Coroners Court

Of New South Wales

Lismore

Findings in the Inquest into the death of Miriam Merten

The primary function of the Coroner is to ascertain the time date place, manner and cause of death of a known person. In this matter there is no doubt of those matters and I find that the deceased Miriam Merten died at Lismore Base Hospital at about 10:30 am on 3rd June 2014 of traumatic and Hypoxic brain injury caused by numerous falls and the self-beating of her head on various surfaces the latter not done with the intention of taking her own life.

The death occurred as a result of her admission to the mental health unit of the Lismore base hospital.

There are a number of protocols and Systems in place at the Lismore Base hospital mental health unit.

The deceased was a well-known patient at the hospital and had numerous admissions over many years. She was at times difficult to handle being manic and abusive. As indicated above at the relevant time the area health service had a number of protocols in place which applied or should have applied to the management of the deceased given her presentation at the hospital on 26 May 2014. Due to the deceased's management issues she was placed in seclusion

at 2350 hours on 1st June 2014 and this ended at 5:10 on 2nd June 2014. During that seclusion a number of Health policies applied.

During the first 60 minutes of seclusion Ministry of Health Procedure PD2012_035 specifies that the required observations for the first 60 minutes of being placed in seclusion to include both the provision of information to the patient on entering seclusion (point 4.9) observations (point 4.10) and clothing (point 4.11).

The inquest had available as part of the brief a report from Christine Muller a registered nurse of some 36 years' experience with amongst other qualifications a Master's degree in Nursing-Mental Health Nurse Practitioner. In her opinion the treatment of the deceased did not comply in numerous respects with the relevant standards in that the deceased:

(a) Was not provided with information as specified in point 4.7 above

(b) Did not have her physical health assessed, particularly in regard to neuro observations following episodes of reported head banging on previous shifts or consider falls risks associated with high doses of psychotropic medication.

(c) Was not offered water or opportunity to use the bathroom either prior to seclusion or during the initial 60 minute period.

(d) Was not verbally communicated with while awake.

(e) Was only observed via a video monitor in a darkened room which in turn did not allow her to be monitored or assessed properly

(f) Was constantly observed via video monitor contrary to the spirit of the procedure/policy directive

(g) Was not assisted in utilising a dressing gown prior to being placed in seclusion but had the gown thrown in the room.

The evidence from the CCTV footage discloses the deceased having at least 25 falls between 2350 on 1st June and 6:49 on 2nd June. The observation charts and clinical records do not reflect any observations of those falls. It is inconceivable that the nature and number of falls were not observed. The charts do disclose that the deceased was incontinent of faeces as at 0440 hours but was not given access to toilet facilities until 0515 hours. Ms Muller found and I accept that the adequacy and appropriateness of the deceased's observations and subsequent care fell significantly below the standard that would reasonably be expected in the circumstances.

For a significant period that the deceased was in seclusion

she can be seen on the CCTV to be naked. Ministry of Health Procedure PD 2012_035 POINT 4.11 PROVIDES "No person will be placed naked into seclusion unless this compromises their safety or the safety of others. If the consumer removes their clothing while in seclusion, staff will make efforts to maintain their dignity by offering alternative clothing..." The CCTV clearly shows the deceased unclothed during the period of seclusion and walking in the corridor after seclusion. No effort was made to assist in having her attired except by apparently throwing a gown I the room as detailed above.

Failure to ensure one to one observation of the deceased for the first hour of seclusion.

The Ministry of Health Policy PD 2012_035 provides for actual observation and communication due to ensure that the nurse is "able to ensure the patients physical safety and continually assess behaviour with the view to ceasing the intervention as soon as possible." The senior nurse deliberately made a decision not to comply with this protocol leading, together with other conduct, to conclude that there was no intention to cease the seclusion during her shift.

Failure of the senior nurse to take action after observing a fall.

The deceased had, to the senior nurse's knowledge, been sedated with psychotropic drugs and had on at least one occasion fallen. Ms Muller in her report sets out details a summary of minimum standards of care in those circumstances, including

1. Removing the patient from an environment where there are high risks of falls
2. Reassure and support the patient
3. Assess the patient for any possible injuries sustained as a result of the fall
4. Assess and monitor the patient's level of consciousness
5. Complete physical observations, including neuro observations if the patient has hit her head
6. Monitor the patient for any deterioration such as headache, nausea, vomiting and confusion as injuries may not be apparent at the time of initial fall
7. Be aware that the best indication for future falls is an actual fall
8. Document the fall, observations and monitoring regime

9. Report the fall and arrange for a doctor to assess the patient

In this instance I am satisfied the senior nurse failed with respect to all of the above protocols. Not only did this occur on one occasion but based on the CCTV evidence it occurred on multiple occasions. In particular the deceased was provided with no proper care following the obvious falls between 06:38:44 and 06:49:41 on 2 June 2014 and indeed was treated with complete indifference.

