STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of James Barton
Hearing dates:	24-26 July 2017
Date of findings:	8 September 2017
Place of findings:	Coroners Court, Newcastle
Findings of:	Magistrate Robert Stone, Deputy State Coroner
Catchwords:	CORONIAL LAW – Intentional taking of life, adequacy of mental health assessment, interpretation of S14 and 15 of the Mental Health Act 2007,return of medication to patient from overdose admission
File number:	2013/94673
Representation:	Mr Peter Aitken Counsel Assisting the Coroner instructed by Ms Carolyn Berry solicitor Crown Solicitors Office Mr Chris Bryett for Ms Quanita Chivers, James' mother Mr Patrick Rooney counsel for the hospital and health facilities, Dr Stanhope, Dr Gupta and also witnesses Dr Mahmood, Mr Surgenor, Mr Drinkwater Ms Peggy Dwyer counsel for Dr Newnham Mr Buck for witness Ms Anne Mearrick
Non publication order:	No non publication order made

Findings:	I find that James Barton died on 27 March 2013 at John Hunter Hospital, Lookout Road, New Lambton Heights, NSW 2305. The cause of James's death was external neck compression due to hanging. James died as a consequence of actions taken by him with the intention of ending his life.
Recommendations:	To the Chief Executive Officer, Hunter New England Local Health District: I recommend that consideration is given to the following changes; 1. To amend the policy "Accountable Drugs – Handling and Recording PD2013 – 043:PCP 13" as follows: (I) to include at clause 13, "patients own accountable drugs" (and consequentially at clause 5) the following requirement; "where a patient is admitted with deliberate self-poisoning, the discharging medical practitioner, should be consulted before the patient's own accountable drugs that were brought into the hospital are returned to the patient from ward storage". (II) to include at the appropriate place a reminder that a patient's identifiable sticker/label should not be applied to the patient's own accountable drugs brought in to the hospital. 2. That the proposed recommendation be brought to the attention of all staff at the relevant emergency departments involved in patient admission in the Hunter New England Local Health District.

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Inquest into the death of James Barton

The Inquest

1.Section 81 of the *Coroners Act* 2009 (Coroners Act) requires a Coroner presiding over an Inquest to confirm that the death occurred and make findings as to: –

- the identity of the deceased;
- the date and place of the death; and
- the manner and cause of the death.

2. Under s. 82 of the *Coroners Act* a Coroner may make such recommendations as are considered necessary or desirable in relation to any matter connected with the death, including in relation to public health and safety.

3. James Barton died at the John Hunter Hospital on 27 March 2013. As James's death was not from natural causes, it was reported to the Coroner who has an obligation to investigate matters surrounding the death. A Coroner's primary function is to establish firstly, the identity of the person who died, secondly, when and where the death occurred and thirdly, the cause and the manner of death. The manner of a person's death refers to the circumstances surrounding the death and the events leading up to it.

4. This Inquest was primarily focused on the manner of James' death and in particular what happened in the last month and days of James's life and importantly what occurred on 24 March 2013 and the ultimate tragedy of James dying on 27 March 2013.

5. In the course of investigating the manner of James' death several issues were identified. Primarily the issues concerned James' care and treatment and in particular the assessment of his medical condition on 3, 4 and 23 March 2013. These assessments were made by doctors from the Psychiatric Emergency Care Centre (known as the PECC Unit) at the Mater Mental Health Unit and at the Emergency Department of the private Calvary Mater Newcastle Hospital. The Mater Mental Health Unit is administered by the Hunter and New England Local Health District (HNELHD).

6. The focus of the investigation was to consider whether the care and treatment afforded to James was adequate and appropriate. The investigation reviewed the assessment process and policies created by HNELHD insofar as it related to James' care. This review was done to consider whether the assessment process or any aspects of it were deficient, and, if so, whether they could be improved.

7. An issues list was prepared to focus attention to matters arising for consideration. Those issues were:

1. The cause of James Barton's death;

2. The manner of James Barton's death, including:

a. The adequacy of the risk assessments and subsequent decisions to discharge James on 4 March and 23 March 2013 from the Mater Mental Health Centre and Calvary Mater Hospital respectively;

b. The policies and principles governing assessment of risk, including the application of the Guideline "Framework for suicide risk assessment and management" as it applied at the relevant time;

c. The approach to the interpretation by clinicians of the mentally ill and mentally disordered persons provisions in Sections 14 and 15 of the *Mental Health Act 2007* at the relevant times;

d. The provision of Xanax medication to James following his discharge on 4 March 2013 and, consequentially, the relevant policies and procedures applying to storage and release of medication to patients on discharge.

3. Any recommendations considered necessary or desirable in relation to any matter connected with James' death, pursuant to section 82 of the *Coroners Act 2009*.

The Cause of Death

8. James was seen alive and well on Sunday, 24 March 2013 at 11:30am when his mother Ms Chivers left the house to go to the shops. His mother spoke to James by telephone at 12:30pm to ask him what he wanted for lunch. At about 1pm she returned home and found him hanging by his neck from a rope from an upstairs balcony. He was unresponsive and not breathing and an ambulance was called. Extensive resuscitation was performed and he was admitted to the Intensive Care Unit at John Hunter Hospital. Multiple investigations revealed extensive brain injury and life-sustaining measures were withdrawn on 27 March 2013. The cause of death is not contentious.

Legislation that is Relevant

9. The following sections of the *Mental Health Act 2007* (the Act) were relevant for consideration at the Inquest:

12 General restrictions on detention of persons

(1) A patient or other person must not be involuntarily admitted to, or detained in or continue to be detained in, a mental health facility unless an authorised medical officer is of the opinion that:

(a) the person is a mentally ill person or a mentally disordered person, and

(b) no other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the person.

(2) If an authorised medical officer is not of that opinion about a patient or other person at a mental health facility, the officer must refuse to detain, and must not continue to detain, the person.

(3) An authorised medical officer may, immediately on discharging a patient or person who has been detained in a mental health facility, admit that person as a voluntary patient.

13 Criteria for involuntary admission etc as mentally ill person or mentally disordered person

A person is a mentally ill person or a mentally disordered person for the purpose of:

(a) the involuntary admission of the person to a mental health facility or the detention of the person in a facility under this Act, or

(b) determining whether the person should be subject to a community treatment order or be detained or continue to be detained involuntarily in a mental health facility,

if, and only if, the person satisfies the relevant criteria set out in this Part.

14 Mentally ill persons

(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:

(a) for the person's own protection from serious harm, or

(b) for the protection of others from serious harm.

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

15 Mentally disordered persons

A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:

(a) for the person's own protection from serious physical harm, or

(b) for the protection of others from serious physical harm.

19 Detention on certificate of medical practitioner or accredited person

(1) A person may be taken to and detained in a declared mental health facility on the basis of a certificate about the person's condition issued by a medical practitioner or accredited person. The certificate is to be in the form set out in Part 1 of Schedule 1.

(2) A mental health certificate may be given about a person only if the medical practitioner or accredited person:

(a) has personally examined or observed the person's condition immediately before or shortly before completing the certificate, and

(b) is of the opinion that the person is a mentally ill person or a mentally disordered person, and

(c) is satisfied that no other appropriate means for dealing with the person is reasonably available, and that involuntary admission and detention are necessary, and

(d) is not a designated carer, the principal care provider or a near relative of the person.

(3) A mental health certificate may contain a police assistance endorsement that police assistance is required if the person giving the certificate is of the opinion that there are serious concerns relating to the safety of the person or other persons if the person is taken to a mental health facility without the assistance of a police officer. The endorsement is to be in the form set out in Part 2 of Schedule1.

(4) A mental health certificate may not be used to admit or detain a person in a facility:

(a) in the case of a person certified to be a mentally ill person, more than 5 days after it is given, or

(b) in the case of a person certified to be a mentally disordered person, more than one day after it is given.

(5) In this section:

near relative of a person means a parent, brother, sister, child or spouse of the person and any other person prescribed for the purposes of this definition.

The Evidence

Social History

10. James was aged 21 years. He is survived by his mother Quanita Chivers, his father Brian and his sister Alex.

11. Ms Chivers described her son James, as a person who wanted to live life to the full and had an adventurous spirit. He gave generously, invariably without thinking, and was someone with a very big heart. She recounted that at the hospital, when the family were discussing organ donation, no one thought that his heart should be donated.

12. She said that James brought so many people into his life. A huge number of people attended his funeral service. He had the "gift of the gab" and loved people without reservation, particularly those closest to him.

13. James was not judgemental but accepting of others, a young man that did not have any prejudices. He was known as “Bardo” by his friends. He had a smile to melt your heart and could light up the room with his presence.

14. It is impossible, in any meaningful way to summarise what James meant to those who loved him. All those present at the Inquest who heard Ms Chivers describe her son would have been affected by her real sense of loss, her pain and grief. She showed great courage and grace in providing some insight into the personality and character of her very much loved son.

15. When James was about 9 years old his parents separated. James lived with his father Brian until he was about 16 or 17 years of age when he returned to live with his mother. At the age of 18 he returned to live with his father and began an apprenticeship as a cabinet maker/shop fitter. At about the same time he met Larissa. They had an on and off again relationship for some time.

