MAGISTRATES COURT TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

(These findings have been de-identified in relation to the name of the deceased and family by the direction of the Coroner pursuant to s 57(1)(c) of the Coroners Act 1995)

I, Olivia McTaggart, Coroner, having investigated the death of VY

Find, pursuant to Section 28(1) of the *Coroners Act* 1995, that

a) The identity of the deceased is VY, date of birth 10 January 1942.

b) VY was 82 years of age, was widowed, and lived independently in Moonah. VY received regular support from her family and community nursing staff. Her medical history included recurrent cellulitis and leg lymphoedema, breast and bowel cancer, hypertension, atrial fibrillation and stroke. Leading up to her death, she was experiencing severe groin pain. VY was admitted to the Royal Hobart Hospital (RHH) on 2 September 2024 for her pain and was assessed as having acute exacerbations of her lower limb cellulitis and functional decline. VY remained an inpatient at RHH, receiving treatment and physical therapy, and her symptoms improved.

The physiotherapist and occupational therapist were of the view that VY would require further support at home due to incapacity from weakness and tremors. On 13 September 2024, the medical consultant had a discussion with VY about her care needs and raised the possibility of her entering a residential aged care facility. She became distressed over this possibility and, in the evening, told her daughter that she did not *"want to go on anymore"* and that she *"wanted to die."* VY's daughter was concerned that her mother was suicidal and reported this concern to nursing staff who, in turn, requested a doctor to review VY. The hospital records note that VY's mood appeared to be down, and she was frustrated at her own lethargy and inability to feed herself.

When the doctor arrived that evening, VY was asleep and the doctor elected not to wake her up to talk about her distress. A plan was developed

to consider psychiatric or psychological review if VY's suicidal ideation continued.

VY was found deceased in her hospital bed by nursing staff the following morning, 14 September 2024. There were two plastic bags over her head.

c) The evidence in the investigation, including inspection of the scene by attending police officers and autopsy by the State Forensic Pathologist, allows me to find that VY died of plastic bag asphyxia. I find that VY placed the plastic bags over her head with the intention of depriving herself of air and bringing about her own death. In this situation, her death was caused by irreversible vasovagal-induced cardiac arrhythmia which occurred rapidly following the placement of the bags over her head. There are no suspicious circumstances, and no other person was involved in her death. The plastic bags belonged to VY and were part of her personal possessions in her room. During the night of her suicide, she had requested a staff member obtain one of her plastic bags so that she could use it in conjunction with her heat pack.

d) VY died on 14 September 2024 at Hobart, Tasmania.

In making the above findings, I have had regard to the evidence gained in the investigation into VY's death. The evidence includes:

- The Police Report of Death for the Coroner;
- Tasmanian Government Death Report to Coroner;
- Toxicology report of Forensic Science Service Tasmania;
- Affidavits confirming identity;
- Opinion of the forensic pathologist who conducted the autopsy;
- Report from Kevin Egan, SFMS Clinical Nurse Consultant;
- Affidavits of BN and DT, daughters of VY;
- Affidavits of RHH medical and nursing staff regarding the care and treatment of VY and the circumstances surrounding her death;
- Tasmanian Health Service Final RCA Report 9 January 2025; and
- Correspondence to Coronial Division from Department of Health regarding completion of RCA recommendations.

Comments and Recommendations

I do not consider that hospital staff could have reasonably foreseen that VY would choose to end her life at that time, nor that she had the ability to carry out her intentions as she did.

Nevertheless, the Department of Health, Final Root Cause Analysis (RCA) report identified a missed opportunity for hospital staff to respond to VY's suicidal ideation in accordance with best practice. This would have involved staff conducting a full suicide risk assessment upon receiving the information from her daughter to determine the seriousness of her intent. As this did not occur, they were unable to implement better-informed mitigation strategies to prevent VY's suicide. Even if this had occurred, VY may still have ended her life.

The RCA identified that the staff involved in VY's care followed all existing processes to provide support to her but that there was a lack of essential systems and processes regarding a response to an acute deterioration in a patient's mental well-being, including assessment and recognition of potential suicidal ideation, and appropriate and timely response to at risk patients. This being the case, the RHH did not have processes in place that ensured compliance with the national standards, namely processes that *'ensure rapid referral to mental health services to meet the needs of patients whose mental state has acutely deteriorated'*.[1]

Hospital staff are required to use the Comprehensive Care Plan ("CCP") and CCP continuation tools to assist them in identifying whether a patient is at risk of self-harm. The RCA notes that the initial CCP was not completed on admission, as required, but was completed on 5 of VY's 11 days in hospital. It is noted in the RCA that the CCP tool is not designed to assess a patient's mood or emotional wellbeing and therefore is not an adequate tool to assess risk in patients who may have acute distress following their admission into hospital.[2] Recommendations from the RCA have been implemented by the hospital around improving completion rates of the CCP and the quality of information obtained in them.

Significantly, the RCA panel recommended the development of a framework for recognising and rapidly responding to acute deterioration in the mental well-being of patients. The RHH has responded by, since January 2026, including mental state deterioration in the revised Adult Deterioration Detection System. The RHH has also

[1] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards (2nd edition)* 8.12.
[2] It is more focused on patient challenging behaviours and cognitive impairment concerns, neither of which were relevant for VY.

provided education to its staff regarding recognising and responding to acute deterioration.

I **recommend** that the THS, at an appropriate interval, conducts a review of the operation and efficacy of its framework for recognising and rapidly responding to acute deterioration in the mental well-being of patients; and, based upon the results of the review, make any desirable changes to the framework and deliver necessary staff education.

I convey my sincere condolences to the family and loved ones of VY.

Dated: 17 August 2026 at Hobart, in the State of Tasmania.

Olivia McTaggart

Coroner