the fact that the clinical nurse consultant had left the Ward at the time of the incident to attend to public education duties at Casuarina. Certainly Mr Siermans gave evidence to the effect that the clinical nurse consultant could not properly be included in the staffing calculation, and to the extent that Ms Bradley's evidence was to different effect, I reject that evidence.

58. There was a shift handover at 1300 hours. The consequence of this is that whilst there were probably twelve staff on the Ward, those numbers were comprised by both the early and late shifts. During the handover it is likely that there were only six staff, and at most seven, available to attend upon and observe the patients.

59. Applying the formula, the appropriate staff allocation at the time of the deceased's death was nine. There were not nine staff available at the material time. There may have been as few as six. It is not difficult to draw the inference that the failure to conduct appropriate observations on the deceased, and the subsequent failure to allocate some other person to

conduct observations of the deceased when Ms Mulherin was called away, was due in part to that shortage. Having said this, it is not possible to draw the further inference that the staff shortage was due to any budgetary restriction. Mr Siermans and Ms Bradley both gave evidence to the effect that additional staff could have been called in had the clinical nurse consultant determined to do so. I formed the view during the course of the Inquest that a culture had developed on the Ward whereby staff largely made do with the numbers rostered notwithstanding any fluctuation in patient numbers during the course of a shift.

60. The staff shortage was no doubt exacerbated by the patient numbers on the Ward at the relevant time. With 21 patients on Ward, the Joan Ridley Unit had been opened to accommodate the overflow. The Cowdy Ward and the Joan Ridley Unit are somewhat remote from each other, meaning that the staffing allocation would necessarily be split from time to time between those two facilities.

61. These matters were also the subject of some consideration in a report commissioned by Territory Health Services entitled "A Review of Circumstances Surrounding the Death of a Patient in Cowdy Ward". The review was conducted by Professor Ross Kalucy. For the purpose of conducting his review, Professor Kalucy travelled to Darwin and interviewed Cowdy Ward staff. This report had apparently been in the possession of Territory Health Services from some time in 2002. It was not produced to the Coroner's office until shortly before the Inquest, and then on the basis that Territory Health Services did not seek to rely on the document and did not accept its findings. The Coroner's office has always enjoyed a frank and open working relationship with Territory Health Services. The timing of the provision of this report would appear, at first blush, to run contrary to the prior tenor of that relationship. I am assured that the report was not purposefully withheld from the Coroner's office, and

that the delay in providing the document was sourced in Ms Sievers's exceptionally heavy workload in the months leading up to the Inquest and the consequent inability to tum her attention to the matter. Ms Sievers was the solicitor acting for Territory Health Services in the matter of this death. I accept those assurances.

62. Neither Counsel assisting nor Counsel for Territory Health Services sought to call Professor Kalucy to give evidence during the course of the Inquest. In those circumstances, and notwithstanding the tender of the report, I do not accord it any independent weight. It does, however, reinforce certain of the conclusions drawn by Ms Bradley and Mr Mals in the internal review. Professor Kalucy observed that patient numbers, the size of the Ward, and the consequent stressors on staff combined to increase the risk of critical incidents such as the one the subject of this Inquest.

63. These are matters which must now be well known to administrators within Mental Health Services. They are not amenable to recommendation. I would only make two comments. First, patient numbers have exceeded the Cowdy Ward's capacity for a sustained period. This necessitates the accommodation of patients who would not otherwise be categorised as high security patients in the Joan Ridley Unit. The built environment in that unit is inconsistent with the principle, promoted by Territory Health Services in the context of another issue arising during the course of this Inquest, that patients should be cared for and accommodated in the least restrictive environment possible. The situation needs to be addressed, whether by way of expansion of the Cowdy Ward, the provision of a "step down" facility, or otherwise. Secondly, Ward managers should comply with the staffing formula so far as is possible. It is far preferable to have too many staff on shift rather than too few, and any tendency to be optimistic in relation to likely patient numbers should be discouraged.

64. There is one ancillary staffing issue that also arose during the course of the Inquest. I have already found that any shortage in the numbers of nurses on shift at the relevant time was not the function of any budgetary restriction. The clinical nurse consultant had the facility to call in more staff had he been so inclined. It is plain from certain evidence heard and received during the course of the Inquest that this was not the position with medical staff. There was significant understaffing due to resignations, sick leave and difficulties in recruiting medical staff. I hasten to add that the primary cause of the understaffing was that Mental Health Services had significantly expanded the range of services and facilities offered to the community, but the number of medical staff had not increased commensurately.

