Coroners Act 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref: 51/15

I, Sarah Helen Linton, Coroner, having investigated the death of ***Merita BELICA*** *with an inquest held at the* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth*** *on* ***8 December 2015*** *find that the identity of the deceased person was* ***Merita BELICA*** *and that death occurred on* ***11 September 2012*** *on* ***the train line between Subiaco and Daglish train stations*** *as a result of* ***multiple injuries*** *in the following circumstances:*

Counsel Appearing:

Mr T Bishop assisting the Coroner.
Ms B Burke on behalf of Nurse Ann Dolan.
Ms R Hartley (State Solicitor's Office) appearing on behalf of the Women and Newborn Health Service and the North Metropolitan Health Service, Mental Health.

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INTRODUCTION

1. Merita Belica (the deceased) died on 11 September 2012 when she deliberately put herself in the path of a moving train in Subiaco. She was a young, 25 year old mother of a small child and a newborn baby at the time of her death. Her death devastated her family and shocked the staff of the Mother and Baby unit at King Edward Memorial Hospital, where she was an involuntary patient receiving psychiatric care at the time.

2. As the deceased was an involuntary patient under the *Mental Health Act 1996* (WA) at the time of her death, she fell within the definition of a 'person held in care' under s 3 of the *Coroners Act 1996* (WA). In such circumstances, a coronial inquest is mandatory.[1]

3. I held an inquest at the Perth Coroner's Court on 8 December 2015.

4. The evidence called at the inquest focused primarily on answering three key questions posed by counsel assisting at the commencement of the inquest, namely:

   i. Was it appropriate to admit the deceased to the Mother and Baby Unit, having regard to the deceased's level of risk of self-harm and the deceased's level of risk of absconding?

   ii. In having regard to the deceased's level of risk of absconding, was her history of absconding considered and if so, how was that history of absconding factored into the decision to admit the deceased into the Mother and Baby Unit?

   iii. What changes have occurred at the Mother and Baby Unit as a result of the deceased's death to reduce the risk of other patients absconding?

5. The documentary evidence included a comprehensive report of the death prepared by the Western Australia Police.[2] In addition, a number of exhibits were tendered at the inquest, including some photographs and a floor plan of the Mother and Baby Unit, some closed circuit television footage of the deceased's escape from the unit and policy documents relating to the unit.[3] A number of witnesses were also called to give oral evidence at the inquest.

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[1] Section 22(1) (a) *Coroners Act 1996* (WA).
[2] Exhibit 1.
[3] Exhibits 2 – 6, including those items specifically mentioned and others.

THE DECEASED

6. The deceased was born on 24 January 1987 in Australia and was the second child of Macedonian parents. She was described by her brother as a happy person who could achieve anything she put her mind to accomplish. She was very family orientated and enjoyed spending time both with her immediate family and at events with her large extended family, which took place almost every weekend.[4]

7. The deceased had a short-lived marriage at the age of 19 years. That marriage was unhappy and she experienced some situational depression, which resolved without the need for medical treatment after the marriage ended.[5]

8. The deceased married her second husband, Blerim Belica, on 30 August 2008.[6] By all accounts the deceased was happy in her marriage and they had a loving and supportive relationship.[7]

BIRTH OF FIRST CHILD

9. The deceased became pregnant with her first child in 2011. The pregnancy was not planned but the deceased and her husband were happy about the pregnancy and looked forward to the birth of their first child.[8] The deceased was reported to be in generally good health during the antenatal period.

10. The deceased's first child, a son, was born in March 2009. The deceased was induced two weeks prior to her due dates due to oligohydramnios (a deficiency of amniotic fluid).[9] The baby, who will be referred to as AB, was born by vacuum extraction. AB was small for his gestational age, attributed to the fact that the deceased was a smoker.[10]

11. The deceased and her husband lived with her husband's family and they provided family support to the new parents after the birth.[11]

12. The deceased was quite anxious as a new mother as she wanted to provide the best care for AB but felt inadequate. She began to experience depressive symptoms, which progressively worsened.

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[4] T 17 18.
[5] T 19; Exhibit 1, Tab 18, ED Continuation Notes, 23.4.2009, 4.15 pm, Dr Hartley.
[6] Exhibit 1, Tab 5.
[7] T 19; Exhibit 1, Tab 20, First Admission Inpatient Summary, 1.
[8] Exhibit 1, Tab 20, First Admission Inpatient Summary, 1.
[9] Exhibit 1, Tab 8.
[10] Exhibit 1, Tab 20, First Admission Inpatient Summary, 1.
[11] T 19.

About three weeks after the birth she saw her general practitioner who diagnosed post-natal depression and prescribed escitalopram (an antidepressant). Four days later, on 21 April 2009, the deceased impulsively attempted suicide by ingesting 75 mls of weed killer. The deceased told her husband soon after of the attempt and he took her to the Emergency Department of Sir Charles Gairdner Hospital (SCGH).[12] Prior to this attempt the deceased's husband had seen no sign that the deceased might hurt herself.[13]

13. At the time of initial assessment the deceased had low mood with limited insight and poor judgment but she denied any on-going thoughts of suicide or infanticide. The admitting doctor formed the impression the deceased was experiencing poorly treated post-natal depression, with resultant impulsive self-harming behaviour. She was given treatment in relation to the poison ingestion and kept in overnight.

14. The deceased was reviewed by the psychiatric team and an admission to King Edward Memorial Hospital (KEMH) was offered but the deceased and her husband expressed a preference for the deceased to be discharged into the care of her family and to be followed up by Mirrabooka Mental Health Services. She was discharged home on 23 April 2009 and prescribed a new medication, Efexor (venlafaxine) 75 mgs daily.[14]

15. On 19 May 2009 (seven weeks after the birth of AB) the deceased attended the Emergency Department of Joondalup Health Campus (JHC) after taking eight of her Efexor tablets. The deceased denied that the overdose was an attempt at self-harm but rather maintained it was intended to improve her mood. She was diagnosed with a major depressive episode and admitted to the Mental Health Unit at JHC. She was continued on Efexor and started on a low-dose benzodiazepine for her anxiety. A plan was made to transfer the deceased to the Mother and Baby Unit at KEMH once a bed became available.[15]

THE KEMH MOTHER AND BABY UNIT

16. The Mother and Baby Unit at KEMH is an eight bed unit for mothers and their babies. In 2009 it was the only approved mother and baby unit able to accommodate involuntary patients

[12] Exhibit 1, Tab 18.
[13] Exhibit 1, Tab 5 [11].
[14] Exhibit 1, Tab 18.
[15] Exhibit 1, Tab 8.

in the State.[16] It is designed to provide a 'homelike' environment for mothers and their babies.[17]

17. The admission criteria for the unit are generally aimed at identifying women with current symptoms of a mental illness of a moderate to severe degree in the post-partum period (generally up to 12 months from the birth) who can be managed safely in the unit.[18] Both the mother and baby are admitted to the unit (the baby as a boarder) so the mother must be able to provide at least some care for the baby.[19]

18. Dr Felice Watt, the current Director of Psychiatry at KEMH, explained that each referral to the unit is considered on its merits. In making the decision as to whether or not to admit the patient, the safety of the particular mother and baby, as well as the safety and welfare of the other mothers and babies already in the unit, is considered.[20] If it is felt that the degree of risk (looking at risk in a global way) cannot be managed safely in the unit, they do not accept the admission.[21] That decision takes into account the fact that although the unit can be locked, it is not considered a secure unit as there is opportunity for patients to leave if they are determined to do so.[22]

