



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

*Coroners Act 1995
Coroners Rules 2006
Rule 11*

I, Simon Cooper, Coroner, having investigated the death of Carole Ann Le Roy

Find, pursuant to section 28(1) of the Coroners Act 1995, that:

- a) The identity of the deceased is Carole Ann Le Roy;
- b) Mrs Le Roy died as a result of hanging, an action undertaken by her voluntarily, alone and with the express intention of ending her own life;
- c) The cause of Mrs Le Roy's death was hypoxic encephalopathy due to asphyxia; and
- d) Mrs Le Roy died on 24 February 2018 at the Royal Hobart Hospital, Hobart, Tasmania.

In making the above findings I have had regard to the evidence gained in the comprehensive investigation into Mrs Le Roy's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Affidavit of Mr Jason Le Roy, Mrs Le Roy's husband;
- An opinion of the Forensic Pathologist who conducted the autopsy;
- The results of toxicological analysis of samples taken at autopsy;
- Medical records – Royal Hobart Hospital;
- Medical records – Department of Health and Human Services – Mental Health Services;
- Final Root Cause Analysis Report;
- Report of Dr Lennie Woo, Psychiatrist;
- Affidavit of Registered Nurse Virginia Hancl;
- Affidavit of Registered Nurse Jalicea Martyn;
- Affidavit of Registered Nurse Jacob Roberts;
- Affidavit of Clinical Nurse Consultant Joanne Thompson;
- Affidavit of Registered Nurse Rebecca Carroll;
- Affidavit of Registered Nurse Jessica Poole;
- Affidavit of Dr Christopher Wilde, Staff Specialist, Department of Anaesthesia and Perioperative Medicine, Royal Hobart Hospital;

- Affidavit of Dr Declan Siedler, Resident Medical Officer, Royal Hobart Hospital (RHH);
- Affidavit of Dr Anil Reddy, Consultant Psychiatrist, Clarence and Eastern Districts Adult Community Mental Health Service;
- Letter Dr Stephen Ayre, Executive Director of Medical Services, RHH, dated 15 September 2020;
- Letter Dr Ben Elijah, Medical Director, Statewide Mental Health Services, dated 15 September 2020; and
- Affidavits of investigating police.

Background

Mrs Le Roy was born in Cumbria in the United Kingdom on 17 October 1977. She was married to Jason for 17 years and the couple had two children together.

In 2006, Mr and Mrs Le Roy emigrated to Australia. From then until her death, Mrs Le Roy lived with her family in Hobart. She worked in the retail industry and was employed at Habitat, Cambridge Park at the time of her death.

Mrs Le Roy had an extensive mental health history including obsessive compulsive disorder, complex trauma disorder and severe depression. She had a well-documented history of self-harm and suicidal ideation, along with anxiety and an eating disorder. In addition, Mrs Le Roy suffered periodic seizures.

Her mental and physical health was, in the lead up to her death, being treated by a multi-disciplinary team, which included a general practitioner, psychologist and psychiatrist. In addition, she was a patient of the Clarence and Eastern Adult Community Mental Health Service.

Mrs Le Roy's medical records indicate admissions to the Royal Hobart Hospital Inpatient Psychiatric and Mental Health Clinic. On occasion, she had Electro Convulsive Therapy. Reportedly, she made two attempts at suicide during 2016.

It is evident that in the lead up to her death, Mrs Le Roy was extremely unwell.

Circumstances of Death

On Saturday 17 February 2018, Mr Le Roy contacted the Clarence and Eastern Adult Community Mental Health Service and asked for the assistance of the service's Crisis

Assessment and Treatment Team (CAT team) for an urgent assessment, because his wife was expressing suicidal ideation.

The CAT team facilitated Mrs Le Roy's transport to the Royal Hobart Hospital where she was evaluated in the Emergency Room. After evaluation, she was admitted to the Open Unit of the hospital's Department of Psychiatry as a voluntary patient (that is, not pursuant to an order under the *Mental Health Act 2013*). The decision to accommodate her in the Open Unit appears to have been made after discussion between a Psychiatric Registrar and a Psychiatric Emergency Nurse who actually carried out the assessment of Mrs Le Roy. Two alternatives to the Open Unit existed, the High Dependency Unit and the Closed Unit. The Open Unit was designed to accommodate patients in lower risk categories.

The following day, 18 February, staff at the Unit contacted Mr Le Roy requesting that he bring her medication to the hospital because a particular prescription was not available in the hospital pharmacy. Mr Le Roy delivered the medication to the Unit that afternoon as requested.

The same day, Mrs Le Roy was seen by a Psychiatric Registrar and consultant. Her medical records indicate she was assessed as having a "suicidal crisis". Her records indicate she stayed mainly in her room, seemed "flat" to nursing staff and was noted as being unable to guarantee her safety.

On 19 February 2018, nursing staff assessed Mrs Le Roy as having a "moderate risk" of intentional self-harm. That assessment is recorded as being made late in the morning of that day. She was seen by staff in the unit at about 1.00pm.