65. The deceased was primarily under the medical care of a Registrar during the course of her admission to the Cowdy Ward. That Registrar had commenced her psychiatric training seven weeks prior to of the deceased's admission. The shortage of consultant psychiatrists within Mental Health Services was such that the Director of Psychiatry could not devote the usual amount of supervision to the Registrar treating the deceased. It must be stressed that this did not lead to any compromise in the medical care of the deceased, largely due to the hard work and dedication of medical staff who stretched themselves to cover any shortages. Dr Campbell expressed the view that the quality of medical care was high. This was also reflected in Professor Kalucy's report, where he noted that the deceased's medical records were of good quality and pointed to high levels of professionalism in both the treating doctors and nurses.

66. During the course of the Inquest I received two reviews conducted by Dr Nagel in relation to medical staffing (psychiatry) resources at Top End

Mental Health Service. These papers suggest that medical staffing issues reached crisis point during 2002. I also received evidence by way of statutory declaration during the course of the Inquest from Dr David Ashbridge, Assistant Secretary of Health Services, and Mr Victor Rowe, a high level mental health administrator within Territory Health Services. That evidence shows that when the medical staffing issues were brought to the attention of management in mid-2002, there was a relatively immediate injection of an additional $300,000 to facilitate the recruitment of more medical staff. The Mental Health Services budget was thereafter increased on a recurrent basis to accommodate the wider range of services that are being provided within that area. Territory Health Services is to be commended for that response.

The Cowdy Ward environment

67. During the course of the investigation and Inquest into the deceased's death, the parents of the deceased noted that during the time of the deceased's admission they were concerned about the lack of stimulation and activities on the ward, and the fact that the ward presented very much as a sterile and clinical environment. This was also reflected in complaints made by the deceased prior to her death. The parents of the deceased harbour some concerns that the clinical nature of the Cowdy Ward environment may have had a negative impact on the deceased's state of mind.

68. Whilst the general consensus seems to be that the deceased's mental state was such that she was properly confined for a further period on 13 March 2002, and I find that to be so, the question arises whether the alienating effect of that confinement could have been ameliorated in any way by some "softening" of the Ward environment. It is always necessary to balance the need for providing a secure environment, with the sorts of

deprivations that necessarily brings, against the need to make the Ward environment as comfortable and comforting as possible. The need to strike this balance was a matter that was addressed in the course of the independent reviews conducted for the purposes of this Inquest. Unfortunately, as Dr Campbell has noted, there is no acute psychiatric unit in Australia that is able to provide the homely atmosphere that administrators and relatives would wish for in an ideal world. Personal belongings get stolen or disappear, and furnishings and ornaments become weapons.

69. That matter has also been addressed in the evidence by way of statutory declaration from Cheryl Furner. That evidence was to the effect that an occupational therapist came onto the Ward between Monday and Friday to conduct programs, and that the medical records show the deceased participated in those programs. This is also reflected in Dr Campbell's observations that by the time of the final tribunal hearing, the deceased was active, and able to take part in Ward activities such as gym and playing cards.

The employment of allied health care professionals

70. An issue related to the Ward environment is the employment of allied health professionals within the Cowdy Ward to provide holistic care. Material tendered during the course of the Inquest indicated that the patient's case manager in the community also adopts that role, in theory at least, during any period of confinement in the Cowdy Ward. This is to ensure that there is a continuity of care from the community to the ward, and back again. In reality, however, experience shows that a case manager's community caseload is such that attendances once a patient is confined to the Ward are difficult to manage. Moreover, case notes in relation to the patient's treatment in the Ward are held on separate hard

files. Case managers cannot readily access the hard copy file from the Cowdy Ward.

71. The deceased's case manager was Ms Christine Butler. She attended upon Sarah on a number of occasions prior to her admission to the Cowdy Ward. She also had various dealings with the father of the deceased in relation to his concerns for Sarah's health and her ability to care for her son. Ms Butler was unable to visit the deceased in the Cowdy Ward as frequently as she would have liked. This was a necessary corollary of her high caseload. It was my assessment, however, that Ms Butler was very experienced and competent and able to handle that high caseload.