16. Ms Chivers described that while James enjoyed life he had moments where he struggled mentally. This increased over time. In her statement of 17 March 2016 at paragraph 7 she said this:

> “I think James felt trapped. He thought the only way out of his problems was death, but at the same time he also loved life – this conflict between his love of life and his thoughts of death, tormented him.”

17. It is important to summarise his earlier struggles so as to give context to what ultimately happened.

<u>Events prior to March 2013</u>

18. On 29 May 2009 at the age of 17 James was admitted to the Emergency Department of St George Hospital. He had called police multiple times saying that people in his house were out to get him. He had been hearing gunshots. On medical examination he was compliant and pleasant and said that he had beer and marijuana that day. He was scheduled at the Hospital as “mentally disordered”. A history of heavy cannabis use was obtained.

19. He was examined by clinicians on 1 June 2009 with his father and mother providing a collateral history. It was possible that people may have been after him, with James having signs of extreme paranoia, agitation for some “months” and decreasing sleep (Volume 3 P1034, 1038). No evidence of thought disorder or psychosis was detected. He was discharged on the same day into the care of his father, with substance abuse disorder (alcohol and cannabis) diagnosed. Drug counselling and General Practitioner follow-up was advised.

20. On 30 July 2012 James was taken to Auburn Hospital by his father after an apparent attempt to take his life by overdose (volume 3 P996). James had been having relationship problems with his girlfriend. He had left letters the previous night to her and to his father saying goodbye and saying he wanted to leave this world. He reported taking 10 ecstasy tablets and drinking two cans of Jim Beam. He was on the way to a hotel to play the “pokies” when his father intercepted him. He told his mother “I’m sorry mum, I just can’t handle it”.

21. On review the next day he told a doctor that he did not want to die but had been feeling low, had not yet finished his apprenticeship and did not want to let his family down. He admitted to using

cannabis, ecstasy and cocaine recently. He said he had no previous mental health history. The diagnosis was of adjustment disorder on a background of substance abuse. A copy of the suicide note to his father was sent with the discharge summary to the Lake Macquarie Community Mental Health Centre. The Centre was contacted about mental health follow-up options. He was discharged on 31 July 2012.

22. It was decided that it would be beneficial if he moved from Sydney. He was released into his mother's care. James was given a referral to a psychologist in Charlestown (near Newcastle) who he saw on two occasions. Ms Chivers described her son saying words to the effect "they are not psychiatrists. They just want to talk. They can't help my brain mum". Ms Chivers tried to engage James with another psychologist at Merewether. Again James said to his mother "don't waste your money mum – they just want to talk". James said he didn't want "to talk about stuff because it hurts too much and I don't want to hurt".

The 2 March 2013 admission

23. On 2 March 2013 Ms Chivers found James unresponsive on his bed, after having written a suicide note. He was admitted to the Emergency Department at Calvary Mater Newcastle at about 11pm. He told his mother and the doctor that examined him that he had taken 30 ecstasy and 5 Xanax tablets. Ms Chivers indicated the reason for the overdose was a breakup with his girlfriend.

24. He was seen initially in the Toxicology Unit of the Calvary Mater Hospital however he was referred for assessment by a psychiatrist from the PECC unit of the Mater Mental Health Unit.

25. The progress notes in the Emergency Department indicated he was initially cooperative but then tried to get out of bed. He required restraining and sedation for the safety both of himself and staff. Wrist restraints were removed at 2am when James promised that he would not become aggressive. Ankle restraints were removed at 4:30am however they were reapplied at 8:30am at the medical officer's request.

26. At 2am on 3 March 2013 James was transferred to the Emergency Short Stay Unit at the Calvary Mater Hospital.

27. At 10am on 3 March James was described as withdrawn and uncooperative. He had removed the intravenous catheter from his arm.

Dr Dina Farli Mahmood

28. Dr Dina Mahmood commenced her shift at the Mater Mental Health Unit at 8am on 3 March 2013. She was a first year Psychiatric Registrar employed by Hunter New England Local Health District. By reference to the Hospital notes, Dr Mahmood knew that James had been referred by the Toxicology Unit. There was a verbal handover at the Calvary Mater Hospital. Dr Mahmood saw James in the Short Stay Unit of the Hospital at about 2pm. In accordance with policy requirements Dr Mahmood completed a Mental Health Assessment form. She had access to James' earlier mental health history through various computer information systems. Those systems are known as CAP (Clinical Access Portal-Inpatient material within the hospital) and CHIME (used by the Community Mental Health Team). She was aware that he had previously attended Auburn Hospital as a result of an overdose in 2012. Dr Mahmood had access to James' Lake Macquarie Community Mental Health

Service records. Dr Mahmood also spoke at length with James and conducted a telephone conversation with Ms Chivers in order to formulate a plan and complete the Mental Health Assessment form.

29. When Dr Mahmood saw James he presented as apathetic, meaning that he was not happy or sad. He showed no emotion. He was restricted with inappropriate smiles when describing suicide and his mood was variable, although mostly angry. He denied any auditory hallucination. His cognitive and intellectual function was grossly intact, meaning that in conversation he was orientated in terms of time place. There were no cognition problems evident. Dr Mahmood did not consider it was necessary to complete a more detailed cognitive assessment. James appeared to have partial insight and judgement however he would not engage in problem solving concerning his progress.

30. James was not taking responsibility for his behaviour. He stated he was not suicidal now but will "sort things his way" if "bad stuff kept happening". He did not explain what this meant and he would not clarify what "his way" involved. This was of concern to Dr Mahmood. While with James, Dr Mahmood observed that he was abrupt, dismissive and reluctant to provide answers. She noted his extensive history of poly substance use involving cannabis, methamphetamines, steroids and heroin. James told Dr Mahmood that he was currently only using ecstasy on weekends and occasionally inhaled cocaine.

31. Ms Chivers disclosed to Dr Mahmood that James had an aunt who had committed suicide when James was 10 years old. The aunt had suffered from depression. James also disclosed that he was using alprazolam (Xanax) at a dose of 2mg in the night and day, which was not prescribed.

32. Ms Chivers reported a period of mood labilities over a number of hours vacillating between angry and sad. He had periods of mood variability that would last for a few days where he would ask his mother to stay in her room, which terrified her. Ms Chivers said that she was not frightened of him, but that he would make loud noises outside her door appearing angry and exhibiting aggressive behaviour.

33. Dr Mahmood conceded that when completing the Mental Health Assessment form she had not ticked two of the boxes on the form. One box stated "significant past history of risk". Dr Mahmood should have ticked the "yes" box. The second question was "considering the above factors and information available from your assessment, is a more detailed assessment suicidal violence risk required". Dr Mahmood should have ticked "yes" but left it blank. To a third question "recent thoughts, plans, symptoms indicating risk" Dr Mahmood had ticked "no", but she now acknowledges that she should have ticked the "yes" box.

34. Dr Mahmood's overall clinical impression was that James was a 20-year-old male with presentation through the Emergency Department of the hospital for deliberate self-poisoning with recreational substances, suicidal in nature. This was reported as his second attempt at suicide since August 2012. The trigger was the same unstable relationship, involving frequent breakups. In her statement, Dr Mahmood said that James presented as a gentleman who was choosing to rely on substances and not accepting life's responsibilities. He reported being impulsive and angry and not generally willing to engage for further follow-up. [Volume 1, P175 Paragraph 35].

35. Dr Mahmood concluded James was mentally disordered, as that term is defined in the *Mental Health Act*. Dr Mahmood concluded James was a significant threat to his own safety. She was not sure whether he had an underlying mood disorder or his behaviour was induced by illicit substances.

36. Dr Mahmood did not consider that James was mentally ill (within the terms of the Act). In her opinion he did not exhibit signs of a mental illness, which involved factors of capacity, insight into behaviour, judgement and cognitive issues.

37. As a first year Registrar Dr Mahmood was required to discuss James' presentation and history with a Senior Consultant Psychiatrist.

38. Dr Mahmood telephoned Dr Ivan Surfranco and discussed the content of the assessment form, the presentation and history provided by James and his family. Dr Surfranco assisted Dr Mahmood to formulate a plan. The plan was:

(a) to admit James as mentally disordered;

(b) to administer, when required, medications including Temazepam for sleep and other medications for his aggressive behaviours;

(c) for review by the treating team the following day concerning any underlying mood disorder; and

(d) the nurses to notify any concerns.

39. Dr Mahmood then completed the form described as "*Mental Health Act* (Section 19) Schedule 1- Medical Certificate as to examination or observation of person". This form enables assessment of a patient in a mental health facility for mental health examination. The Calvary Mater Hospital is not a mental health facility and accordingly the form was completed prior to his transfer to the Mater Mental Health Unit for further assessment and management.

40. Dr Mahmood then arranged for transfer of James to the Mater Mental Health Unit. A bed manager determines whether a bed is available for a patient and where the patient will go. When Dr Mahmood examined James he had no drugs with him. Any drugs would have been taken from him when he was in the Emergency Department and would have been with his belongings and his clothes. Her understanding was that his belongings would be sent or transferred with him when he was being transferred to the Mater Mental Health Unit.

