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Health Insights

Coroner recommends new standard for in patient observations

The Coroner has recommended that the Chief Psychiatrist in Victoria formulate a directive in relation to standard protocols for conducting visual observations of patients at in-patient facilities. The recommendation comes as the result of findings at the inquest into the death of a woman who passed away whilst she was an in-patient at a private facility (the 'Facility') in February 2017.

The deceased had a long history of mental health disorders and voluntarily admitted herself to the Facility on 14 February 2017. Importantly, and despite autopsy, the cause of her death was unascertainable. This limited the ambit of the inquest, which focussed primarily on events which took place during the afternoon/evening of her untimely death on 27 February 2017. In particular, there was some controversy between the deceased's sister, and a nurse who was on-duty at the nurses station at the time, which pertained to the content of a conversation they had when the deceased's sister reported being worried about the deceased's wellbeing. Following on from that, but dependent on the resolution of that controversy, was whether the nurse was sufficiently responsive to those concerns. In fact, the Coroner described the separate versions of events as being "diametrically opposed[1]", and it was this contradiction which resulted in the referral of the matter to inquest.

Despite hearing viva voce evidence from both parties the Coroner felt unable to reasonably reject either version, however His Honour did feel in a position to comment on and make recommendations about the adequacy of visual observations that were conducted on the deceased on the afternoon and evening of her death.

In accordance with the Facility's risk assessment and patient observations policy at the time, formal visual observations of the deceased were conducted from her doorway at 3.20pm and 6pm on 27 February 2017, at which time it was noted she was breathing[2]. The Coroner acknowledged that this being a psychiatric facility,

> *"…it seems the focus of the policy is on establishing whether a patient is…'present and accounted for', in effect to establish that a patient has not absconded, or is at risk of doing him or herself a mischief, not to generally gauge the patients' psychical (sic) wellbeing. To that end an observation from a doorway is probably reasonable, but certainly not sufficient to make a judgement as to the patients' physical condition.[3]"*

The Coroner noted that the deficiency in the policy had been recognised and replaced with a new policy, in August 2017.[4]

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[1] Inquest into the death of Elizabeth Honor Ewart, 29 October 2019, at paragraph 24.
[2] Ibid, paragraph 75.
[3] Ibid, paragraph 73.
[4] Ibid, paragraph 76 – 77.

However, it was noted that the Coroners Prevention Unit clinician had been unable to find a guideline amongst the online guidelines published by the Chief Psychiatrist in Victoria that "prescribe(s) a standard of medical observation or assessment for patients who may be developing a medical condition[5]" in this State. As such, and in an effort to create consistency throughout the industry, the Coroner recommended that:

> *"The Chief Psychiatrist formulate a directive to prescribing a standard protocol/practice in all inpatient facilities that visual observation of a patient include not only full faced unequivocal identification but, to ensure the physical wellbeing of the patient, a screening for any changes in presentation that may indicate an acute or developing medical condition.[6]"*

In light of these findings and recommendation, it would be prudent for all in-patient facilities to review their policies for risk assessment and patient observation, and ensure that they are sufficiently robust as to meet this standard. Extrapolating outwards, any other facilities which ordinarily conduct risk assessments and observations on patients, such as prisons, would also be judicious in reviewing their policies.

Meridian Lawyers regularly provides advice and assistance to practitioners and organisations who may be involved in coronial investigations or inquests. This article was written by Principal Kellie Dell'Oro and Associate Anna Martin. Please contact us if you have any questions or for further information.

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[5] Ibid, paragraph 92.
[6] Ibid.