72. Mr O'Grady's report strongly advances the view that inpatient psychological management of psychotic symptoms is an effective adjunct therapy, particularly for patients with treatment resistant psychosis, and recommends resourcing for allied health professionals on Cowdy Ward. That is reflected in the opinions of both Dr Campbell and Dr Nagel.

73. Mr O'Grady recommends that a clinical psychologist, a social worker, a full-time occupational therapist and community carers be employed on the Cowdy Ward to implement a range of psychological and social interventions, thereby providing a more holistic approach to treatment. That would require a significant increase to the current resource allocation. I do not make any comment or recommendation in relation to that matter. It has a tenuous connection only with the circumstances of the death, and requires a more detailed level of consideration and analysis than was possible during the course of the Inquest.

Minimising hanging points

74. One matter arising from the police investigation is whether steps might be taken to minimise hanging points in patient rooms. The deceased was able to turn the bed on its side so as to use it as a hanging point. Whilst it is not possible to eliminate all hanging points, the risk can be minimised. Having said this, I have reviewed the findings in the Inquest into the death of Chun Huang and note that the deceased in that case was able to hang herself from the bed head without need to turn the bed on its side. It was for that reason that I did not make any recommendation in relation to hanging points in the course of that Inquest.

75. I also note that Ms Bradley gave evidence to the effect that since the death of the deceased beds have been fixed to the floor and that furniture is otherwise selected to minimise hanging points.

The deceased's medication regime

76. The question arose during the course of the investigation into the death as to whether the deceased's medication regime prior to her death was appropriate.

77. Prior to the death of the deceased, Dr Robert Parker had recommended the introduction of Venlafaxine to the deceased's medication regime. At the material time, Dr Parker was the Psychiatric Consultant for the Early Intervention Team at Tamarind Centre. He attended on the deceased on 1 March 2002. From her presentation, Dr Parker considered that the deceased had a major depression with psychosis. He felt it was advisable to make the deceased an involuntary patient because of the severity of her depression. He considered that the deceased's then current anti-depressant medication (Cipramil) was unlikely to provide therapeutic

benefit and recommended that her antidepressant be changed to a better adapted medication (Venlafaxine). Whilst Venlafaxine was introduced to the deceased's medication regime, Dr Parker's recommendation for a rapid increase to a therapeutic dose was not undertaken.

78. Following Dr Parker's attendance on the deceased, she came under the care of Dr Nagel. Dr Nagel was of the view that the deceased was suffering from a primary psychosis with attendant depression and adopted a slightly different course in relation to the deceased's medication.

79. This matter was the subject of comprehensive discussion by Dr Campbell in the course of his review of the matter. He was of the opinion that Dr Nagel was correct in being cautious with the dose of Venlafaxine and that the medication regime in place was appropriate as implemented and maintained by Dr Nagel. He also opined that Cipramil, which was the primary medication prescribed by Dr Nagel, was appropriate in the circumstances.

80. Having regard to that evidence I find that the deceased's medication regime prior to her death was adapted and appropriate to her circumstances and condition.

The delay in notifying Police

81. The deceased attempted suicide on the afternoon of 14 March 2002. She was discovered hanging at about 1400 hours and conveyed to the Intensive Care Unit within the Royal Darwin Hospital. Police were not notified of the attempted hanging until approximately 1800 hours on 16 March 2002. The reason for that delay is not immediately apparent. There is no suggestion that in this case the delay seriously compromised the investigation, but the possibility remained. It is essential that in such

circumstances police are informed as soon as practicable to allow the appropriate investigations to be conducted. One consequence of not reporting the matter earlier in this case is that the whiteboard which contained details as to who was responsible for observations during the course of the shift was cleaned prior to the attendance of police.

82. In the findings in the Inquest into the death of Chun Huang it was observed that the room had been cleaned and the scene disturbed before the notification and attendance of Police. That matter was addressed by a protocol concerning the maintenance of the scene, and which authorities should be informed concerning a death on the Ward. There is no reason why the protocol should not also extend to attempted suicides, particularly where the victim has been rendered unconscious and requires life-support. I recommend that consideration be given to amending the protocol in those terms.

Dated this the 19th day of December 2003

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GREG CAVANAGH

Territory Coroner