FIRST ADMISSION TO THE MOTHER AND BABY UNIT

19. On 25 May 2009 the deceased was transferred from JHC and admitted to the Mother and Baby Unit under the care of Dr Philippa Brown. She described difficulties bonding with her son and wanted help to improve her mood. Examination at this stage did not reveal any psychotic symptoms. She denied any suicidal ideations or intentions and had no thoughts of harming her baby. The deceased was continued on her medication and reviewed regularly by a Consultant Psychiatrist, Dr Jonathon Rampono. The deceased also received input and support from the nursing team and mothercraft nurses in the unit.[23]

20. The day after her admission the deceased expressed a desire to be discharged, telling staff that she felt better. However, she was advised that as well as needing help with her mothercrafting, she particularly needed to stay for stabilisation of her mood symptoms and could be made an involuntary patient if she

[16] T 40 – Another unit has recently been opened at Fiona Stanley Hospital.
[17] T 40.
[18] T 40.
[19] Exhibit 6, Admission to the Mother and Baby Unit Guidelines.
[20] T 40.
[21] T 41.
[22] T 41; Exhibit 6, Admission to the Mother and Baby Unit Guidelines.
[23] Exhibit 1, Tab 20, KEMH Inpatient Summary for admission 25.5.2009 – 17.6.2009.

insisted on leaving. She agreed to stay as a voluntary patient but continued to express a desire to go home during the following day.[24]

21. On 28 May 2009 the deceased saw a clinical psychologist at 7.30 am and then absconded from the unit at approximately 8.20 am, leaving her baby and belongings behind. It is not clear how she left the ward. Nursing staff and security staff searched the hospital and surrounding area and the police were informed.[25]

22. While outside the hospital the deceased telephoned her husband and told him she was having suicidal thoughts. He persuaded her to tell him where she was and staff from the Mother and Baby Unit collected her and brought her back to the unit.[26]

23. Upon her return the deceased was made an involuntary patient under the *Mental Health Act 1996* (WA). Her dose of Efexor was gradually increased and she was supported and supervised closely by the treating team during this period. Her mental health improved over the following weeks and she became more confident in her care of AB. She did not voice any more suicidal thoughts and began to express hope for the future. She was made a voluntary patient again on 7 June 2009 and after several trial periods of home leave she was discharged on 17 June 2009.[27]

24. The deceased was reluctant to engage with community supports as she felt she had enough support from her own family. She was provided with short-term follow up with the Community Nurse at the Mother and Baby Unit and then left to her own support network. The deceased apparently stopped taking her antidepressant medication about a year after the birth and remained well until the birth of her second child in 2012.[28]

25. The deceased's brother noted that the deceased loved her son and loved spending time with him. In those early years, AB was "her first priority in life".[29]

BIRTH OF SECOND CHILD

26. The deceased became pregnant again around the end of 2011. The pregnancy was wanted. The deceased and her husband

[24] Exhibit 1, Tab 20, KEMH Inpatient Summary for admission 25.5.2009 – 17.6.2009.
[25] Exhibit 1, Tab 20, First Admission, Integrated progress notes, 28.5.2009.
[26] Exhibit 1, Tab 20, First Admission, Integrated progress notes, 28.5.2009.
[27] Exhibit 1, Tab 20, KEMH Inpatient Summary for admission 25.5.2009 – 17.6.2009.
[28] Exhibit 1, Tab 20, KEMH Inpatient Summary for admission 25.5.2009 – 17.6.2009.
[29] T 18.

discussed the previous problems she had experienced after the first birth and she told her husband she knew what to do now.[30] The pregnancy was uncomplicated.[31]

27. The deceased's second child, VB, also a son, was born on 1 September 2012 at Osborne Park Hospital with no complications.[32]

28. Given the deceased's previous experience of post-natal depression, the deceased's husband and family were consciously looking for any signs of a change in her mood following the birth.[33] Her change in mood was much more immediate and more noticeable than after the birth of her first child. Within a few days the deceased became more quiet and withdrawn and reported feeling anxious, overwhelmed and unable to cope.[34]

29. The deceased's husband noted a dramatic change in the deceased's mental state three days after the birth.[35] That day she ran out of their home and the deceased's husband searched for her until he found her in Koondoola.[36]

30. The following day the deceased left home again and her brother found her and brought her home.[37] The deceased's husband was very worried about her deteriorating mental state so he took her to SCGH. She was triaged at 2.21 pm on 5 September 2012. At that stage she was four days post-partum and reported low mood and an inability to cope with two children.[38] The deceased denied thoughts of suicide. The assessment was that the deceased was not depressed but had vulnerability given her previous history. She was started on an antidepressant (mirtazapine). Possible admission to KEMH was discussed and a request for urgent psychiatric review was faxed to KEMH.[39] The deceased was subsequently discharged and advised to re-present if the depressive symptoms worsened or if she had recurrent thoughts of self harm or harm to others.[40]

31. The deceased's brother noted the deceased continued to appear drained and express a sense of hopelessness at this time.[41]

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[30] Exhibit 1, Tab 5 [21] – [23].
[31] Exhibit 1, Tab 7.
[32] Exhibit 2 [23].
[33] T 9.
[34] T 9.
[35] Exhibit 1, Tab 5 [25].
[36] Exhibit 1, Tab 5 [26].
[37] Exhibit 1, Tab 5 [28] – [29].
[38] Exhibit 1, Tab 18, SCGH Emergency Dept Medical Notes (sheet one).
[39] Exhibit 1, Tab 9.
[40] Exhibit 1, Tab 9.
[41] T 10.

32. On the evening of 6 September 2012 the deceased's husband rang the mental health help line with concerns about the deceased's behaviour. She had apparently left the house again that day and wandered aimlessly. A home visit was made at 7.00 pm. During the assessment the deceased admitted to a depressed mood, which fluctuated, and feeling unable to cope. She admitted to occasional suicidal thoughts but denied any current plan or intent. She also denied any psychotic symptoms, although it was noted that she appeared somewhat mistrusting and possibly mildly paranoid. The deceased expressed a desire for medication but did not particularly want an admission to the Mother and Baby Unit as she didn't feel it would help. Her family disagreed and noted her improvement when she was admitted there previously.[42]

33. Different management options were considered and it was noted that the Mother and Baby Unit was currently full and did not admit patients after hours. It was also noted that a referral to the unit was already in progress. The deceased was felt to be safe to stay home overnight with her family to watch over her. She was happy to have some medication to help settle her and the family agreed with the plan. The deceased was given the antipsychotic olanzapine to settle her, which she took immediately.[43]

34. On 7 September 2012 the deceased re-presented to SCGH in the company of her husband. The deceased's brother joined them at the hospital shortly afterwards. The deceased reported depressed mood and feelings of inability to cope. She had stopped breast feeding two days earlier. The deceased denied suicidal thoughts or any intention to harm others but exhibited passive suicidality. It was noted that she had been assessed by Community Mental Health staff the previous day and was assessed as being at high risk but was unable to obtain admission to the Mother and Baby Unit as it was full at the time.[44]

35. The deceased was reviewed by Dr Damoon Nezhad, who was a Psychiatry Registrar at SCGH working the day shift that day.[45] Dr Nezhad conducted a psychiatric assessment of the deceased during the morning of 7 September 2012. He saw the deceased with her husband, and a medical student was also in attendance. Dr Nezhad estimates the assessment took approximately one hour.[46]

[42] Exhibit 1, Tab 18, North Cert Adult Service Event 6.9.2012.
[43] Exhibit 1, Tab 18, North Cert Adult Service Event 6.9.2012.
[44] Exhibit 1, Tab 9.
[45] Exhibit 1, Tab 10 [4].
[46] Exhibit 1, Tab 10 [6].