Should the papers be referred to the Director of Public Prosecutions?

Given the circumstances enunciated above I have looked at the question of a referral to the Director of Public Prosecutions on the question of involuntary manslaughter by an unlawful and dangerous act or by criminal negligence. Sgt Rowe provided an excellent summary of the law in that regard. The main point in my view is the test enunciated in Wilson v The Queen (1992) 174 CLR 313 where the High Court stated "For a person to be guilty of manslaughter by an unlawful and dangerous act, the circumstances must be such that a reasonable person in the accused's position would have realised that he or she was exposing another or others to an appreciable risk of serious injury. It is not sufficient that there was a risk of some harm resulting, albeit not serious harm."

In this inquest there is no evidence of any severe single obvious trauma although the repetitive head blows (self-inflicted) raise obvious concerns.

I am not satisfied in all the circumstances that a referral should be made and decline to do so.

Final Comments

According to the Area Health Service Protocol and policy a patient entering the system should be treated with dignity and respect and be afforded proper health care.

The deceased's care was in the hands of two nurses. The senior and by far the most experienced nurse was Nurse Christine Borthistle. Assisting was Nurse Mark Andrew Burton. All relevant decisions were made by Nurse Borthistle who gave evidence at the inquest. The report of Christine Muller is to say the least damning in its assessment of the treatment afforded the deceased. In respect of the lack of care and indifference shown to the deceased her report indicated that the treatment in many ways "falls significantly below the standard" expected and that it "invites my strong criticism." I concur with these views. The lack of care and compassion showed to the deceased was monumentally disgraceful and appeared to emanate from an" Oh it's just Miriam" mentality. This particularly relates to Nurse

Borthistle who had dealt with the deceased on many occasions.

Nurse Burton declined to give evidence and was excused. He did however provide a statement to Detective Light which formed part of the brief. Nurse Burton was a very inexperienced mental health nurse who had finished a 12 month transition to practice mental health in February 2014. At the completion of the course he was placed in a casual pool as he had been advised there were no employment opportunities in the hospital. Between April and June he received some shifts including 3 shifts in the High Dependency Unit. After observing the deceased being medicated by Nurse Borthistle he was directed by her not to enter the ward, the effect of which was to not comply with health policy. He was told this was necessary due to the deceased's behaviour and IN PARTICULAR, poor staffing levels. Nurse Borthistle specifically directed Nurse Burton not to approach the deceased for the 10 minute observations which are usually performed when a patient is placed in seclusion. When questioned as to whether he should sit in the seclusion corridor Nurse Borthistle advised that due to **LACK OF STAFF NUMBERS** he should use the video monitor in the nurses' station. His statement continues "Given her seniority and explanation I deferred to her decision."

Nurse Burton found himself in a difficult position. With limited experience and in the presence of an extremely

experienced mental health nurse he accepted her decisions and directions in the circumstances. I make no other comment.

During the course of the inquest a number of mentions were made of lack of staffing and the availability of more senior staff to approve additional staffing. Nurse Borthistle justified a number of her decisions on the basis of lack of staff. During her evidence she made mention of the theoretical availability of obtaining assistance from hospital management. Her view was that **IN FACT** nursing staff were actively discouraged from seeking that assistance.

In this inquest those questions in the end were irrelevant to the subject matter at hand but as a general proposition if there is a protocol in place for management to be approached then it should be a protocol encouraged in practice not only in theory.

This was a very sad inquest. To see a mentally ill person in 2014 at a public hospital in NSW treated in such an appalling manner is really beyond comprehension. The sight of the deceased wandering the corridor naked and covered in excrement while the senior nurse is seen to mop the floor apparently oblivious to her is horrific. While this appears not to be a system failure it is clearly a serious human failure. It is for another place to take such disciplinary proceedings as appear necessary.

I express my condolences to the family of the deceased

I wish to thank Detective Rohan Light for the inordinate hours he put in to this matter and the outstanding brief compiled by him.

I also thank Ms Christine Muller for her invaluable expert report which formed the basis of much of this decision.

I than Sgt Gary Rowe, counsel assisting, for his invaluable assistance in the running of the inquest

Finally I thank the legal representatives of the Area Health Service and Nurse Burton for their valuable assistance in the hearing.

I direct that a copy of these findings and comments be sent to the Minister for Health for her information and the Health Care Complaints Commission for their consideration.

His Honour

Magistrate J.Linden

Coroner

7 September 2016