41. Dr Mahmood was unaware of what occurred with any drugs that he may have had on him at the time of admission. She was aware that James had brought Xanax with him. Generally her understanding was that if the medication had a label on it indicating the drugs had been prescribed including the name, date of birth and address of the patient, the drugs would be returned ultimately on discharge. She believed that non-prescribed drugs would not be returned. She did not give any instructions to anyone about what was to happen at discharge concerning any medication James had brought in at admission.

42. From her experience as a Psychiatric Registrar, Dr Mahmood considered that if a patient was not motivated to change their behaviour, you just have to "leave the door open". However, if there was no motivation to change, then liaising with the family became more important.

43. Dr Mahmood agreed that the use of the tick boxes in the assessment of risk form was not a reliable predictor of the real risk of self-harm. In her view the overall clinical assessment and the assessment of static and dynamic factors at the time of assessment are important. The assessment of risk and use of indicators was part of an assessment as a patient presents. It is not an assessment of the patient compared to the general population or compared to other patients who might present at a mental health facility.

Dr Kim Elizabeth Newnham

44. On 4 March James was seen by Dr Kim Elizabeth Newnham who at that time was working as a Visiting Medical Officer-Consultant Psychiatrist. Her evidence was based on her review of hospital notes. She said that James' presentation was discussed that morning as part of a multi-disciplinary review meeting about patients. Also present at the meeting were James' allocated nurse, a social worker and a Registrar, Dr Gasemotse. Dr Newnham has no specific recollection of the meeting or of the assessment of James which followed the meeting. This is not surprising as she was requested to make a statement for the first time in about October 2016. From a review of the clinical notes she knew he had been admitted as a mentally disordered person.

45. Dr Newnham was asked to explain the difference between a "mentally ill" and a "mentally disordered" person as described in the Act. A mentally disordered patient has behaviour that is so extreme that they are a risk to themselves or to others. Such a person needs protection to avoid serious harm. For a mentally ill person, evidence of a psychosis, delusions, or thought disorder are primarily the matters of concern.

46. Dr Newnham agreed that she would have had Dr Mahmood's assessment before her. There is a requirement to review a mentally disordered patient and assess the patient every 24 hours. The maximum period an involuntary patient can be detained is three days.

47. Dr Newnham performed a mental state assessment of James. He did not show objective evidence of a sustained disturbance of mood, or of a psychosis, depression, mania or thoughts of harm to others. Patients who present with mania do not come into hospital one day and wake up the next morning and be able to have a logical conversation (as James did). Again if he was bipolar the episodes of mood elevation tend to last very much longer and do not settle very quickly. She eliminated mental illness as being relevant to James' diagnosis. He expressed regret at the suicide attempt and he outlined plans for his future. She concluded he was no longer a mentally disordered person under the Act and could not be detained under the Act. In Dr Newnham's view James had a vulnerable personality structure and some form of adjustment disorder.

48. James requested discharge from Hospital. He was offered outpatient follow-up care with both Community Mental Health Services and Drug and Alcohol Services. He declined this follow-up. He was provided with outpatient services contact information and the Psychiatric Emergency telephone number.

49. Dr Newnham said that people such as James had a vulnerable personality structure. They are more likely to do poorly or very badly in a hospital ward (therapeutically). This can cause a clinical worsening of their health. James would be placed in an eight bed ward where the other patients were more likely to be acutely mentally ill, such as psychotic patients. Therefore her view was that

he would be unlikely to cope. He would have very disturbed sleep and it would be very unpleasant for him. It would be an untherapeutic environment. In fact she considered he would have been less safe if he had remained in the hospital environment. Despite this, she said it is normally her usual practice to offer voluntary admission. She was of the firm opinion that it was better to manage James on an outpatient basis.

50. Dr Newnham had no recollection of whether Dr Mahmood had completed the risk assessment boxes accurately but it would not have made any difference to her assessment of James when she saw him on 4 March.

51. Dr Newnham was asked to consider whether James could learn behaviours to make it easier for him to be discharged. She did not agree that this could happen. In her view if a patient is agitated and angry she would not discharge a patient but would detain them. In her opinion it is very difficult to learn to pretend not to be agitated and angry. She agreed that in some circumstances it would be an advantage to obtain further history from a family member, but this depends on the individual circumstances of each patient. If James had been transferred to an open ward (as distinct from a locked ward within the mental health section of the hospital) he would unlikely have done well.

52. Dr Newnham indicated in general terms that a psychiatrist's ability to predict risk in suicidal patients is extremely poor. The statistical predicators that are contained in the assessment form are simply that – statistical. It is very difficult to predict risk. In her opinion the *Mental Health Act* does not permit a doctor to detain someone involuntarily in a hospital if they do not fulfil the criteria for involuntary admission. Furthermore, she was adamant that involuntary detention did not, usually, improve outcomes.

53. Dr Newnham considered that James needed dialectic behaviour therapy. However this is very demanding on patients and there is only one programme in the Hunter Region. There is a wait list of at least 6 months. To gain entry James would have needed to undertake drug rehabilitation before participating. She was not sure whether it was a viable option when you looked at James' attitude and his denial of a drug problem.

54. She considered that James did not warrant voluntary admission. James' mother was notified of his discharge and seen by the social worker.

<u>Anne-Maree Mearrick</u>

55. Ms Anne-Maree Mearrick was employed by Hunter New England Mater Mental Health Unit and working as a social worker at the Hospital. She had been with the unit for seven years and had been a social worker for 30 years. She has no recollection of speaking to James and her evidence was based solely upon a review of the clinical records, her personal notebook and what she considered was her usual practice.

56. Ms Mearrick works on weekends and Monday. Each Monday is extremely busy. Follow-up referrals are prepared for patients that came to the unit over the weekend. These patients are expected to require short stay periods only. She does not recall being at the multi-disciplinary review meeting on the morning of Monday 4 March 2013 but it was her usual practice to attend. If she had any issue concerning a patient being discharged she may voice her opinion. If a contrary view was expressed it would have usually been documented in the clinical notes. There is no entry to that

effect in the notes and she concludes that she did not take issue with the decision to discharge James.

57. Her notes say she saw Ms Chivers as a result of being specifically asked to do so by a treating doctor. It is not always a normal routine to see family members of a patient. The bigger priority in her day-to-day routine is to see the patients to help them. She does not remember any particular piece of information that she had been given. She believes her involvement was limited and centred around James being discharged, his mother was upset or distressed about that and the doctor asked her to speak to the mother.

58. Ms Mearrick was taken to her email of 4 March 2013. She cannot remember the source of the words "bullying his mum" in the email. She speculated that it may have come from the mother, from the doctor or it may have been her interpretation of events.

59. Ms Mearrick has read the statements of Ms Chivers. She was aware of certain comments that Ms Chivers says were made to her concerning James being "streetwise" and the suggestion to kick James out of the home. She has no recollection of saying the words "does he hurt you?", "Does he push you?" and "we have more reason to admit you". She considered that the language and tone and content of the conversation as described by Ms Chivers as being inappropriate language for a social worker. Such language reflected an attitude of being very judgemental. Her role was to help, discuss options with families, and assist them with choices and to link patients with services. It was not her normal practice to make judgements and if she had said anything concerning James being "streetwise" it may have been information given to her by a doctor.

60. Ms Chivers said there was a meeting at the hospital on the discharge of James on 4 March 2013. Her evidence of the conversation is not clear. She was certain the words were said. She was not questioned about her ability to recollect the conversation. There is some corroboration from Ms Mearrick concerning the suggestion of bullying. Ms Chivers could recall three people in a room however didn't know who they were, either their names or the position they held in the hospital or even if they were nurses, doctors, welfare workers or a combination of those that I've described. She remembered talking to a lady, the main thrust of the discussion was about her safety and the suggestion being made that James might have been bullying her. Ms Chivers was at pains to tell the Inquest that James had never physically hurt her. The lady's interpretation of what might have been happening was very hurtful to her. She was understandably very emotional in giving her evidence.

61. The enquiry of Ms Chivers about whether or not she was being bullied was not inappropriate. Ms Chivers is very small in stature and James' behaviour in the Emergency Department of the Calvary Mater Hospital on admission indicated aggressive behaviour. Ms Chivers remembered that he was agitated and behaving poorly – in fact she described him behaving at that time as "a little shit". Ms Chivers had also indicated to Dr Mahmood that James had been displaying erratic mood behaviour in the preceding days.

62. Ms Chivers was very clear in her evidence that James did not at any time become physical or in any way show any inappropriate conduct towards her. There is no evidence that he did. I accept her evidence entirely.

63. Ms Mearrick said that in the PECC Unit there were beds for short stay patients. Those patients usually require 24 to 48 hour admission but could be up to a week. There are other wards. The allocation of a patient to a particular ward depends on circumstances, priority, and the needs of the patient assessed by the doctor. General Wards have a ratio of one nurse for every five patients, whereas for more intensive care wards, there can be one nurse to every two patients.