36. The deceased appeared very depressed and suicidal and described an inability to cope with her current situation. She reported that she was no longer breastfeeding VB because of the psychological distress she was suffering.[47] She expressed recurrent feelings of guilt and worthlessness throughout the assessment.[48] She displayed no signs of psychosis and she denied any suicidal ideation, although she showed signs of passive suicidality.[49] Based on all the available information, Dr Nezhad considered the deceased to be at risk of another suicide attempt.[50]

37. Both the deceased and her husband expressed some reservations about separating the deceased from her older son, AB, but agreed in the end that hospitalisation was the best treatment for her at the time.[51] The deceased agreed to be admitted as a voluntary patient, with a preference to be admitted to the Mother and Baby Unit at KEMH.[52]

38. The deceased's husband told Dr Nezhad that the deceased had wandered from home on two occasions in the previous days and had to be brought home by him on each occasion. He also expressed concern she might abscond from hospital after being admitted, like she had done so during her previous admission to the Mother and Baby Unit. Given her past history, Dr Nezhad assessed the deceased as being a "high risk" patient in terms of absconding.[53]

39. At the end of Dr Nezhad's psychiatric assessment the deceased asked Dr Nezhad if she could go outside to smoke a cigarette.[54] The deceased was a regular smoker, smoking about 12 cigarettes a day.[55] Dr Nezhad told the deceased she could but only if her husband and brother took her. Both men said that they were happy to look after the deceased while she went outside for a smoke.[56] The deceased then went outside at 11.25 am.[57]

40. Dr Nezhad spoke to the on duty Psychiatric Consultant about his assessment of the deceased and his plan for her care. Enquiries were then made with the Mother and Baby Unit and as a bed was available, it was agreed that the deceased would be transferred to

[47] Exhibit 1, Tab 10 [8] – [11].
[48] Exhibit 1, Tab 10 [12].
[49] Exhibit 1, Tab 10 [17].
[50] Exhibit 1, Tab 10 [17].
[51] Exhibit 1, Tab 10 [13] and Tab 18, SCGH Inpatient notes 7.9.2012, 10.45 am.
[52] Exhibit 1, Tab 10 [14].
[53] Exhibit 1, Tab 10 [15] - [16].
[54] Exhibit 1, Tab 10 [20].
[55] Exhibit 1, Tab 10, Attachment 2 and Tab 19, Graylands NRT Assessment.
[56] Exhibit 1, Tab 10 [20].
[57] Exhibit 1, Tab 17.

the unit as a voluntary patient.[58] The paperwork was faxed through to the unit for the medical staff there to consider and Dr Nezhad went to treat other patients.[59]

41. In the meantime, Emergency Department staff became aware that the deceased had not returned from having her cigarette. It became apparent the deceased had attempted to abscond and hospital security staff were informed and with the help of the deceased's husband and brother they retrieved her.[60] She returned to the Emergency Department at about 12.20 pm. The deceased expressed some renewed reluctance to be admitted to the Mother and Baby Unit but eventually agreed to voluntary admission after speaking to Dr Nezhad again. Staff at the Mother and Baby Unit were informed of her behaviour and they indicated they could accept and contain her.[61]

42. At about 2.00 pm the deceased attempted to run away again while going to the toilet with her husband.[62] When Dr Nezhad was informed that the deceased had tried to abscond he spoke with the deceased again. She appeared very frustrated and told him that she had had thoughts of harming her baby, but had no intention or plan to do this.[63]

43. The combination of these two pieces of information caused Dr Nezhad to revisit his plan for the deceased's care as he was concerned she might need to be admitted as an involuntary patient.

44. Dr Nezhad spoke with a Consultant Psychiatrist from the Mother and Baby Unit who had read the deceased's paperwork and expressed the view that the deceased's level of risk was too high to be admitted to the Mother and Baby Unit.[64] The Consultant suggested that the deceased should be sent to a secure ward, such as at Graylands Hospital to allow her to stabilise.[65] Dr Nezhad then spoke to the SCGH on duty Consultant again and they decided that the deceased should not be admitted as a voluntary patient and instead she required referral for a psychiatric assessment under the *Mental Health Act* to determine whether she should be detained involuntarily for treatment.

45. Dr Nezhad completed a Form 1 Referral for examination by a psychiatrist for the deceased, with Graylands Hospital as the

[58] Exhibit 1, Tab 10 [21] – [23].
[59] T 21.
[60] T 11.
[61] Exhibit 1, Tab 18, Emergency Dept Continuation Notes.
[62] T 12; Exhibit 1, Tab 18, Emergency Dept Progress & CommentsNotes.
[63] T 22; Exhibit 1, Tab 10 [28].
[64] T 26.
[65] T 22; Exhibit 1, Tab 10 [29] – [30].

place of referral.[66] Dr Nezhad informed the deceased and her family of the change of plan[67] and they agreed to transport the deceased to Graylands Hospital.[68]

ADMISSION TO GRAYLANDS HOSPITAL

46. The deceased was received at Graylands Hospital (Graylands) at 8.15 pm that evening and admitted to a closed ward.[69] She had apparently been given some diazepam while at SCGH, which she reported had improved her mood.[70] The deceased was given some temazepam at Graylands to help her sleep and she appeared to sleep well that night.[71]

47. The deceased was seen by a Consultant Psychiatrist, Dr Rajan Iyyalol, the following morning for a mental state examination. The examination revealed "syndromal depressive features like extreme low mood, high level of stress, helplessness, guilt and lack of sense of bonding"[72] with her newborn child. She harboured a general sense of an inability to cope.[73] However, the deceased also reported that following a good night's sleep the previous night she had started to feel better. She was not feeling hopeless or helpless anymore and rated her mood as "five out of ten."[74] In Dr Iyyalol's assessment the deceased was being honest and genuine about her change in mood, which had been noted by other staff.[75]

48. Dr Iyyalol's examination revealed no evidence of psychotic symptoms nor signs of agitation or arousal. The deceased categorically denied any thoughts, plans or intent of self harm.[76] Dr Iyyalol assessed the deceased as having no immediate risk issues. The deceased was distressed by being in a locked ward where she was in proximity to severely psychotic patients exhibiting bizarre behaviour.[77]

49. Despite signs of an improvement in her mental state, Dr Iyyalol still made the decision to make the deceased an involuntary patient on a Form 6 under the *Mental Health Act* as her history showed that her mental state fluctuated and was unpredictable.

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[66] Exhibit 1, Tab 10 [31] and Attachment 4.
[67] Exhibit 1, Tab 10 [24] – [26].
[68] Exhibit 1, Tab 10 [32].
[69] Exhibit 1, Tab 10, Attachment 4, Tab 11 and Tab 19.
[70] Exhibit 1, Tab 11.
[71] Exhibit 1, Tab 19, Integrated Progress Notes 7.9.12.
[72] Exhibit 1, Tab 11, 2.
[73] Exhibit 1, Tab 11, 2.
[74] Exhibit 1, Tab 11, 2.
[75] T 28.
[76] T 29.
[77] T 35.

