



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 12th and 13th days of February 2013 and the 4th day of March 2013, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Nobuko Nagasue Homewood.

The said Court finds that Nobuko Nagasue Homewood aged 61 years, late of 45 Charlbury Road, Medindie Gardens, South Australia died at the Royal Adelaide Hospital, North Terrace, Adelaide, South Australia on the 10th day of August 2010 as a result of hypoxic brain injury following cardiac arrest due to neck compression due to hanging. The said Court finds that the circumstances of her death were as follows:

1. Introduction and reason for Inquest

- 1.1. Nobuko Nagasue Homewood died on 10 August 2010. She was aged 61 years. Mrs Homewood had been detained pursuant to the Mental Health Act 2009 at the Royal Adelaide Hospital on 3 August 2010. The order expired on 9 August 2010, but by that time Mrs Homewood was in a coma in the Intensive Care Unit from which she never recovered. Accordingly, hers was a death in custody within the meaning of the Coroner's Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act.
- 1.2. Mrs Homewood had been found hanging from a curtain on the hospital ward C3 on 8 August 2010. At the time she was found she was in asystolic cardiac arrest but she was successfully resuscitated following approximately 45 minutes without cardiac output. She was admitted to the Intensive Care Unit but a CT scan of the head showed changes consistent with hypoxic brain damage. She showed no evidence of

neurological recovery and was declared deceased on 10 August 2010. An autopsy was performed by Dr Karen Heath who gave the cause of death as hypoxic brain injury following cardiac arrest due to neck compression due to hanging¹, and I so find.

2. The circumstances leading to Mrs Homewood's hospitalisation

- 2.1. On 2 August 2010 Mrs Homewood's husband awoke and commenced his daily activities. After some time he noted that his wife had not gotten up for the day and he assumed she was sleeping in. At about 12pm he went into the kitchen and saw a red box on the kitchen table with a note on it. The note was written in Japanese and was addressed to him. The contents of the note suggested that Mrs Homewood may have attempted to take her life. He went into the bedroom and saw Mrs Homewood lying on the bed. He said that she looked almost dead because she was pale and was lying with her mouth wide open². He immediately called an ambulance and they arrived soon after. In the meantime Mr Homewood opened the red box in the kitchen and saw that it was full of money in Japanese and Australian notes. He later counted the money and found that there was about \$10,000.
- 2.2. Mr Homewood later reported to staff at the Royal Adelaide Hospital Emergency Department that he had found empty packets of the antidepressant medication, Mirtazapine, by the side of Mrs Homewood's bed with approximately 30 to 50 missing tablets³.

3. Mrs Homewood's mental health history

- 3.1. Mrs Homewood had come to Australia in 1980 with her husband. They had one son. Mr Homewood said that Mrs Homewood had first experienced depression when their son was in primary school. He said that approximately 3 years prior to her death Mrs Homewood had been diagnosed with high blood pressure. Mr Homewood said that she became 'paranoid'⁴ about this condition and she had two admissions to the Royal Adelaide Hospital as a result of feeling unwell soon afterwards.
- 3.2. In 2009 Mrs Homewood's son had been the victim of a home invasion and serious assault. He reported the matter to police and moved interstate. The Court case

¹ Exhibit C3b

² Exhibit C1b, page 5

³ Exhibit C18, page 305

⁴ Exhibit C1b, page 2

against his assailants was pending at the time of Mrs Homewood's death, but she was very worried about her son and what had occurred. She was also worried about the fact that he was living interstate by himself and the pending Court case in which he would have to give evidence. As a result it appears that her depression had returned.

- 3.3. Mrs Homewood consulted general practitioner Dr Yuen who recorded soon after her diagnosis with high blood pressure that Mrs Homewood was:

'Highly anxious and I have told her that she shouldn't worry too much about her blood pressure.'⁵

- 3.4. Dr Craig Raeside, who gave expert evidence in this case, commented that this note and other indicators in the notes demonstrated an increasing anxiety in Mrs Homewood about her wellbeing⁶.

- 3.5. From about 2007 Mrs Homewood was prescribed sleeping tablets in the form of Temazepam and the antidepressant Prozac. This was substituted with Avanza (Mirtazapine). Dr Yuen noted that Mrs Homewood showed signs of depression after her blood pressure was found to be very high in late 2007. Dr Yuen said that Mrs Homewood was anxious and wary of medication and was often reducing or ceasing her medication herself⁷ against medical advice.

- 3.6. The Mirtazapine was prescribed at the dose of 15mg per day which was described by Dr Raeside in his evidence as a low starting dose and well below a therapeutic level which he said would be achieved at 30mg per day⁸. While it is difficult to be certain, as a result of Mrs Homewood's apparently irregular compliance with her medical advice, it appears that she remained on this low starting dose of Mirtazapine because of her reluctance to take medication at all, and particularly to increase the dose even when recommended by Dr Yuen. Indeed, an entry in Dr Yuen's medical notes on 7 June 2010 noted that Mrs Homewood was reluctant to take the 30mg and that although she still felt anxious and her mood was low, despite Dr Yuen's 'insistence' she wanted to keep the dose at the status quo (ie. 15mg)⁹.