64. Ms Mearrick is not normally present when doctors make their assessment of a patient. In her experience it would be up to the doctor to discuss voluntary admission if needed and also to consider treatment on discharge. She considered that her email of 4 March 2013 was sent to a particular unit because it also dealt with other families of patients who suffered from substance abuse issues.

65. She was asked if she could remember using the words to Ms Chivers concerning "setting boundaries" but she couldn't specifically remember. That is hardly surprising to try and remember conversations some three or four years later. I find on balance that Ms Mearrick did discuss the issue of bullying with Ms Chivers. I also find that the other comments that Ms Chivers gave evidence about were said to her either by Ms Mearrick or by one of the hospital staff or clinicians that were in the room at the time of the discussion. I am unable on the evidence available to determine who said the other words to her.

66. James' father had also been contacted by Ms Chivers when he was first admitted. He rang and spoke to someone in the Mater Mental Health Unit. He says he told them the history of James' previous admissions and he says that he pleaded with the person on the telephone to keep him in. He asked to speak to James and he was told that James would ring him back but it never occurred. The following day Ms Chivers rang him to tell him that James had been released back into her care and that the doctors had given the Xanax back to him.

67. Ms Chivers remembers being given a referral to a support group for parents who had children with substance abuse difficulties/addiction. She attended, but saw the group as helping parents distance themselves from their troubled children. Her priority was to try and help James deal with his problems.

68. Ms Chivers accepted there was some contradiction in James' attitude and behaviour in that James would say to her words such as "don't give up on me", yet he would also say "I just want to die" and then also criticise the way that health clinicians spoke to him. He would refuse to do anything to help his addiction and health concerns. Ultimately she concluded that he was not in the right mind to get help. She considered that James learned the behaviour needed to obtain a discharge. She also acknowledged that what James may say to her in times of crisis could be different from what he might say to the clinicians that he was seeing shortly thereafter when she was not with him.

69. She remembered that when he was discharged on 4 March 2013 that he walked out holding a small bottle and said words to the effect "see mum they want me to do it", simultaneously holding up a small medicine bottle. She didn't realise that the tablets that James had were gained illegally until he disclosed that at the hospital. She could remember that the bottle had his name on it, with a hospital label on it. She was told by James that they were similar to the tablets that he had taken to overdose himself with, that is Xanax (alprazolam).

70. When James was discharged he was given the Xanax tablets in a bottle. Ms Chivers disclosed at the Inquest that she still retained the small medicine bottle that James took from the hospital on this day. She made arrangements for it to be brought to the Inquest and ultimately the bottle and its label were shown to a number of witnesses and a copy of the label on the outside of the bottle became an exhibit.

Vincent Drinkwater

71. Vincent Drinkwater was a nurse manager of clinical services with Calvary Mater Hospital. It was normal practice to remove prescribed drugs from a patient on admission. Those drugs are identified, placed in a register and stored safely in a drug cabinet. Illicit or non prescribed drugs are taken from a patient and destroyed. If the drugs were prescribed by a doctor within the Hospital then the drugs are not normally placed in the safe. James' medication had a patient ID sticker which came from the Calvary Mater Hospital.

72. The label on the bottle was similar to labels used by the Hospital to attach to documentation, to medication prescription charts and placed on other hospital documents. It should not be on medicine bottles. Labels are printed out in multiple copies. It was not normal practice to label drugs that have been brought in. If the drugs brought in were a prescribed drug they would already have a label on them and there would be no need. Mr Drinkwater appeared to be confused as to why there would be a hospital ID patient sticker on the bottle in view of the fact that underneath that sticker was another label (which could not be read).

73. The Hospital ID sticker had reference to Dr Geoffrey Isbister, along with James' name on it. Dr Isbister was the treating clinical toxicologist who saw James on 3 March in the Emergency Department of the Calvary Mater Hospital.

74. Mr Drinkwater had not seen a hospital label sticker on a bottle of medicine previously. It was not the practice of nurses to label drugs that have been brought in. If drugs had been brought in and didn't have a label and they were not prescribed to the patient, he would expect that the drugs would be destroyed in accordance with hospital policy. The only drugs that should be stored safely are those that are the patient's prescribed medications. He did not think the bottle was one that the hospital would dispense medicine in. He agreed that the label appearing on the bottle, with James' name on it and with a doctor's name on it, could mistakenly be regarded as a legitimate label for a prescribed medication. Even though the original pharmacy sticker could not be seen, the patient's ID sticker was apparent. This would not have prevented the bottle being returned to the patient.

75. Mr Drinkwater believed that a discharging doctor should authorise the return of any medication to a patient, particularly to a patient with a history of deliberate self-poisoning.

Carl Andrew Surgenor

76. Mr Surgenor was a clinical nurse specialist at the Mater Mental Health Unit. He has no recollection of James. On review of the clinical progress notes he was aware that there was a multi-disciplinary team review that occurred at about 9:20am on 4 March 2013. He says he may have attended the review but has no recollection of it.

77. It was likely he participated in the handing back of the bottle with the alprazolam (Xanax) contained therein to James. He agreed that he was involved in the process of discharging James on 4 March 2013.

78. The normal practice is that only drugs that are prescribed to the patient are held in the drug safe and returned to a patient.

79. He was shown the bottle with the sticker and agreed that it looked like it had been generated at the Calvary Mater Hospital. Dr Isbister worked there. Mr Surgenor assumed that the bottle had been brought in by the patient as a prescribed medication and was able to be returned to him. Although it was not common in his 9 years working at the hospital, he had seen on occasion medicine bottles with hospital ID stickers being returned to a patient.

80. He conceded that he could have read more of the details on the bottle and made some further investigation. It was not normal practice to go back and consult with a doctor about whether or not a drug should be returned. He considered it could be possible that a prescribed drug that a patient had taken by way of an overdose could be returned to the patient on their discharge because they were still in need of the medication.

81. Dr Newnham in her evidence considered that the return of the medication to James was not ideal. The expression she used was that it was "a great downside" for this to have happened. She also considered that the discharging medical officer should be consulted before prescription drugs were released to a patient with a history of a deliberate self-poisoning admission.

82. I am satisfied on the evidence that the bottle containing tablets of alprazolam (Xanax) was taken from James while in the Emergency Department of the Calvary Mater Hospital when he was first admitted. By error the bottle was affixed with a Hospital ID sticker/label in the Emergency Department or in the Toxicology Unit. The evidence does not allow me to conclude who affixed the label. The bottle along with James' clothes was transferred with him to the PECC unit and again by error the bottle was recorded in the Drug Register and stored until James' discharge from the unit.

83. Ms Chivers was informed at the time of James' discharge that James had been assessed as "low risk" of self-harming. She could not understand this assessment particularly given James' recent history of suicidal ideation and volatile behaviour.

84. Over the next few weeks Ms Chivers observed James' behaviour becoming more erratic. His sleeping patterns were inconsistent. He had episodes of confusion, frustration, anger and tears. She found him one day at 2am in the morning chopping trees down with a machete. He would sleep through the day, would often cry and have episodes of severe anger.

<u>Saturday, 23 March 2013</u>

85. Ms Chivers received a telephone call from James' girlfriend Larissa telling her that James had been talking about ending his life and that he had sent a suicide message to her. Ms Chivers was not at home when she took the call. She drove quickly home and as she was entering her home another car pulled up containing some of James' friends. She found James on the bed frothing at the mouth. She tried to get his attention however observed he was disorientated and she was unable to make out words. She called out to James' friends to help and although they were about to ring an

ambulance they decided it would be quicker if they got James into a motor vehicle and drove to the Calvary Mater Hospital.

86. When they arrived at the Emergency Department Ms Chivers spoke to a triage nurse. The notes record that James was admitted to the Emergency Department at about 1:30pm. She described James as being very disorientated, stumbling around unaware of his surroundings. Just as they were about to go through into an area where he could be seen he appeared to recognise where he was and looked to run away. The nurse saw this and called a Security Officer to assist James inside. The Security Officer held on to James and attempted to direct him however James yelled angrily and tried getting away. James hit the Security Officer on the nose and his nose started to bleed.

87. There was yelling and commotion and another Security Officer came out to assist. James continued to struggle however they controlled him and brought him into the treating area. James was placed on a bed with straps holding him down. Ms Chivers was asked for a history and how she had found James. She waited with James and then noticed that James was not particularly responsive and appeared to fall asleep. One of the nursing staff said to her that she should go home and try to rest. She left the Hospital and returned home.

Dr Stephen Stanhope

88. On Saturday, 23 March 2013 Dr Stanhope was working as the on-call Psychiatric Registrar. He commenced a shift at about 4pm. He had been handed over James Barton who was then based at the Mater Hospital Emergency Department. He said he received a telephone call in relation to Mr Barton from Dr Zoe Walker. Dr Walker provided a brief clinical history to him but he cannot now remember if he wrote it down. If he did so, he has not retained the notes of the conversation. Dr Walker has no recollection of this conversation and in fact does not consider she was the doctor that Dr Stanhope spoke to.