Dr Iyyalol indicated that he made the order on the basis of a diagnosis of post-natal depression with changing mood and behaviour. He considered she needed to be in hospital to ensure her safety and to carry out treatment.[78]

50. Although she required hospital treatment, Dr Iyyalol did not necessarily consider that Graylands was the best option for the deceased. The deceased was keen to be reunited with her baby, who was not permitted to remain with her while at Graylands.[79] Dr Iyyalol considered that reuniting the deceased and her baby was important for the mental health of the deceased, as well as the best thing for the baby. The only place where this could occur at that time was the KEMH Mother and Baby Unit. That unit was also able to provide specialised care in treating post-natal depression. For those reasons, Dr Iyyalol recommended transfer to the KEMH Mother and Baby Unit if they accepted her for admission.[80] If they did not, the plan was that the deceased would stay at Graylands without her baby until her mental health improved.[81] Dr Iyyalol indicated that she would have stayed there as an involuntary patient, although there seems to have been some confusion about that from the perspective of Mother and Baby Unit staff who thought she would have been kept there as a voluntary patient.[82]

51. While she remained at Graylands Dr Iyyalol commenced the deceased on venlafaxine, an antidepressant that had been successful in treating her post-partum depression after the previous birth.[83] Dr Iyyalol advised that the medication can take some to build up to a therapeutic level and have an effect on the patient's mood, with the length of time ranging anywhere from two to six weeks.[84] In more severe cases of post-partum depression, treatments that have a more definitive immediate response, such as electroconvulsive therapy, are used but that was not considered necessary in this case.[85]

SECOND ADMISSION TO MOTHER AND BABY UNIT

52. In order for the deceased to be transferred to the Mother and Baby Unit (MBU) she had to be approved for admission by a psychiatrist from the unit.

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[78] T 30, 33; Exhibit 1, Tab 11, 3 and Tab 19, Involuntary Patient Order 8.9.2012, 4.00 pm.
[79] T 28.
[80] T 29; Exhibit 1, Tab 11, 2.
[81] T 36.
[82] Exhibit 2 [14].
[83] T 28; Exhibit 1, Tab 11, 3.
[84] T 34.
[85] T 34 – 35.

53. On Saturday 8 September 2012 the 'on call' Consultant Psychiatrist for the MBU was Dr Felice Watt, who is the current Director of Psychiatry at KEMH and was acting in that role in late 2012.[86] A nurse from the MBU telephoned Dr Watt and told her that the psychiatrists at Graylands had a patient they considered would be appropriate for admission to the unit.[87]

54. Dr Watt telephoned Graylands and spoke to the duty psychiatrist, Dr Iyyalol. He told Dr Watt that the deceased had been admitted the day before and had slept well and now seemed quite settled. She was really frightened by the other patients in the locked ward and she wanted to see her baby, so he felt it was appropriate for the deceased to be admitted to the MBU.[88]

55. Dr Watt had not met the deceased during her previous admission to the MBU in 2009[89] so she spoke to one of the nurses at MBU and obtained some information about the deceased's background. She also was told about the previous day's events involving the attempted referral of the deceased from SCGH to the MBU that had been cancelled based upon the concerns of Dr Rampono, a psychiatrist at the MBU, about admitting her to the MBU over the weekend.[90] It was likely the deceased would eventually be admitted to the MBU, but probably not until Monday.[91]

56. Dr Watt unsuccessfully tried to call Dr Rampono then rang and spoke to the on call Medical Officer at the MBU that weekend, Dr Stanojevic, to discuss the staff concerns about admitting the deceased.[92] Dr Stanojevic knew the deceased from her previous admission to the MBU and told Dr Watt there had been some distressing incidents involving the deceased during her previous admission to the MBU.[93] There were concerns that the deceased might not be containable at the unit and that she might possibly abscond.[94]

57. After receiving all of this information, Dr Watt decided the complexity of the case warranted taking the relatively unusual step of going to Graylands and assessing the deceased herself rather than leaving the possible admission until Monday.[95] Given the early onset of the illness (which was different from her previous admission), Dr Watt wanted to make sure that the

[86] T 39.
[87] T 47.
[88] T 47; Exhibit 1, Tab 12 [6].
[89] T 47.
[90] T 47.
[91] Exhibit 1, Tab 12 [7].
[92] T 48.
[93] Exhibit 1, Tab 12 [9].
[94] T 48.
[95] T 48; Exhibit 1, Tab 12 [10].

deceased wasn't suffering from a very severe form of illness, called post-partum psychosis. Dr Watt also wanted to try to understand why the deceased had absconded from SCGH and satisfy herself that the deceased really wanted to be in the MBU, so that she could assess the risk of the deceased absconding again.[96]

58. Dr Watt prepared for her attendance at Graylands by reviewing all of the deceased's MBU medical records, which included the paperwork relating to Dr Nezhad's assessment conducted at SCGH the day before.[97] Dr Watt then went and interviewed the deceased at Graylands that day. She was accompanied by a senior nurse from the MBU to assist in the assessment. The deceased's brother was also present for part of the interview.[98]

59. Dr Watt was particularly looking for symptoms of psychosis so she questioned the deceased very carefully about those types of symptoms, such as hearing voices or feeling that people were after her. The deceased denied having any of those symptoms.[99]

60. Dr Watt also spoke with the deceased about any thoughts of self harm, which she denied.[100] Dr Watt observed at the inquest that suicidal ideation and attempts are a known risk of a depressive illness and the risk can fluctuate, so Dr Watt still considered there was a risk that the deceased might have such thoughts. She recorded in her note relating to the assessment that it was likely the deceased was minimising her symptoms and there was a risk she "may be harbouring suicidal ideation."[101] However, it was a risk Dr Watt thought could be safely managed in the MBU.[102]

61. Given her history, Dr Watt also thought there was a risk the deceased might abscond but she considered that measures could be put in place to prevent that from happening, namely: she would be admitted as an involuntary patient, she would not be allowed to leave the unit without permission and she would be kept under an appropriate level of observation, starting with 30 minute observations (15 minute when with her baby).[103]

62. Dr Watt felt encouraged by the deceased's desire to be with her baby, her expressed wish to get better and her hope that the admission to MBU would really help her to do that. The fact that

[96] T 49.
[97] Exhibit 1, Tab 12 [13] – [14].
[98] T 50.
[99] T 50.
[100] T 51.
[101] Exhibit 1, Tab 12 [19].
[102] T 51 – 52.
[103] T 54 – 55; Exhibit 2 [42] – [43]..

the deceased wanted treatment and was hopeful that it would make her better was a positive sign.[104]

63. At the end of the assessment Dr Watt made a provisional diagnosis of major depressive disorder post-partum with a differential diagnosis of puerperal psychosis.[105] Dr Watt was satisfied that it was appropriate to admit the deceased to the MBU for treatment as an involuntary patient. A plan was put in place to transfer the deceased from Graylands to the MBU and Dr Watt indicated a change of medication for the following day, with the deceased to be weaned off venlafaxine and started on Pristiq (desvenlafaxine) and to be given the benzodiazepine lorazepam regularly.[106]

64. The deceased was transferred from Graylands to the MBU and arrived at 5.00 pm on 8 September 2012.[107] Dr Stanojevic had been waiting for her and had already reviewed the available records for the deceased, including Dr Watt's note of her assessment.[108]