At about 3.10pm, Mrs Le Roy was found hanging by the shoulder strap of a duffle bag attached to a door handle in the room. Staff cut the strap and Mrs Le Roy fell heavily to the floor, hitting her forehead. Mrs Le Roy was unconscious and in cardiac arrest. She was resuscitated, intubated, ventilated, and transferred to the Intensive Care Unit. In the ICU, Mrs Le Roy remained critically unwell. She was neurologically unresponsive.

After consultation with family, ventilator support was withdrawn at 6.30pm on 24 February 2018. She died shortly after, at 6.52pm.

Investigation

The fact of Mrs Le Roy's death was reported pursuant to the provisions of the *Coroners Act 1995*. Her body was formally identified and then transferred to the hospital's mortuary. At the

mortuary, Forensic Pathologist Dr Donald Ritchey, performed an autopsy. After autopsy, Dr Ritchey provided a report in which he expressed the opinion, which I accept, that the cause of Mrs Le Roy's death was hypoxic encephalopathy (brain injury). Toxicological analysis of samples taken at autopsy revealed only the presence of therapeutic levels of prescription drugs.

The focus of the investigation was how it could be that a person such as Mrs Le Roy, admitted to a psychiatric unit in a hospital because of suicidal ideation, could in fact commit suicide in that unit. To that end, Mrs Le Roy's medical records were obtained and reviewed. Reports and affidavits from staff at the unit, as well as her broader treating team, were sought and obtained. The result of the hospital's own investigation was obtained. All this information informed the conclusion and comments which follow.

Discussion

It is quite apparent, as I have already said, that at the time of Mrs Le Roy's admission to the Royal Hobart Hospital, she was extremely mentally unwell. That fact should have been apparent at the time of her admission. She was receiving a high level of mental health care and support in the community and was evidently in a crisis because of an escalation of her symptoms.

I am satisfied she was appropriately assessed when she reached the hospital but the decision to admit her to the hospital's Department of Psychiatry's Open Unit seems to have been the wrong one given the significant change in the pattern of her presentation from previous admissions. The hospital in its Final Root Cause Analysis Report acknowledged that this was so. The RCA indicated that this decision was made in the context of:

- Chaotic lack of governance, nursing processes and structures;
- A ward that is managed as a single ward yet is 3 discrete units geographically separated;
- Lack of team structure; and
- A lack of systematic management of risk and operationalising [sic] this through uses of policies and documents.

I am satisfied that all of these factors contributed to the decision which led to Mrs Le Roy, obviously a suicide risk, being accommodated in the open ward. A number of other factors, all unfortunately adverse, contributed to her death.

First, after Mrs Le Roy was reviewed by a consultant, there is no evidence in her medical records that the management plan formulated for her was actually followed. This is particularly important because the management plan required hourly observations. Had those observations been undertaken, staff may have been given a clue as to her intentions.

Second, Mrs Le Roy was accommodated in a room that allowed her to use a ligature to hang herself.

Third, the door to the room could be locked from the inside. This meant, given the nursing staff did not appear to be carrying a key to the door, that there was a delay in entering her room once the emergency was detected.

Finally, the fact that Mrs Le Roy had in her possession the strap which was able to be used as a ligature seems to me to be indicative of a failure of basic care for a suicidal psychiatric patient.

The decision to accommodate Mrs Le Roy in the Open Unit was a poor one. The care she received after being admitted to that Unit was, in my view, significantly below the standard reasonably expected.

These findings were sent in draft to the responsible agencies for comment. I acknowledge and appreciate the level of cooperation received from both the Royal Hobart Hospital and Statewide Mental Health Services in relation to this investigation. The medical director of Statewide Mental Health Services said in his comprehensive response:

“What is not in doubt, is the failure to follow the one hourly nursing review in the admission plan, an apparent absence of proactive consideration of material on hand in a patient’s possession (when admitted for suicidal distress), and a built environment which allowed for hanging.”

This response is completely in accordance with the clear evidence surrounding Ms Le Roy’s death. The medical director also pointed out, and I accept, that Statewide Mental Health Services have been moved to a new and specially planned design within K Block which feature anti-ligature amenities designed in accordance with contemporary practice in Mental Health Units.

Finally, I should say that I consider the evidence makes clear that the treatment Mrs Le Roy received after she was discovered hanging in her room in the Department of Psychiatry Open Unit was of an appropriate standard.

Comments and Recommendations

I am aware that there has been changes to the physical environment of the Department of Psychiatry at the Royal Hobart Hospital. Accordingly, I do not consider it necessary to make any formal recommendations. I **comment**, however, that the issues I have highlighted above, in my respectful view, directly contributed to Mrs Le Roy's death. It is imperative that they are addressed by the hospital.

I convey my sincere condolences to the family and loved ones of Mrs Le Roy.

Dated: 9 October 2020 at Hobart in the State of Tasmania.

Simon Cooper
Coroner