⁵ Exhibit C17

⁶ Exhibit C24

⁷ Exhibit C12a, page 6

⁸ Transcript, pages 146-147

⁹ Exhibit C17

4. Mrs Homewood's admission at the Royal Adelaide Hospital

- 4.1. As I have said, Mrs Homewood was admitted to the Royal Adelaide Hospital Emergency Department on 2 August 2010 following the overdose. She was assessed by consultant psychiatrist Dr Kent on 3 August 2010 and he confirmed the detention order that had been made in the Emergency Department. He noted ongoing suicidal ideation in the context of a depressed mood. He diagnosed a major depressive disorder. He wondered whether there may have actually been some psychotic symptoms as well, possibly because Mrs Homewood's worry could have been construed as almost delusional in its context. However, he was confident that any psychotic symptoms would be detected during further assessment. No doubt as a result of this, he did not introduce any antipsychotic medication¹⁰. In any event, Dr Raeside's evidence was that even if antipsychotic medication had been introduced during Mrs Homewood's hospital stay, it would not have had time to have effect prior to her hanging herself on 8 August 2010. The matter of antipsychotic medication need not therefore be further considered.
- 4.2. A psychiatric assessment of Mrs Homewood was made on 5 August 2010 by Dr Hartstone, the consultation liaison psychiatric registrar at the Royal Adelaide Hospital. Dr Hartstone entered the following in the notes:
- 'Since the incident, Nobuko has been preoccupied with her son's safety, her failure to protect him, ways that the invasion could have been avoided, eg sell house. Since he moved this became more intense and created a significant internal conflict, challenging her view of herself as a mother and ability to think positively about the future. Sought help from GP Dr Yuen who prescribed Mirtazapine 15mg which was helpful.'¹¹
- 4.3. Dr Hartstone gained the impression that Mrs Homewood had suffered from a major depressive disorder which stemmed from her belief that she had failed to live up to cultural and personal expectations. She had planned a suicide attempt in the context of her perceived failure to live up to her own inner image of herself. Her judgment was impaired by depression¹². Dr Hartstone arranged for Mrs Homewood to be transferred to the psychiatric unit at Ward C3 when a bed became available. Dr Hartstone increased the dose of Mirtazapine prescribed by the general practitioner

¹⁰ Exhibit C6a

¹¹ Exhibit C18

¹² Exhibit C19

from 15mg to 30mg¹³. Dr Raeside considered this to be an appropriate medical decision.

- 4.4. Mrs Homewood was transferred to Ward C3 on Saturday 7 August 2010. The admitting nurse was Enrolled Nurse Denise Tolhurst¹⁴. Nurse Tolhurst gave evidence at the Inquest. She said that her role was to admit Mrs Homewood to Ward C3 which she did at about 8am that day. She said that it was a Saturday morning and there were 6 nurses on the ward but that the team leader did not have a patient load. Therefore, there were 5 nurses for the patients on a 20 bed ward, that is 4 patients per nurse¹⁵. Nurse Tolhurst was taken in her evidence to the admission documentation which she completed. She said that she was confronted by the clinical services coordinator, Alison Charlesworth, sometime after Mrs Homewood's tragic death. CSC Charlesworth was critical of what she said was the inadequate information contained on the mental health nursing assessment completed by Nurse Tolhurst¹⁶. CSC Charlesworth also gave evidence at the Inquest and confirmed that she was critical of the documentation prepared by Nurse Tolhurst¹⁷. It was her evidence that the inadequacy of the mental health nursing assessment document in no way contributed to any lack of care or nursing decision which was causative of Mrs Homewood's death¹⁸. The issue was not raised by Dr Raeside and, accordingly, I do not consider it necessary to discuss the issue further.
- 4.5. Nurse Tolhurst carried out a risk assessment upon Mrs Homewood and assessed her risk at a level which meant that she would be observed on an hourly basis. No-one was critical of that assessment, including the Registered Nurse on duty, Ms Langford, and CSC Charlesworth. Dr Raeside had no criticism of this level of observations given the information known to staff.
- 4.6. On Sunday morning, 8 August 2010, Mrs Homewood spent the morning with her husband who left at approximately midday with the intention of returning at 2pm. Mrs Homewood was being nursed by an agency nurse, Deborah Glenn. Ms Glenn made a statement¹⁹ that she spent as much time as she could around Mrs Homewood without seeking to agitate her or her condition. She said that she spent about 20