65. Dr Stanojevic began the process of admitting the deceased to the unit. The deceased's brother was present for the initial assessment.[109] Dr Stanojevic completed a medical assessment and risk assessment form for the deceased. Dr Stanojevic recorded the deceased's risk of absconding/non-compliance with intervention as '0' at that point, as at the time of assessment she saw nil evidence of such risk. When asked about why she left SCGH the deceased minimised the events and said that she left because she wanted a cigarette, not because she wanted to leave the hospital.[110] Dr Watt had been told something similar by the deceased.[111] The deceased told Dr Stanojevic she was glad to be at the MBU so she could be with her baby and she wanted to do what it took to get better.[112] In making the risk assessment Dr Stanojevic also took into account Dr Watt's decision to admit the deceased to the MBU, as the MBU does not usually receive patients at high risk of absconding.[113]

66. Dr Stanojevic went through the psychiatric assessment with the deceased, asking her set questions and noting her answers as well as her body language.[114] At the time of admission she rated

[104] T 51.
[105] Exhibit 1, Tab 12 [19].
[106] Exhibit 1, Tab 12 [19].
[107] Exhibit 2 [16].
[108] Exhibit 2 [15].
[109] Exhibit 2 [17].
[110] Exhibit 2 [25].
[111] T 53.
[112] Exhibit 2 [18].
[113] Exhibit 2 [19].
[114] T 80 – 82.

her mood as being 6 out of 10 (with 1 being profoundly depressed and 10 being happy).[115] The deceased admitted low mood, which was consistent with her presentation of depression. She was calm and showed no signs of agitation or external stimuli suggesting psychosis. Dr Stanojevic specifically asked the deceased if she had any suicidal thoughts or thoughts of harming others or her baby, which she denied.[116] The deceased appeared to understand the management plan and was cooperative and accepting of the plan.[117] She was keen to be reunited with her baby and specifically asked for help to better bond with her baby.[118] The deceased appeared to Dr Stanojevic to be honest in her answers and genuinely wanted to get better.[119]

67. At the end of the assessment the deceased indicated she was happy with the management plan and both the deceased and her brother indicated they did not have any questions.[120] They had earlier discussed the issue of smoking and the deceased had indicated she was not interested in nicotine replacement therapy and wished to continue smoking cigarettes. Dr Stanojevice explained she would be allowed to smoke when accompanied by a staff escort.[121]

68. The deceased's husband brought in baby VB that evening at about 9.30 pm. After spending some time with the deceased, who gave him a cuddle and started getting him ready for bed, the baby was kept in the nursery and cared for by staff overnight.[122]

69. The deceased was reviewed by Dr Watt in the company of a mental health nurse at 9.30 am the following morning. The deceased was seen to be loving and attentive to her baby, which Dr Watt saw as a very positive sign.[123] The deceased showed no sign of psychosis.[124] The deceased was calm but her mood was low and she expressed anxiety about coping with two children at home. She admitted feelings of hopelessness but denied any suicidal ideation. Dr Watt was struck by the deceased's profound sense of sadness, which gave her reason to be cautious as there was the possibility that the deceased was harbouring suicidal ideation but minimising the symptoms. For that reason Dr Watt decided to maintain the same level of observation of the deceased.[125]

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[115] Exhibit 2 [28].
[116] Exhibit 2 [39].
[117] T 80 – 82.
[118] T 82 – 83.
[119] T 83; Exhibit 2 [38].
[120] Exhibit 2 [48].
[121] Exhibit 2 [51].
[122] Exhibit 1, Tab 20, Integrated Progress Notes 8.9.2012; Exhibit 2 [32].
[123] T 56; Exhibit 1, Tab 12 [23], [28].
[124] Exhibit 1, Tab 12 [29].
[125] T 58; Exhibit 1, Tab 1 [26].

70. The plan formulated by Dr Watt was to start the deceased on Pristiq that day, with a plan to gradually increase her medication, and continue with lorazepam and the same level of observation. The deceased was permitted to keep her baby with her overnight.[126]

71. At 2.10 pm a nursing entry records that the deceased was feeling upset and teary as she was missing her three year old son. However, she wanted to be at the MBU to feel better in herself. She reported that she was bonding more with her baby and enjoying life again. She was visited by various family members throughout the day, including her husband and older son. She was seen to be warm and loving with her baby. The only concerning sign was that she ate little throughout the day.[127]

72. The deceased seemed settled that night. She described herself as 'better' although her sister felt that the deceased was not yet back to her normal self and thought her mood was still low. The deceased denied having suicidal thoughts throughout the day and evening. She went to sleep at about 8.30 pm and appeared to sleep well overnight.[128]

73. The following day at 9.20 am the deceased was reviewed by Dr Rampono, Dr Stanojevic and other MBU staff. Dr Rampono, who is a very experienced psychiatrist and was responsible for the original creation of the MBU,[129] had been the deceased's treating psychiatrist during her previous admission to the MBU in 2009. Dr Rampono led the review and screened the deceased for depression and anxiety.[130] She presented as calm and well groomed. She reported she was feeling better and assessed her mood as 8 out of 10.[131] She spontaneously denied any suicidal ideation and claimed that the last time she had had any suicidal thoughts was after the birth of her first baby in 2009 (that is, not at any time in 2012).[132] She denied having insomnia and denied experiencing diurnal mood variation (feeling worse in the morning with mood lifting over the day).[133] She admitted having little appetite and experiencing undue tearfulness but felt both were improving.[134] Dr Rampono spoke to the deceased about escapist ideation (feeling like she just wants to get away) and she said that

[126] T 56; Exhibit, 1 Tab 20, Integrated Progress Notes 9.9.2012, 0930.
[127] Exhibit 1, Tab 20, Integrated Progress Notes 9.9.2012, 1410.
[128] Exhibit 1, Tab 20, Integrated Progress Notes 9.9.2012, 1410 & 2200 and, 10.9.2012 0600.
[129] Exhibit 1, Tab 13.
[130] Exhibit 2 [54].
[131] Exhibit 1, Tab 13 [35].
[132] Exhibit 1, Tab 13 [44].
[133] Exhibit 1, Tab 13 [36] – [38].
[134] Exhibit 1, Tab 13 [39], [41].

this was what had happened at SCGH when she just wanted to get away from all the fuss and get some fresh air.[135]

74. At the end of the review Dr Rampono considered the deceased was suffering from post-natal anxiety with some symptoms of depression. He did not think she was suffering from a full blown major depressive disorder.[136] The deceased's anxiety seemed to be primarily focussed on how she would manage with a three year old and a baby, particularly in terms of managing feeding and getting enough sleep. Dr Rampono noted the medications the deceased was prescribed should assist with her anxiety and he also emphasised to the psychologist the need to address the deceased's anxiety as a priority. In addition, Dr Rampono made practical suggestions as to how she could structure her routine and establish a feeding and sleeping pattern that would work once at home. The deceased seemed positive about the proposed plan.[137]

75. Erring on the side of caution, Dr Rampono decided that the deceased should remain on the same level of observations as set on admission for another day. If nothing untoward happened that day then the next day he intended to drop her to hourly observations unless with her baby.[138] The deceased indicated she was happy to cooperate with the treatment plan, including the same level of observations and an increase in her antidepressant medication.[139] The deceased's only expressed concern was that it was very important to her that she be allowed to smoke, which does not appear to have been considered problematic.[140]

76. The deceased attended a group therapy session that day and participated appropriately. She ate well and was seen to be loving and caring with her baby. He was troubled by some nappy rash and the deceased was given practical advice by the mothercraft nurse and Dr Stanojevic. The deceased seemed calm at the time, even though her baby was unsettled and crying, and Dr Stanojevic was not concerned about her mental state.[141]