89. Dr Stanhope conducted a psychiatric assessment at the bedside of James at around 5pm. It was his opinion that James was at the time a low risk of harm to himself. He did not meet the requirements of involuntary admission under the *Mental Health Act*. There was no evidence of current major mood disorder or psychosis. James denied he had attempted suicide and he was denying any current self-harm or suicidal thoughts. James was prepared to accept a follow-up with the Community Mental Health Team. Dr Stanhope only has a partial recollection of James.

90. Dr Stanhope's recollection of conversations was poor. He remembers speaking to the mother yet doesn't recall the specific content of the conversation. When he saw James he did not identify any issues of disordered thought. He did not see him as being mentally disordered as described in the definition contained in the Act. To detain James he would have to have been of irrational behaviour with issues of physical harm. On his assessment of James on that day he concluded there was no irrational behaviour with issues of self-harm. He was taken to the toxicology admission form at page 287 and agreed that he probably looked at that to get the history that he allegedly had taken 30 tablets of Alprazolam. He however was told a different story by James when he saw him; that is that he had taken only 5 tablets to help him sleep. James denied he took more than this and denied he felt suicidal or was attempting to take his own life. He indicated to Dr Stanhope that he was not feeling hopeless or worthless. The doctor thought he could accept what he was then being told at face value. He concluded that James was very drowsy and disorientated when he first disclosed the

number of tablets as distinct from his present demeanour where he was orientated and clearer in speech. James told him that he had recent illicit substance use particularly ecstasy. James was guarded in discussing this. He denied he had an issue with drugs and alcohol.

91. He noted that whilst in the Emergency Department he had attempted to leave and had become threatening, assaulting a Security Officer and requiring an injection of Droperidol. This is an anti-psychotic medication injected into a muscle in order to sedate a patient. It is commonly used to de-escalate situations when other less restrictive methods have failed. This drug was administered to James twice.

92. Dr Stanhope had access to the CAP/CHIME database which contains the Calvary Mater Hospital's electronic records, discharge summaries and community mental health records. He was aware of the history of long-standing poly substance dependence and suicidal ideation. He was also aware that James had previously refused to engage with Drug and Alcohol Services.

93. James engaged in brief conversation and exhibited no overt psychomotor agitation or retardation. He was oriented to place, name, date of birth, address, day, month and year. James requested to be discharged home saying he would consent to a mental health follow-up. He also consented to the Doctor telephoning his mother, which he did. The assessment form states the following:

> "Phone call to mother. States James has been volatile over the last two days. Stated he has been extremely angry and at times verbally aggressive to her. Mother suspicious he has continued to use illicit substances. She stated awareness of ongoing interpersonal conflict between James and his girlfriend. Her interpretation of last night events was that James was arguing with his girlfriend. She (the mother) found him in the lounge appearing quite drowsy and slurring his speech. She was suspicious he had overdosed on a medication and found on his phone text messages in which James was stating "goodbye" to his girlfriend. Mother concerned about his mood fluctuations, Xanax use and that he continues to travel to Sydney frequently, she suspects to meet up with friends who may well supply him with illicit substances. Mother states he "needs help" and is concerned he may repeat such behaviour again."

94. Dr Stanhope concluded that James did not meet the criteria for a mentally disordered patient. There was no evidence at the time of the assessment of irrational behaviour warranting the need for further temporary care, treatment and control. He did not assess a need to protect him from serious harm to self or to others. Specifically there was no evidence of any major mood or psychotic disorder. He had denied any current self -harm or suicidal thoughts. He took into account his previous recent admission. In his opinion the least restrictive option (as is required under the Act) was for James to be discharged.

95. Dr Stanhope noted that James denied any current suicidal ideation. This was consistent with James' denial to Professor Ian Whyte when the Professor had seen him that morning in the Toxicology Unit at about 9:15am.

96. Dr Stanhope in his statement of 4 April 2017 [Volume 1 Tab 9I Page 94] said:

"Assessment of suicidality does not rely only on a statement by a person. It needs to be considered within the context of the individual's mental state and circumstances. On assessing Mr Barton's mental state, the rapport, engagement, lack of psychiatric illness was consistent with a lack of acute suicidal ideation, and this adds weight to his denial of such thoughts. Further, the lack of current intoxication is important here. I also could not elicit any evidence of a major mood or psychotic disorder. Other factors most likely taken into account would have included other domains within the mental state examination such as behaviour, affect, thought form, thought content, current cognition i.e. being alert and orientated during the assessment process and other corroborative acquired. I accepted Mr Barton's claim that he was not feeling suicidal."

97. He did not view James' demeanour as downplaying his state of mind and/or mood nor did he feel that he was deceitful in his responses or minimising his distress.

98. He has no independent recollection as to whether he discussed with James the option of remaining in hospital voluntarily. It was his usual practice to do so. However, he clearly recalled that James was keen to be discharged and eager to go home. In his opinion, assuming that he did make an offer to James, he did not consider the offer would have been accepted.

99. Ms Chivers' recollection is that after arriving home she had a shower but could not sleep, being worried about James. She decided she would return to the Hospital. Before leaving for the Hospital the telephone rang and a Dr Stanhope identified himself to say that he had spoken to James and was going to release him.

He asked "when are you able to pick up James?"

She said words to the effect:

"what do you mean? James needs help; he wants to kill himself. If you discard him how can I keep him safe?

100. Dr Stanhope said that he couldn't keep James because he was not suicidal. She argued saying:

"he is, he has admitted it. He has left suicide notes and tells me often that he wants to die".

101. Dr Stanhope responded:

"yes but we can't just admit someone because they meant it at the time. We can only admit them if they are suicidal now".

102. Ms Chivers argued with Dr Stanhope that he was suicidal and that he appeared to her to be getting worse and trying harder. Dr Stanhope said words to the effect:

"he hasn't got a mental illness."

103. Ms Chivers became very distressed. She told Dr Stanhope about James' mood swings. He would get angry then teary and sometimes paranoid. The Doctor then asked:

"what was he paranoid about?"

She said:

"when he gets anxious he sometimes thinks people are out to get him and he often takes situations out of perspective, struggling to interpret them logically."

104. Dr Stanhope indicated he would speak to a colleague and ring her back. He telephoned after a few minutes and said words to the effect:

"you will need to come and pick James up. I cannot admit him."

She said: "but how can James be safe?"

He responded: "I can organise a check-up phone call from a psychologist tomorrow but you will need to come out to pick up James".

105. Ms Chivers was trying to get help for her son and not for herself. She remembered that when she spoke to Dr Stanhope concerning his intended discharge she remembered him saying words to the effect "he is not suicidal, the best I can do is to get someone to call him".

106. Ms Chivers says that Dr Stanhope said "you have to work on your boundaries". She was shocked, offended and appalled at his words. While Ms Chivers recollects the conversation this way Dr Stanhope's contemporaneous notes refer to the conversation as:

"I've spoken to the mother regarding simple mental health safety plan for discharge, this involves boundary setting, contacting mental health services if concerns arise with such and risk escalates…."

107. The doctor appears to be suggesting the need to identify boundaries by Ms Chivers for James' behaviour and was not at all concerned with her own personal boundaries.

108. Within the form of assessment under the heading "overall level of risk", Dr Stanhope placed a cross next to "low" for suicide. He also indicated in the assessment form that he had discussed a management plan with the on-call consultant psychiatrist Dr Rahul Gupta.

109. Dr Stanhope made a Discharge Plan with a follow-up by way of an Intensive Community Care Plan with the Lake Macquarie Community Mental Health Team. James had refused drug and alcohol input. Dr Stanhope gave follow-up advice including emergency contact numbers to James and to his mother including details of a drug and alcohol service. Dr Stanhope made a telephone call at about 6:30pm to the on-call worker of the evening shift at the Lake Macquarie Community Mental Health Team, Mr Bradley Shaw. Mr Shaw spoke to Dr Stanhope who requested that James be placed on the intensive community contact list for short term monitoring of his mental state and risk assessment. The first point of contact for James would occur the following morning of Sunday, 24 March.

<u>Dr Rahul Gupta.</u>

110. Dr Gupta did not see James at any time. From reference to the clinical notes he is aware that Dr Stanhope refers to discussing the management plan with him. He has no recollection of this consultation. He has reviewed the medical records of this presentation on 23 March and the earlier one on 2 March 2013. He concurs with Dr Stanhope's assessment that James was not detainable under the Act. He qualified this conclusion because he was not present at the assessment process and the way the patient presents is important in making a determination. He noted that James had a

history of significant drug use which, by itself, is not a ground for detention under the Act. He noted that James was accepting of follow-up and adequate and reasonable discharge arrangements were made, consistent with the least restrictive care requirements under the Act.

111. He was of the opinion that admitting patients into a Hospital environment was not necessarily good for the patient and could escalate their behaviour.

112. Dr Gupta also considered it prudent that before drugs are returned to a patient in an overdose situation, that there should be a consultation with the discharging doctor to consider the appropriateness of the return of any medication.