¹³ Exhibit C18, page 352

¹⁴ Exhibit C20

¹⁵ Transcript, page 40

¹⁶ Exhibit C18, page 319

¹⁷ Transcript, pages 114, 117-118, 120

¹⁸ Transcript, page 136

¹⁹ Exhibit C7a

minutes with Mrs Homewood in an effort to develop a better rapport with her while she observed her and took her vital signs. She realised that Mrs Homewood was deeply depressed. Ms Glenn asked Mrs Homewood how she felt about being in hospital following her overdose and Mrs Homewood was polite although somewhat evasive in her responses. She did state however that she did not wish to hurt her husband. After approximately 20 minutes Mrs Homewood politely advised Ms Glenn that she was fine and looking forward to seeing her husband who was due to arrive at 2pm. Ms Glenn was mindful of assessing Mrs Homewood's level of risk and she asked her how she viewed the future. Mrs Homewood again referred to her husband and said that he was a good and kind man and that she did not want to hurt him and again said that she was looking forward to seeing him when he was expected to arrive at 2pm. Ms Glenn last saw Mrs Homewood at approximately 1:35pm. She said that at no time during their conversation did Mrs Homewood seem actively suicidal and her comments about Mr Homewood led Ms Glenn to believe that she did not pose an imminent risk of intentional self-harm or suicide at that moment. Ms Glenn said:

'The impression I had was that she was genuinely looking forward to seeing her husband.'²⁰

- 4.7. Nurse Tolhurst had spent time with Mrs Homewood the previous day and commented that she was a quiet person but that she mixed quite well with other patients. Nurse Tolhurst did not see any issues of concern on the Saturday. She said that Mrs Homewood was eating and drinking well and voiced no suicidal intentions. Nurse Tolhurst saw her again early the following morning and thought she seemed quite peaceful. Nurse Tolhurst observed her doing origami with other patients and Mr Homewood and noted that she seemed happy to see her husband and was animated when he arrived²¹. Nurse Tolhurst said that Mrs Homewood never gave any indication to her that she would try and harm herself.
- 4.8. Dr Raeside regarded these two nursing observations as indicating that Mrs Homewood was settled by the time she was transferred to Ward C3 and that she interacted appropriately with other patients and her husband and gave no indication that she was actively or imminently suicidal. He thought it significant that she was

²⁰ Exhibit C7a, page 6

²¹ Exhibit C20, page 4

aware that her husband was due back on the ward to visit her at 2pm and that she had spent 20 minutes with her nurse until 1:35pm²².

- 4.9. In the result Mrs Homewood was found hanging shortly after 2pm. Tragically, this was almost at the same time that her husband returned to the ward. Mrs Homewood was discovered by her roommate who alerted nursing staff immediately. There was no suicide note on this occasion.
- 4.10. Mr Homewood expressed concern about the conditions he found in Ward C3 which he regarded as drab and depressing²³. He was also concerned that Mrs Homewood had not yet spoken to a specialist psychiatrist after being admitted to Ward C3 on the weekend.
- 4.11. On the other hand, Mr Homewood recalled in his statement that he and his wife and 3 other patients did origami on the Sunday morning but he found his wife to be withdrawn and disinterested. She completed her swan without saying much and then left the room²⁴. He later excused himself to be with her and found her walking up and down the corridor. He walked with her and talked to her about remaining positive. He could see that she had not slept well and was not herself. She complained of being cold. He left saying that he would return later in the day. He said that he had no idea when he left Mrs Homewood that she would try and kill herself²⁵. Dr Raeside drew the following conclusion:

'... consistent with nursing observations, Mr Homewood, who clearly knew his wife better than anyone else, also had no inkling that she was imminently suicidal. Indeed if she had already planned to kill herself when she did she does not appear to have shown indication of this to her husband.'²⁶

5. Conclusion

- 5.1. Dr Raeside was not critical of the decision to conduct only hourly observations on Mrs Homewood. He noted that Mrs Homewood had spent 20 minutes one-on-one with her assigned nurse within no more than half an hour of hanging herself. Thus, half hourly observations may not have made any difference. He certainly did not

²² Transcript, pages 162-163

²³ Exhibit C1b, page 6

²⁴ Exhibit C1b, page 7

²⁵ Exhibit C1b, page 8

²⁶ Exhibit C24, page 10

think that observations more frequently than that were warranted in the circumstances of Mrs Homewood's presentation²⁷.

5.2. It was Dr Raeside's opinion that on clinical grounds he did not believe that Mrs Homewood's suicide could have been prevented without the imposition of significant restrictions which did not appear to be clinically indicated at that time. As a result he had no recommendations to offer in this case²⁸.

5.3. I invited Mr Homewood to address the Court about his own concerns. Mr Homewood was understandably very distressed and upset that his wife could have taken her own life on a ward in the Royal Adelaide Hospital. He said that he had thought she would be safe there. He was critical of the drab and unwelcoming conditions to be found on Ward C3. He was also critical of the fact that his wife was not assessed by a psychiatrist over the weekend of 7 and 8 August 2010. In short, he was understandably angry and upset. I take this opportunity to express my sincere condolences on the tragic death of his wife. However, on the evidence before the Court in this case, I do not believe that her death could reasonably have been predicted and prevented.

6. Recommendations

6.1. I have no recommendations to make in this matter.

Key Words: Death in Custody; Suicide

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 4th day of March 2013.

State Coroner

Inquest Number 4/2013 (1205/2010)

²⁷ Exhibit C24, page 13

²⁸ Exhibit C24, page 14