77. The deceased told a nurse she felt her mood was improving, although she still felt "low".[142] She was still experiencing anxiety at the thought of how she would cope with the two children after discharge and she was interested in speaking to a social worker

[135] Exhibit 1, Tab 13 [33], [45].
[136] Exhibit 1, Tab 3 [53].
[137] Exhibit 1, Tab 13 [55] – [65].
[138] Exhibit 1, Tab 13 [66] – [67].
[139] Exhibit 2 [56].
[140] Exhibit 2 [60].
[141] Exhibit 2 [61] – [66].
[142] Exhibit 1, Tab 20, Integrated Progress Notes, 10.9.2012, 1435.

to discuss the supports that were available. She denied any thoughts of suicide or deliberate self-harm.[143]

78. The deceased was visited by her husband and son that afternoon. The deceased's husband described her as appearing "very low" when he saw her. Mr Belica recalled asking the staff why she wasn't on medication and after speaking with them the deceased was given her medication and her mood then seemed to improve.[144] The deceased hugged her son before he left with his father.[145] The related nursing note records that the deceased reported feeling anxious and overwhelmed, worrying about how she would cope at home. She was given lorazepam to settle her and she stated that she felt better as the evening progressed.[146]

79. The deceased was visited by her brother and sister that evening and she was seen to be smiling and interactive with them. The deceased's brother recalls the deceased seemed tired and worn out but otherwise fine during the visit. She did not talk of harming herself during the visit.[147] The deceased interacted well with her baby that night. She was given her evening medication and was asleep by 9.00 pm. [148]

80. Thirty minute observations were continued overnight and the deceased was asleep on all checks.[149]

EVENTS ON 11 SEPTEMBER 2012

81. The deceased was up at 6.00 am in the lounge to feed her baby. The baby was then given into the care of staff.[150]

82. At 7.00 am Registered Mental Health Nurse Ann Dunbridge (now Dolan) started her shift in the MBU and was assigned to care for the deceased for the day as her only patient.[151] Nurse Dunbridge had met the deceased during her previous stay in the MBU in 2009 and knew her quite well.[152] Nurse Dunbridge was told during the handover from the night staff that the deceased had been quite settled and there was nothing to raise concern or indicate she was agitated.[153]

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[143] Exhibit 1, Tab 20, Integrated Progress Notes, 10.9.2012, 1435.
[144] Exhibit 1, Tab 5 [39] – [41].
[145] Exhibit 1, Tab 21 [50].
[146] Exhibit 1, Tab 20, Integrated Progress Notes, 10.9.2012, 2130.
[147] Exhibit 1, Tab 21 [49].
[148] Exhibit 1, Tab 20, Integrated Progress Notes, 10.9.2012, 2130.
[149] Exhibit 1, Tab 20, Integrated Progress Notes, 11.9.2012, 0600.
[150] Exhibit 1, Tab 20, Integrated Progress Notes, 11.9.2012, 0600.
[151] T 92.
[152] T 91.
[153] T 100.

83. At 7.30 am the deceased requested permission to go outside for a cigarette. As an involuntary patient, the deceased could only use the MBU's designated smoking area. The smoking area requires staff keycard access and is a fenced and secure area so she had to be accompanied by a nurse.[154] She was escorted to the back corridor exit by Nurse Dunbridge and into the back smoking area. Nurse Dunbridge recorded the deceased's last thirty minute observation at this time and noted she appeared calm.[155]

84. Outside in the smoking area Nurse Dunbridge chatted with the deceased about the deceased's children while the deceased smoked. The deceased appeared well-groomed, made good eye contact and was calm for the time they were out there. She was quiet and not spontaneous in the conversation but answered all questions that were put to her politely.[156] The deceased did not say anything to indicate that she was considering suicide or ending her life.[157]

85. After the deceased had finished her cigarette they returned inside to the unit. Nurse Dunbridge told the deceased she was going to get her medications. The deceased indicated she would check on her baby and wait for her medications.[158] Nurse Dunbridge left the deceased in the corridor and then went to the nursing station to dispense the deceased's morning medications.[159] Nurse Dunbridge estimates she was busy for about five or six minutes[160] dispensing the medications and then she went to look for the deceased in the unit to give her the medications.[161] The time was approximately 7.45 am.[162] When Nurse Dunbridge could not find the deceased quickly, she enlisted other staff to help.

86. The unit is small[163] and they were well staffed that day, so it didn't take Nurse Dunbridge and the other MBU staff long to establish that the deceased was not in the unit.[164] Nurse Dunbridge informed KEMH security at 8.00 am that the deceased was missing.[165]

87. Nurse Dunbridge's initial thought was that the deceased had gone out the door when another mother was coming in or out.

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[154] T 79 – 80.
[155] Exhibit 1, Tab 20, Visual Observation Report.
[156] T 91 – 92.
[157] Exhibit 1, Tab 14 [13].
[158] T 95.
[159] T 93.
[160] T 95.
[161] T 93.
[162] Exhibit 1, Tab 20, Integrated Progress Notes, 11.9.2012, 0830.
[163] Exhibit 3.
[164] T 93.
[165] Exhibit 1, Tab 20, Integrated Progress Notes, 11.9.2012, 1340.

Staff went outside and searched the immediate surrounds of the unit but could not find the deceased. Nurse Dunbridge and another staff member were sent to drive around the immediate vicinity and the deceased's husband and police were informed.[166]

88. Included in the brief of evidence was CCTV footage of the West Wing Corridor of the MBU and the laundry courtyard of the MBU on the morning of 11 September 2012.[167] The deceased is seen in the footage walking up and down the corridor before being accompanied by Nurse Dunbridge into the small secure smoking area.

89. At the other end of the corridor to the smoking area access door is the laundry. Accessed through the laundry is a courtyard/drying area. In September 2012 it was normal practice in the unit for the door from the laundry to the courtyard to be left open to allow patients easy access to the washing line in the garden courtyard.[168] The courtyard was surrounded by a limestone and iron wall that separated it from the surrounding carpark area and would appear, at first glance, to be relatively secure.

90. The courtyard CCTV footage shows the deceased at 7.47 am (according to the CCTV time stamp, which is approximately 15 minutes out)[169] hanging out laundry onto the drying rack in the courtyard before returning indoors.[170] She can be seen to glance briefly towards the carpark before returning inside.

91. Approximately 10 minutes later (at 7.59 am according to the time stamp) the deceased is shown on the CCTV footage returning to the courtyard. She walks purposefully towards the fenced wall and initially makes several unsuccessful attempts to scale the iron fencework. The deceased then drags a small children's playtable closer to the limestone portion of the fence and uses it to help her to climb over the limestone fence. The deceased is last seen running away from the courtyard through the adjoining carpark.[171] It took the deceased just over thirty seconds to climb the wall. In total the time from the deceased entering the courtyard, climbing the wall and the disappearing from view was less than a minute.[172]

92. The CCTV cameras at the hospital record, but are not monitored, so there was no one to alert staff to what had happened at the

[166] Exhibit 1, Tab 20, Integrated Progress Notes, 11.9.2012, 0830.
[167] Exhibit 1, Tab 22.
[168] Exhibit 1, tab 15.
[169] Report from Engineer to KEMH.
[170] Exhibit 1, Tab 2, 2 and Tab 22.
[171] Exhibit 1, Tab 2, 2 and Tab 22.
[172] Exhibit 1, Tab 2, 2 and Tab 22.

time it occurred.[173] It is apparent from the evidence that it did not occur to the staff that the deceased might have left the MBU from that location.