24 March 2013

113. At about 10:30am on 24 March 2013 Mr Shaw attempted to contact James on the mobile telephone number that was provided with the referral. He remembers Ms Chivers answering the phone. Ms Chivers said James was sleeping and suggested that he phone later that same day after midday.

114. At about 12:50pm he telephoned the mobile phone again and Ms Chivers said that she was not then at home, that she planned to return home soon and could he ring again in about 20 minutes. Mr Shaw attempted again shortly after that however there was no answer. He called again at about 1:30pm and on this occasion he left a message requesting that Ms Chivers return his call. He attempted again and on the next occasion the mobile telephone was answered by Constable Harmer from Toronto Police who told Mr Shaw of what had transpired in relation to James.

Medical Expert Opinion

115. Dr Lee Ingram provided a Report dated 27 April 2015. He reviewed all of the medical material and noted that, from a clinical perspective, it was difficult to discern if James was suffering from a major mental health disorder. He noted that he was diagnosed with an Adjustment Disorder in 2012 and also following the admission on 3 March 2013. Adjustment Disorders are a group of disorders, which are characterised by a maladaptive emotional response to a stressful event. He was of the view given the presentation and the documented stress that this may be an appropriate diagnosis. However there were not enough clinical details or longitudinal assessments to state this clearly. Dr Ingram thought the picture was complicated by poly substance use which can lead to a similar symptom complex. He also thought that James may have some Cluster B personality traits.

116. In his opinion there were several risk factors to conclude that he was at a moderate to high risk of suicide. They included that he was male, unemployed had an unstable relationship with a recent breakdown, used illicit substances, a history of impulsive behaviour, a recent discharge from hospital, previous suicide attempts and a family history of suicide.

117. Dr Ingram considered that a thorough clinical assessment had been performed on the admission on 23 March by Dr Stanhope. However he was concerned that the risk assessment performed by Dr Stanhope noted positive responses to all four questions with regard to increased risk, yet Dr Stanhope recorded the overall risk as low. On that basis he thought that the risk assessment was not adequate in the circumstances.

118. In his opinion James could have been scheduled as a mentally disordered person under the Act following the assessment on 23 March. He took into account his moderate to high risk of further suicide, noting the two suicide attempts within a three month period. He considered the evidence of suicide notes often suggests an increased intent of suicide attempts. His mother had expressed her concerns about his risk of further attempts. It was noted that James declined mental health and drug and alcohol follow-up and that he appeared to be uncooperative during interviews. He thought the lack of rapport and brief engagement with the assessment process would highlight the need for a more thorough assessment.

119. Dr Ingram concluded James was mentally disordered based on irrational behaviour: the aggression and assault of staff in the hospital requiring restraint. In his view the home environment was not safe as it was unrealistic that his mother could continue to manage the situation and the risk. He concluded that his presentation on 3 March was similar to the presentation on 23 March.

120. It was not clear to Dr Ingram that even if James had been scheduled under the Act, this would have resulted in a different outcome and prevented his death. He had previously been scheduled under the Act and had been released the following day after a further mental health assessment. James was unwilling for drug and alcohol counselling and mental health follow-up and had previously disengaged with community mental health follow-up. Without any engagement with services to try and manage the mental health and substance use issues it is unlikely the outcome would have changed and risk of suicide would have been ongoing.

121. Dr Ingram was also of the opinion that the alprazolam medication should not have been returned to James at the time of his discharge. He concluded that returning the medication on 3 March did not significantly influence James' eventual death.

122. Two other psychiatrists provided reports and were called to give evidence jointly at the Inquest. They were Dr Olav Nielssen, retained by the Crown Solicitor's Office, and Professor Matthew Large, engaged by the solicitors acting for HNELHD.

123. Each of these doctors was provided with the entire brief of evidence and based their opinion on the review of those documents**.**

124. Dr Nielssen provided a report dated 6 June 2017. In summary his opinion of the March 2013 events was:

> I. James was appropriately assessed on 4 March 2013 by Dr Newnham. He noted that the Doctor did not elicit features of a major mental illness or any plan to commit suicide. He said that she offered further care by the community mental health team and drug and alcohol services, but noted that James declined the offer of referral for further care.
>
> He said at page 7 of his report the following:
>
> "Presentations to hospital with deliberate self-poisoning is common, whereas completed suicide after discharge from hospital following a suicide attempt is comparatively rare.….Predicting which patients will go on to commit suicide is not possible and psychiatrists evaluating patients who present after deliberate self-harm are faced with the

task of identifying treatable psychiatric disorder and attempting to arrange appropriate treatment."

2. The clinical assessment performed by Dr Stanhope 23 March 2013 was reasonable and appropriate. Again on page 7 of his report the following: –

"Retrospective risk assessment is 100% accurate. However, positive predictive value of any known method of suicide risk assessment is very small and we are very limited in our ability to identify in advance which patients will go on to commit suicide using any current method of risk assessment. The risk assessment process set out in the NSW Health Department guidelines and policies, although well-meaning, only identify factors that have been shown to be associated with suicide in some retrospective studies. They do not have a scientific basis in the sense that they can successfully identify a category of patient for whom any intervention, including involuntary admission to hospital, can reduce the probability of future suicide. Enquiry about the presence of risk factors amounts to industry best practice, rather than a procedure that can be applied to decisions regarding the care of individual patients.

Research shows that there is no such thing as a low risk patient. Patients described as "high risk" using the results of retrospective studies of factors associated with subsequent suicide show that high-risk patients are 4 to 5 times more likely to commit suicide in the next year. However we also know that males are four times more likely to commit suicide than females, and that anybody who had been admitted to a psychiatric hospital is as much as 70 times more likely to commit suicide than a member of the general public. Based on those findings, suicide risk assessment is unlikely to help in the identification of patients who will commit suicide or in directing interventions to prevent suicide".

Dr Nielssen places little weight on suicide risk assessment because he says it cannot help him make decisions about individual patients. His approach is to consider whether he is able to intervene to improve the patient's circumstances and decision-making by treating psychiatric disorder, in particular, substance use disorder and severe mood disorder. He said you have to also recognise the need to respect a patient's autonomy, and in assessing a person who has recently committed an act of deliberate self-harm, consider whether they are capable of making rational decisions on their own behalf.

3. He was of the opinion that Dr Stanhope's decision not to detain James as an involuntary patient was appropriate. He said that from reading "Dr Stanhope's notes that James' responses at the time of the interview were calm and rational, notwithstanding his behaviour earlier that day when still intoxicated with benzodiazepine medication. Based on Dr Stanhope's description of James' behaviour and responses at the time of the assessment, in particular, his denial of any intention to commit suicide he was of the belief that it was reasonable and appropriate to conclude the James could not be detained under the *Mental Health Act*."[Vol 1 Tab 12C P254.21]

4. Dr Nielssen was of the opinion that James should have stayed in hospital a little longer to enable the Alprazolam to have completely left his system and the opportunity to further

evaluate his mood state and offer the opportunity to counsel him about the effects of substance use and the potential benefit from further mental health care.

5. He was asked in his report to provide his opinion of the optimal assessment for James and he stated:

> "optimal psychiatric assessment includes a review of recent events, establishing the psychiatric, medical, substance use and personal history, careful observations of his current emotional and cognitive state, corroborative information from family and friends, tests to exclude relevant medical conditions and to establish the pattern of recent substance use and where possible, a suitable period of observation to establish whether the initial impression was reliable. In people with substance use disorders, optimal assessment might also include some assessment of attitudes to substance use and imparting information about the likely effect of substance use on mood" [Vol 1 Tab12C P254.22]

6. Dr Nielssen concluded with the following:

> "In Mr Barton's case, the severe dysphoria that followed his ongoing and recent abuse of the euphoriant drug MDMA, and the limited problem solving ability indicated by his life history and level of literacy, is likely to have reduced his ability to take advantage of offers of help, for example, an offer of a voluntary admission and further inpatient counselling, or referral to substance use services. I believe his recent use of MDMA is likely to have been a significant factor contributing to the state of mind that led him to hang himself. However, there was no information in the medical records that I reviewed to indicate that he planned to attempt suicide using that method at that time."

125. Professor Matthew Large's report is dated 14 June 2017 and was contained in Volume 1 Tab 12 E P254 .48. In summary Professor Large agreed substantially with the matters contained within the report of Dr Ingram. He said:

> "I accept Dr Ingram's suggestion that James Barton should have been considered to be at moderate or high risk of suicide. Specifically he was at high risk relative to members of the general community and was a moderate risk when compared to other psychiatric patients.
>
> I disagree that the risk assessment performed by Dr Stanhope should have been more thorough. I do not consider that any further enquiries were needed about the risk factors possessed by James or that documenting them in a single place in the notes was needed.
>
> I agree with Dr Ingram that James could have been scheduled as a Mentally Disordered Person under the *Mental Health Act* on 23 of March 2013. However, I am of the opinion that many, if not the majority of doctors at Dr Stanhope's level of training, in consultation with a psychiatrist on call, would (sic) been of the opinion that safe and effective care was reasonably available in the community and that as a result most such doctors would not have scheduled James as a Mentally Disordered Person at that time.