93. CCTV footage was also obtained from a train proceeding on the Fremantle line south between Subiaco and Daglish train stations. The footage shows the train emerged from a tunnel approximately 200 metres from KEMH at a time recorded as 7.58 am (which suggests the time clocks on either the hospital or train CCTV is slightly inaccurate). The train driver described seeing at that time a "tall figure dancing down the middle of the track."[174] He immediately applied the emergency brakes but was unable to stop the train in time to avoid impact with the person.[175] Given the speed at which the train was travelling at the time, death was instantaneous on impact.

94. Police officers attended the scene and quickly ascertained that the person involved was likely to be the deceased, who had been reported missing by the hospital.[176] The deceased was formally identified by her uncle later that afternoon.[177] Allowing for some discrepancy between the time stamps of the various CCTV footage, the times indicate that the deceased walked fairly directly from the MBU courtyard to the train tunnel exit.[178] By the time she was reported missing at 8.00 am (approximately 20 minutes after she was last seen by Nurse Dunbridge) she had already died.

CAUSE AND MANNER OF DEATH

95. A post mortem examination was conducted by the Chief Forensic Pathologist, Dr C. T. Cooke, which established the cause of death was multiple injuries. There was no evident natural disease.[179]

96. Toxicological analysis showed prescribed drugs at therapeutic levels, including the metabolite of the antidepressant Pristiq, confirming the deceased had been taking her medication.[180]

97. I accept and adopt the conclusion of Dr Cooke as to the cause of death.

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[173] T 60.
[174] Exhibit 1, Tab 6 [13].
[175] Exhibit 1, Tab 6 [14] – [15].
[176] Exhibit 1, Tab 2.
[177] Exhibit 1, Tab 3.
[178] Exhibit 1, Tab 2, 3.
[179] Exhibit 1, Tab 16.
[180] Exhibit 1, Tab 17.

98. On the evidence before me, I find that the manner of death was suicide.

QUALITY OF SUPERVISION, TREATMENT AND CARE

99. Under s 25(3) of the *Coroners Act*, where a death investigated by a coroner is of a person held in care, the coroner must comment on the quality of the supervision, treatment and care of the person while in that care. In this case, that encompasses the deceased's care at Graylands Hospital and then at the MBU.

100. The deceased's stay at Graylands was only overnight and no obvious issues arise as to her supervision, treatment and care while at that facility. However, a significant question is whether the deceased should have remained at Graylands, which is a secure facility, rather than transferred to the MBU?

101. I have outlined above the evidence of Dr Iyyalol as to why he considered it was appropriate for the deceased to be transferred from Graylands to the MBU. His decision was supported by Dr Watt, who conducted her own review of the deceased and also concluded that the MBU was the preferred place to treat the deceased at that time. Emphasis was placed by both doctors on the more therapeutic environment at the MBU (particularly compared to Graylands, where the deceased was sharing a room with a severely psychotic patient) and the fact that she would be able to be with her baby. Their mutual decision was consistent with the expressed desire of the deceased to go to the MBU.

102. The only advantage of the deceased staying at Graylands over the MBU was that she would have been unable to abscond. In hindsight, that advantage takes on greater significance. However, at the time both Dr Iyyalol and Dr Watt underestimated the deceased's risk of absconding.

103. There was clearly evidence in the deceased's history to suggest that there was a risk she might impulsively abscond. She had done so during her previous admission to the MBU in 2009 and had unexpectedly left her home and SCGH on more than one occasion in the lead up to her admission at Graylands. It was primarily the deceased's absconding behaviour while at the SCGH Emergency Department that led to the deceased being sent to Graylands on 7 September 2012 rather than the MBU.[181]

[181] T 26, 47.

104. However, this history of absconding did not appear to be given particular emphasis in the risk assessments that took place after the deceased was admitted to Graylands.

105. Following Dr Iyyalol's assessment on 8 September 2012, a progressive risk assessment nominated the deceased as at low risk of absconding prior to her assessment by Dr Watt.[182]

106. Dr Watt acknowledged that she was aware generally of the deceased's absconding history when she assessed the deceased.[183] After meeting the deceased to assess her, and taking into account what she knew of her history, Dr Watt thought it was possible that the deceased might try to abscond but she believed that admitting the deceased as an involuntary patient with thirty minute observations and regular review, would be sufficient to prevent that from happening.[184] Dr Watt did not, at that time, think the deceased needed one to one 'special' observation,[185] although Dr Watt acknowledged that, with the benefit of hindsight, that would have prevented the deceased from being able to escape from the courtyard in the way that she later did.[186]

107. After being transferred to the MBU Dr Stanojevic completed an assessment of the deceased, which included filling out a Risk Assessment Form. After questioning the deceased Dr Stanojevic rated the deceased's risk of absconding a score of 0 out of 4, with 0 categorised as 'nil evidence of such risk' at that time.[187] At the inquest Dr Watt indicated she probably would not have rated the deceased as being nil risk as there was some risk of the deceased absconding, but Dr Watt also noted that she considered the risk assessment form to be of limited utility.[188]

108. Certainly, the form used at that time did not include a history of absconding as part of the formula for assessing the risk. In comparison, the current Risk Assessment and Management Plan form used in the MBU does include a specific question about a history of absconding, although the new form no longer has the numbering formula.[189]

109. In any event, Dr Stanojevic was guided by the management plan formulated by Dr Watt, which was based upon Dr Watt's assessment of 'some' risk of absconding, so her recording of

[182] Exhibit 1, Tab 19, Integrated Progress Notes, Progressive Risk Assessment (Inpatient) 8.9.202.
[183] T 52 – 54.
[184] T 54.
[185] T 55.
[186] T 68.
[187] Exhibit 1, Tab 20, Risk Assessment Form, 8.9.2012.
[188] T 63 64.
[189] Exhibit 6, Risk Assessment and Management Plan Form.

nil risk is not of great significance. Based upon her own assessment of the deceased Dr Stanojevic could also see no reason to indicate she should contact Dr Watt to discuss varying the observations level to put the deceased on a one to one 'special' (which means a nurse must be within arm's length of a patient at all times)[190] at the time of her admission.[191]

110. None of the nursing staff who then had contact with the deceased saw any signs of deterioration in the deceased's mental health that might suggest a need for increasing the level of observation and when Dr Watt and Dr Rampono separately assessed the deceased over the following days they saw nothing to suggest the deceased's risk of absconding had increased, or that she was experiencing suicidal thoughts.

111. It therefore came as a great shock to all of the doctors and nurses involved in treating the deceased when she opportunistically absconded from the MBU and took her life. Dr Watt described herself as "very surprised" and "horrified" when she was told.[192] Dr Stanojevic also spoke of her "absolute… shock"[193] and Dr Iyyalol also spoke of his surprise when he heard the news of her death. All three doctors were deeply saddened and it is apparent that it prompted a great deal of soul searching and review of what had occurred, to see if there had been signs that were missed and to consider how a similar event could be prevented.

112. It was also apparent that the death of the deceased greatly affected the nursing staff of the MBU. Nurse Gillian Ennis, who is the Nurse Manager at the MBU and was coordinating the unit on the day the deceased died, described it as a "terrible incident" and the aftermath as a "terrible, terrible time" for the staff.[194] She acknowledged that the MBU staff's experience could not match the experience of the deceased's family, and expressed her condolences to them, but emphasised that it had had a "huge impact"[195] on the staff as well.