I share Dr Ingram's opinion that it was likely that James would have been released the following day had he been detained as a Mentally Disordered Person on 23 March 2013 and that a short admission would not be helpful.

I agree with Dr Ingram that non-prescribed Alprazolam should not have been returned to him following his admission on 3 March 2013 and that this error had little or no effect on the hanging suicide of James Barton."

126. Professor Large agreed substantially with the report of Dr Nielssen. He agreed that Dr Kim Newnham's assessment was reasonable and appropriate. He went on to say:

"I agree with Dr Nielssen's opinions about the lack of utility of an approach to risk assessment that relies on the identification of risk factors and risk stratification. One unfortunate consequence of almost all suicide risk assessment guidelines is that they allow the use of a low risk category, when in reality no patients seen in a hospital for a psychiatric issue, can be considered to be at low risk when compared to the general population. Patients who are not admitted, but simply attend an Emergency Department for a psychiatric problem are also at a greatly elevated suicide risk when compared to the general population when compared to patients with a similar diagnosis and demographic features who have never had hospital treatment.

I agree that the immediate presentation of the patient is a most important part of a psychiatric assessment because it allows a psychiatric diagnosis and assessment of the patient's current needs. The immediate presentation is not important because of a need to identify short term risk factors. Even a hypothetically strong short term risk factor is very unlikely to result in suicide over a short period."

Professor Large went on to conclude that when looking at suicide risk, "suicide and thoughts and behaviours are now known not to add very much to chance when considering suicide risk over any timeframe" .[volume1Tab12E P254.72] . Further that suicide notes, like suicide attempts, are probably good indicators of suicide intent however suicide intent is usually transient and the vast majority of those who write suicide notes are not suicidal shortly thereafter.

He did not consider that James could have been detained as a mentally ill person on 23 March because "those assessing James could not reasonably conclude that James was suffering from mental illness which is defined as a condition that seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms: (A) delusions, (B) hallucinations (C) serious disorder of thought form (D) a severe disturbance of mood (E) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (A) – (D). While a severe disturbance of mood is not defined in the Act, and the meaning of this term has not been tested in the courts, it is generally believed by psychiatrists to mean a major depression or an episode of mania.

The presence of a community team that could follow James up daily and of his residing with his mother would also indicate to many psychiatrists that treatment at home was reasonable and possible." [Volume 1 Tab 12E P254.73]"

127. Professor Large's opinion as to whether or not James could be detained temporarily as a Mentally Disordered person was similar to Dr Nielssen's. He said:

"I am of the opinion that some reasonable practitioners might have detained James temporarily as a Mentally Disordered person. However, I am also of the view that a majority of psychiatrists or registrars would not have done so.

In order to have detained James as a Mentally Disordered person an assessing practitioner would have to be of the view that James' behaviour for the time being was so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary and that no other care of a less restrictive kind, that is consistent with safe and effective care is appropriate and reasonably available to the person.

The Mentally Disordered provisions of the Act are open to interpretation. First the word "behaviour" seems to indicate that more emphasis should be placed on the person's conduct than their thoughts, although behaviour is not defined and some might include expressed thoughts as a type of behaviour. Second, the words "time being" seems to indicate that the assessment must be contemporaneous or short lived. Most practitioners would consider a single day to be the outside limits of the meaning of this phrase, but some would think that it was less than a day, particularly in the presence of resolving drug use or of a resolving social crisis. Third, the words "so irrational" would seem to imply a significant degree of irrationality, but irrationality is not defined. Some doctors consider that this is a test of capacity to reasonably refuse treatment – and if their reasons for treatment refusal are reasonable then they are rational. Others have more heuristic definitions.

In the situation on the 23 March 2012 [sic] most practitioners would have considered that efforts should be made to try and manage James in his own home on the basis that community care was available and that he was living with his mother. Other reasonable practitioners might have concluded otherwise."[Volume 1 Tab 12E P254.74]

The Professor concluded that the approach taken by Dr Stanhope to the interpretation of Sections 14 and 15 of the *Mental Health Act 2007* was well within the spectrum of acceptable practice. Finally he concluded:

"I suspect that the decision not to admit James as a Mentally Disordered person was in part due to the unlikelihood of such an admission helping him. James could only have benefited from a more prolonged stay in a psychiatric hospital as a voluntary patient followed by a very long stay in a drug and alcohol rehabilitation facility."

<u>Conclusions and Findings</u>

128. Both Professor Large and Dr Nielssen agreed that there can be disagreement between individual clinicians with regard to the assessment process. It is not an easy task for a mental health clinician to simply fill out a form, tick certain boxes and come up with the correct assessment of risk

and a plan for the patient. It is difficult to predict the risk of suicide. It is also clear that describing risk as “low”, “medium” or “high” cannot help predict risk. It is accepted that there have been changes to the risk assessment form since James’ death. Further the Guidelines and Policy have changed since James’ death.

129. I find that the assessment process undertaken by Dr Mahmood on 3 March 2013 was appropriate and reasonable, notwithstanding her omission to tick boxes correctly. She admitted James as an involuntary patient appropriately and sensibly. There is no expert opinion to the contrary. There are no adverse findings in regard to the assessment by Dr Newnham. The experts all agreed that her assessment was reasonable and appropriate as were the follow up arrangements that were put in place. Dr Newnham impressed as frank, competent and compassionate.

130. In this matter the issue of whether or not James should have been admitted as an involuntary patient on 23 March presentation is open to conjecture. The weight of the expert evidence concludes that even if James had been detained for some further hours it would likely have had little impact.

131. There is one important difference in the presentation on 3 March to that of 23 March. Dr Mahmood was very concerned with James expressing comments such as “sort things his way” if “bad stuff kept happening” and she considered he was not taking responsibility for his behaviour. There are differences in the presentation. I do not agree with Dr Ingram’s opinion that they are similar presentations.

132. Importantly James did not implement or take advice. Although detained on 3 March he did not do anything towards improving his position after his discharge on 4 March. This may have impacted on Dr Stanhope’s assessment.

133. For Dr Stanhope to have assessed James as a Mentally Disordered person he could not rely on what happened three weeks before. The assessment is done at the time of presentation and it is the patient’s behaviour at that time that has to be assessed. James’ behaviour in concealing his intentions and his true state of mind significantly impacted on the clinician’s decision. Dr Stanhope could not detect that James was concealing his intentions. Although he spoke to Ms Chivers and she was distressed and concerned about his release Dr Stanhope was faced with a person who was not showing any signs of a mental illness or disorder as those terms are defined under the Act.

134. The experts agreed that there was considerable scope for reasonable minds to differ about how the mentally disordered provisions of the Act were interpreted. Further some clinicians may have detained James temporarily as a mentally disordered person however others may not have done so.

135. I do not intend to make any adverse criticism of Dr Stanhope’s completion of assessment of risk in view of the weight of evidence from the experts. Their opinion is that the parts of the Form that were not completed had no significance to predicting risk.

136. The experts were reluctant to criticise Dr Stanhope’s acceptance of the number of tablets taken by James and the different versions he gave. He may well have been unreliable when intoxicated. Equally he may have been minimising his actions when he spoke to Dr Stanhope. Ultimately the experts were agreed that it does not help build rapport or improve the relationship between the clinician and patient if the doctor undertaking the assessment disbelieves the patient and makes

that known. Even if James had confirmed the total number of tablets taken as 30 rather than 5 he may still have been discharged then or some hours later.

137. The evidence as a whole during the Inquest from other practitioners, Dr Newnham and Dr Gupta, indicated strong reservations about the utility of an admission for James on 23 March. I accept this evidence. It may well have been counter-productive taking into account James' personality, his own wish to be discharged and his acceptance of an Intensive Care plan in the community.

138. Professor Large also made observations about the undesirability of admitting patients into a hospital. They can be dangerous places. He said there was a lot of downside to hospitals. Dr Nielssen agreed.

139. Dr Stanhope made arrangements for the Intensive Care Plan to have effect the following day. The word "intensive" in my view is instructive. Mr Shaw from the Lake Macquarie Community Mental Health Team telephoned the following morning in an effort to contact James. Care coordinators are assigned to patients and arrangements made to interview the patients over the following days. Appointments to psychiatrists can also be made as part of the process. Sadly and tragically the benefits of this type of care plan could not be utilised to assist James.

140. I conclude and find that Dr Stanhope's assessment was appropriate and reasonable. James could not have been detained under the provisions of the Act on an involuntary basis. James was not at any time mentally ill. There is no evidence from any medical practitioner that James had a mental illness as defined under the Act.

141. On balance I am satisfied that a hospital ID label was placed on the medication in the Emergency Department or the Toxicology Unit. When the medication was transferred with James' possessions to the PECC unit it was mistakenly placed within the safe storage locker for drugs and included on the Register. Human error was involved when Mr Surgenor returned the drugs to James. He had assumed that they were drugs that had been previously prescribed to James. There is a policy in place to take non prescribed drugs from a patient and destroy them. Again it is common practice to return prescribed drugs to the patient even if the patient uses those same drugs in an overdose event.

142. Drs Stanhope, Gupta and Newnham all agreed that there should be a consultation process with the discharging medical practitioner before returning the drugs to the patient. This is particularly so for a patient who is an overdose admission. I propose to make a recommendation concerning that.

143. I make no adverse criticism of any staff member of the Mater Mental Health Unit.

144. Ms Chivers does not seek to apportion blame on any individual. She was making every effort that she could to get assistance for James. She did her very best to work with James to get him help in every conceivable way.

145. James tragically needed assistance with drug counselling and treatment. Fundamentally his own mindset did not assist him. He was resistant to advice about treatment despite all the efforts made by his mother and father. Critically he could be manipulative with what he would say to clinicians and what he would say to his mother. It appears that he would disclose drug use to the medical

clinicians however not be as forthcoming to his parents. These factors played a significant part in the decisions to help James.

146. Ms Chivers had various concerns which were in written form and contained within the brief of evidence – relevantly at Tabs 18 – 19 and 27 – 33 of the brief of evidence and the statements of Ms Chivers and Mr Brian Barton. Primarily, the parents' concerns at the Inquest centred on the risk assessment process and possible improvement in that process.

147. Each of the expert witnesses were provided with the brief of evidence which included this material and the medical and hospital records. The whole of this evidence was made available to the medical experts. The medical and hospital records contain disclosures made by James about his substance use.

148. This Inquest identified significant challenges faced by clinicians with patients who suffer mental illness or who have some form of self-harm or suicidal ideation issues. Clinicians have to work within the framework of the legislation and there are limitations to what they can do. The ultimate aim of the legislation is to provide care that is the least restrictive kind that is available. (section 12(1) (b) *Mental Health Act*).

149. Professor Large and Dr Nielssen agreed that to admit every patient would mean that significant numbers of people who will not ever go on to complete suicide would be detained involuntarily for periods that could be up to a year in length. Completed suicide is rare and such an approach should be avoided.

150. The *Mental Health Act* limits the extent to which doctors can involuntarily detain a person. Even if a patient is involuntarily detained, there are limitations that constrain the ability of mental health practitioners to keep a person so detained. This is particularly so with mentally disordered persons, as opposed to mentally ill persons. The Act specifically provides that such a person cannot be detained longer than 3 days (not including weekends and public holidays) without further review by the Mental Health Review Tribunal. Those persons must be reviewed within each twenty-four hour period. This mandates how patients are to be assessed. It must be on a day to day basis and not over a period of time. All experts agreed that it is the current presentation, how a patient appears, and their behaviour on that day and time that is important.

151. Evidence was provided to the Inquest that from 2015 there had been changes to the Policy Guidelines on management of patients with possible suicidal behaviour. There is a focus on the role and responsibilities of mental health clinicians caring for people at risk. It is now a fundamental component of the assessment process that there is collaboration between the patient and their family and other relevant people, where the patient agrees. The aim is to provide a better clinical outcome for the patient. What now occurs, where possible and where practical, is a discussion with a family member or carer on the discharge of a patient.

152. It is important to communicate accurately and carefully with the family member or carer and to document what is said to them by treating clinicians, nurses and social workers. I do not consider there is a need to make a recommendation about this.

153. Within the Policy document "Clinical Care of People Who May be Suicidal" –publication date 1 March 2016 it now states that: "Risk management checklists or tools should not be used in isolation

to determine treatment decisions. Use of suicide risk factor checklists or screening tools alone cannot be recommended for use in clinical practice as a means of accurately predicting a person's risk of suicide …. There is moderate to low quality evidence for their use…..They lack reliability for predictive purposes".

154. Some of the proposed recommendations suggested by Ms Chivers cut across one key principle of ethics in medical practice, that is to do with autonomy or self-determination. One of the recommendations I have commented on in paragraph 162 of this decision. There were other suggested recommendations including requiring clinicians to gain evidence from relatives and/or friends as to the behaviour of patients who seek discharge.

155. The concept of autonomy is usually expressed as a right of competent adults to make informed decisions about their own medical care. The principal underlies the requirement to seek the consent or informed agreement of the patient before any investigation or treatment takes place. The principle is perhaps seen at its most forcible when patients exercise their autonomy by refusing life-sustaining treatment. This is summed up in the following passage:

> "an adult patient who….Suffers from no mental incapacity has an absolute right to choose whether to consent to medical treatment….This right of choice is not limited to decisions which others might regard as sensible. It exists notwithstanding that the reasons for making the choice are rational, irrational, unknown or even non-existent." Lord Donaldson in Re-T (adult) [1992] 4 All ER 649

156. The keywords relevant to this matter are "no mental incapacity". There is a strong obligation to respect the decisions of autonomous adults – the exception is compulsory treatment under the *Mental Health Act*.

157. In this matter the assessment made was that James did not fall within the provisions of either suffering from a mental illness or mentally disordered such that he required compulsory admission, more so when the legislation provides that care should be the least restrictive kind that is available.

158. When James was spoken to by Dr Stanhope he made decisions relating to James' ability to understand information relevant to the decision to discharge him and treat him in the community. He was satisfied James retained the information long enough to be able to make the decision, and to use the information imparted to him. James was able to do these things according to the Doctor so he was deemed to have sufficient decision-making capacity.

159. Competent adults can refuse treatments or investigations even when doing so will result in their permanent injury or death. All adults are presumed to be competent unless there is evidence to the contrary.

160. The problem for all who care about others such as James' mother is how to reconcile respect for the free choices of others with real concerns for their welfare, when their choices appear to be self-destructive.

161. This is the tension that arises in this matter where James made choices that were clearly destructive to his own health. A decision that someone lacks capacity is therefore a serious one

involving the loss of fundamental human freedoms. In contrast a failure to identify that someone lacks the capacity for autonomous choice can expose them to serious harms.

> "Capacity/incapacity are not concepts with clear…. boundaries. They appear on a continuum which ranges from full capacity at one end to full incapacity at the other end. There are therefore degrees of capacity. The challenge is to choose the right level to set as the gateway to decision-making and respect for persons…." Professor Michael Gunn *"The Meaning of Incapacity" Medical Law Review, 2, Spring 1994 p8, 9*.

162. The suggested recommendation to mandate, by legislation, some form of treatment plan for patients on their discharge in my opinion, cuts across the issue of autonomy. There is already in place Community Treatment Orders for those that are diagnosed with a mental illness. It would require legislative intervention far outside the scope of this inquest to make such a recommendation. In some cases, in any event, it could for some patients be counter-productive.

163. Dr Nielssen offered in his evidence;

> "Compared to international figures, Australia is probably the best–off country in the whole wide world. It's got the highest number of psychiatrists per head of population. It's got ready access to clinical psychologists in private practice. Our general practitioners are very tuned into mental health nowadays……."

164. Sadly our best did not help this young man. His loss is a loss for the community. However, lessons have been learnt and there is now a greater understanding of the complexities that James presented. There is no explanation of why James resisted help. Ms Chivers did not give up and she is commended for her courage to fight for her son. I know his parents did all that loving parents could have done for a son, that within himself, had a torment about living. The debate over what can be done continues, and I wish Ms Chivers well in her efforts to improve mental health outcomes for those that have an illness. John Stuart Mill, an English philosopher, quoted the following which I consider resonates with us all.

> "The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign." John Stuart Mill, *On Liberty*, 65.

165. Before I make the formal findings I would like to acknowledge the great help and assistance I received from Counsel Assisting Mr Peter Aitken and his instructing solicitor Ms Carolyn Berry from the Crown Solicitor's Office. I consider the Inquest proceeded in a most dignified and respectful manner appropriate for this matter. The compassionate way they dealt with Ms Chivers and others is commended. I also acknowledge the help and assistance given by the legal representatives of all the interested parties during the Inquest. Lastly I acknowledge the invaluable help of the Officer–in-Charge of the investigation Senior Constable Ben Hayward.

166. I extend my sincere condolences to Ms Chivers, Mr Barton and family on the death of their much adored son. I make the following findings:

Findings

167. I find that James Barton died on 27 March 2013 at John Hunter Hospital, Lookout Road, New Lambton Heights, NSW 2305.

168. The cause of James' death was external neck compression due to hanging. James died as a consequence of actions taken by him with the intention of ending his life.

169. I close this Inquest.

Recommendations

To the Chief Executive Officer, Hunter New England Local Health District:

I recommend that consideration is given to the following changes;

1. To amend the policy "Accountable Drugs – Handling and Recording PD2013 – 043:PCP 13" as follows:

(I) to include at clause 13, "patients own accountable drugs" (and consequentially at clause 5) the following requirement;

"where a patient is admitted with deliberate self-poisoning, the discharging medical practitioner, should be consulted before the patient's own accountable drugs that were brought into the hospital are returned to the patient from ward storage".

(II) to include at the appropriate place a reminder that a patient's identifiable sticker/label should not be applied to the patient's own accountable drugs brought in to the hospital.

2. That the proposed recommendation be brought to the attention of all staff at the relevant emergency departments involved in patient admission in the Hunter New England Local Health District.

Magistrate R G Stone

Deputy State Coroner

Local Court of NSW

Newcastle

29/08/2017