113. The deceased died in September 2012 and this inquest took place in December 2015. Understandably, and properly, rather than wait for the outcome of the coronial investigation the hospital immediately undertook a formal review to identify any changes that could be made to hospital infrastructure or procedures to

[190] Exhibit 2 [45].
[191] T 85; Exhibit 2 [44] – [45].
[192] T 57.
[193] T 89
[194] T 104 - 105.
[195] T 104.

prevent a similar event occurring. Following the review KEMH implemented a number of changes to the MBU, namely:

i. A standardised risk assessment has been implemented that considers the history of absconding as part of assessing the risk;
ii. An education program regarding the appropriate referral to MBU was developed to target all referral services;
iii. The laundry courtyard can now only be accessed through the closed laundry door by staff using a security electronic swipe card;
iv. All patients detained under the *Mental Health Act* (ie. involuntary patients) are supervised when out in the courtyard at all times; and
v. The height of the wall that was scaled has been significantly raised as well as additional railings added to the top. The height of the wall is now 2.4 metres.[196]

114. I have been provided with a photograph of the new fencing in the courtyard and it is noticeably higher than the previous fence, although I imagine it could be climbed if a person was determined to do so. However, the implementation of 'one to one' supervision of involuntary patients while in the courtyard, similarly to the smoking area, should alleviate the risk of that occurring.[197]

115. That does not mean the risk is eliminated entirely. As Nurse Ennis, explained at the inquest, it is impossible for practitioners working in mental health to eliminate risk entirely. Nurse Ennis stated that "[m]ental health is unpredictable. People are unpredictable....We can reduce risk, we can minimise risk, but we can never, ever totally take it away."[198]

116. The deceased managed to abscond in less than a minute, which is a very short time frame. Although the opportunity to do the same in that particular way has hopefully been removed, the 'home-like' environment of the MBU means that there are occasionally other opportunities to leave through the main access door, and there are also mechanisms available for self-harm within the unit. When events can take place in seconds, it is impossible to eliminate the risk entirely.

117. However, in the vast majority of cases the care, supervision and treatment provided at the MBU is successful in helping the women who are admitted as patients there to become well and go

[196] Exhibit 1, Tab 15; Exhibit 5.
[197] Exhibit 4.1.
[198] T 105.

home to their families.[199] That is what occurred when the deceased was treated following the birth of her first child, and it was anticipated that the deceased would have a similarly good outcome on this occasion.

118. Unfortunately, it seems that the deceased was not entirely forthcoming about her thoughts and feelings when asked by the nurses and doctors. She was asked regularly throughout her admission whether she had any suicidal intent and she always denied having such thoughts.[200] The MBU staff believed her answers were honest but, as Dr Watt acknowledged, the deceased "had something in terms of her thought processes that we didn't see."[201]

119. Dr Watt theorised that it was possible the deceased may have had the early phases of an evolving postpartum psychosis, that they were unable to detect despite questioning designed to identify if symptoms of psychosis were present.[202]

120. I accept that there was no obvious signs that the deceased was intending to take her life on the day of her death, up until the moment that she is seen on the CCTV footage climbing the wall. The events then happen so quickly that there was no opportunity for the MBU staff to prevent it.

121. What these events reinforce is that people experiencing mental illness can be unpredictable and there is, therefore, a need to exercise caution in relation to the structural and supervision aspects of treatment, that can be controlled. As Dr Watt explained, those things are a "safety net" for when diagnostic techniques fail.[203]

122. That does not mean that I believe the decision to transfer the deceased from Graylands to the MBU was an error. The environment at Graylands was clearly not a therapeutic one for the deceased, and it was important that she be given an opportunity to bond with her baby, which seemed to be one of her major concerns. Given the ethos of the *Mental Health Act*, both in 2012 and as currently enacted, is to ensure that people who have a mental illness are provided with the best treatment and care with the least restriction of their freedom necessary,[204] it is difficult to see how keeping the deceased in a locked ward at Graylands and separated from her newborn baby, could have

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[199] T 73.
[200] Exhibit 1, Tab 20, Integrated Progress Notes.
[201] T 60.
[202] T 59 – 60.
[203] T 70.
[204] S 10 *Mental Health Act 2014* (WA); S 5 *Mental Health Act 1996* (WA).

been justified based upon her answers and presentation at the time. As Dr Watt observed, the changes that have been made to the legislation since the death of the deceased would, if anything, have made it difficult to treat the deceased as an involuntary patient for as long as they did.[205]

123. In the end, I am satisfied that the deceased was properly admitted to the MBU, irrespective of her history of absconding, and was receiving an appropriate level of medical treatment and care. However, there was a failing in the supervision of the deceased in that she was allowed unsupervised access to the laundry courtyard, which was inadequately fenced to contain her. This was demonstrated by her ability to leave the courtyard with minimum effort in a very short period of time. The structural 'safety net' failed in this case.

124. The deceased's unsupervised access to the courtyard in those circumstances was inappropriate given the ward had been 'locked'[206] as a consequence of the admission of the deceased as an involuntary patient. I make that comment even while acknowledging that the MBU is not designed to be fully secure in the same way that a locked ward at Graylands is considered secure. There was an appropriate procedure in place at that time for the deceased to smoke a cigarette in a fully secure area under supervision, and a similar procedure should have been in place for the deceased (who was an involuntary patient at the time) when accessing the laundry courtyard.

125. I am satisfied the changes implemented in the MBU following the death of the deceased should greatly reduce the risk of a similar event occurring again.

CONCLUSION

126. The deceased presented to various psychiatric services in the days following the birth of her second child. She was ultimately diagnosed with major depressive disorder post partum (similar to what she experienced following the birth of her second child).

127. After a short time at SCGH and Graylands, the deceased was provided with the majority of her treatment, care and supervision at the Mother and Baby Unit at KEMH. During her admission she consistently denied any suicidal thoughts and there were no obvious indications that her denials were not genuine. The

[205] T 71 – 72.
[206] Exhibit 5.

deceased appeared compliant with her management plan and medications and showed some signs of improvement.

128. The evidence suggests the deceased's suicide was unplanned, impulsive and opportunistic. Having said that, it is apparent from the CCTV footage and the manner of her suicide that once she had made the decision she was purposeful in her intent. It is concerning that she was able to put her plan into effect so easily, given she was an involuntary patient at the time with a history of absconding.

129. Sadly, if the deceased had been more securely contained, I am confident based on the expert evidence given at the inquest that the deceased would most likely have responded to treatment and eventually been able to go home to love and care for her two little boys, as she so desperately wanted. Instead, the deceased's sons are left to be cared for by their father and close relatives, and will never have the opportunity to know their mother as they grow into young men. Dr Stanojevic described the deceased's death as "a tragedy," which I agree is an apt description.[207]

130. What is hoped by the deceased's family is that out of this tragedy lessons are learnt. The same hope is shared by the MBU staff. As Nurse Ennis expressed it, "we never want to experience what the family have experienced and our staff have experienced ever again."[208]

131. At the conclusion of this investigation I am satisfied the staff and management of the MBU and KEMH have done their utmost to identify the failings in the care of the deceased that allowed her the opportunity to take her life that day and to implement measures to prevent a similar event in the future.

S H Linton
Coroner
16 February 2015

[207] T 89.
[208] T 105.