STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Tyson Mathews
Hearing dates:	5 -7 June 2017
Date of findings:	22 August 2017
Place of findings:	Coroners Court, Newcastle
Findings of:	Magistrate Robert Stone, Deputy State Coroner
Catchwords:	CORONIAL LAW- Self-inflicted death, involuntary admission considerations, risk assessment and suicide predictability, the use of Paliperidone, level of care in community.
File number:	2013/337391
Representation:	Mr Harris assisting the Coroner Mr Lynch for Hunter New England Health Mr Cavanagh for Mrs K Mathews Ms Mathur for Dr Vankatesh and Dr Raggat
Non publication order:	Not made
Findings:	I find that Tyson Matthews died on 7 November 2013 at 1/40 York Street Teralba New South Wales 2284. The cause of Tyson's death was external neck compression due to hanging. Tyson died as a consequence of actions taken by him with the intention of ending his life.
Recommendations:	Not made

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Inquest into the death of Tyson Matthews

Introduction

1. Tyson Matthews died just six days after his 30th birthday. He is survived by his mother Kerrie, father Darrel and a sister Leisa. Ms Matthews described Tyson as an empathetic loving man with a great respect for others and as a strong character devoted to family and friends that endeared him as a champion to them. The Inquest was told that Tyson was respected and loved by all who knew him. Tyson was loved by his family and they were very supportive of him. Despite the care and devotion of his family, despite the treatment afforded to Tyson he still took his own life on the morning of 7 November 2013.

2. To assist the Inquest counsel assisting prepared a statement of background facts. That document was provided to all parties prior to the commencement of the hearing of the inquest and was admitted into evidence. It was accepted that the material in that statement was factually correct.

Why was an inquest held?

3. A Coroner's function and the purpose of an inquest are provided by law as set out in the *Coroners Act 2009* (the Act). All reportable deaths must be reported to a coroner or to a police officer. One form of reportable deaths is in the Act described as an unnatural death (see Section 6 (1) (a)). Usually an unnatural death means where a person has died from other than natural causes and some external factor has contributed to that person's death.

4. Tyson did not die from natural causes. Once a person's death is reported to a Coroner, the Coroner has an obligation to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to fulfil his or her functions. A Coroner's primary function is to answer questions about the identity of the person: who died, when and where they died, and what the cause and the manner of their death was. The manner of a person's death means the circumstances surrounding their death and the events leading up to it.

5. In Tyson's case, evidence was gathered during the investigation following his death to allow the questions about his identity, his cause of death and when and where he died to be answered. This inquest was primarily focused on the manner of Tyson's death and in particular what happened in the last months and days of Tyson's life and how these events affect what occurred on 7 November 2013.

6. In the course of investigating the manner of Tyson's death several issues were identified. Again, helpfully a list of issues were agreed and circulated among the parties and the inquest concentrated on these matters. Primarily the issues concerned the care and treatment of Tyson and in particular the assessment of him on 3 November 2013 at the Psychiatric Emergency Care Centre of the Mater Mental Health Service, which is a part of the Hunter New England Mental Health Service (the acronym PECC was used in the hearing) which is administered by the local health district, the Hunter and New England Local Health District (HNELHD). This is a separate organisation to the Calvary Mater Hospital and its Emergency Department where Tyson was initially treated for his physical wounds on 3 November.

7. The investigation gathered evidence about these issues from various mental health professionals directly involved in Tyson's care. This was done in order to consider whether the care and treatment afforded to Tyson was adequate and appropriate. The investigation also reviewed the assessment process and policies created by HNELHD which governed the way in which treatment was given to

Tyson and how his care was managed. 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.

Tyson's life

8. We were privileged to hear from Ms Kerrie Matthews on the last day of the inquest. She showed great dignity in sharing her memories of Tyson and the problems she believed occurred in relation to the treatment of Tyson. Her belief in general terms centred on the mental health system failing Tyson. I have no doubt that Ms Matthews has suffered and will continue to suffer significant pain and grief over the loss of her son. She had to experience the traumatic actions of seeing him hanging and cutting the ligature around his neck. No person, let alone a loving mother should see or have to experience such a traumatic event. Her words were heartfelt courageous and moving.

9. I cannot in any meaningful way, by a few brief paragraphs summarise what Tyson meant to those who loved him. I was affected by Ms Matthews' very real sense of loss. I am very grateful to her in showing courage and grace in providing a glimpse of Tyson as a young man and the son she knew.

10. Ms Matthews told us that Tyson at an early age was gifted in maths. From the age of about five he began to experience epileptic seizures, hallucinations and sleep deprivation. School became difficult for Tyson. He showed some aggression and found it difficult to relate to his peers. By age 12 he had started to self-harm by cutting his wrists.

11. He was formally diagnosed with attention deficit hyperactivity disorder (ADHD) at about 14 years of age and commenced on the drug Ritalin which he took until he was 16 years of age.

12. His parents separated and he moved school. Schooling remained challenging and he left after achieving his school certificate in year 10.

13. He initially worked with his father, as a painter and continued this work on and off until his death.

14. Tyson began to use drugs and alcohol from his late teens, mainly cannabis but later also amphetamines including the drug known as "Ice". He undertook drug and alcohol rehabilitation several times but did not successfully complete them. Sadly substance-abuse remained a problem for him throughout his life.

15. Tyson's mental health and in particular the last months of his life was the focus of this inquest. Consistently the diagnosis from clinicians who treated Tyson in the years up to his death included antisocial personality disorder, substance abuse disorder, either paranoid schizophrenia or drug induced psychosis, depression and anxiety. He was on antipsychotic medications and he was also taking anticonvulsants for his epilepsy.

16. Compliance with his medication regime was, at times, poor, and with drug use and other stressful events resulted in episodes of deteriorating mental health issues and admissions to Hospital. He was admitted to hospital on six occasions for mental health issues throughout his life.

17. He broke up from his then partner in about August 2011 who was then pregnant with their daughter. His daughter Ruby- Lee was born in February 2012. Shortly afterwards he was charged with damaging his ex-partner's property by fire. He poured petrol on the front door and set it alight with his ex-partner and daughter inside the house. At the time the offence was committed Tyson

was experiencing hallucinations and also suicidal ideation following a failure to take his medications and intravenous "ice" use.

18. He subsequently received a suspended sentence by a Local Court magistrate of 7 months under S12 of the *Crimes (Sentencing Procedure) Act 1999*.

19. On 9 August 2013 the Section 12 bond was revoked and he was sentenced to 7 months imprisonment as a result of further offending. He appealed the sentence to the District Court of New South Wales and the severity appeal hearing was listed in Newcastle for 8 November 2013.

20. Tyson had other criminal matters. He was convicted of a range of offences between 2001 and 2013 including common assault, damaging property, offensive behaviour, high range drink driving and possession of prohibited drugs.

Tyson's history of drug and alcohol treatment

21. Tyson had a history of drug and alcohol usage. Between 2001 and 2012 he undertook rehabilitation for drug and alcohol abuse. This was over four consecutive years at Lake Macquarie Recovery Services Centre in Morisset, during which time Tyson was prescribed Seroquel, Tegretol and anti-depressants.

22.Tyson undertook a residential drug and alcohol program at Lakeview Rehabilitation Service in the Hunter region on four occasions, but was discharged four times in two years for violent behaviour.

Tyson's history of mental illness and admissions and treatment prior to 2013

23. In 2001, at the age of 18, Tyson was admitted to James Fletcher Hospital in Newcastle following a psychotic episode. He was treated with anti- psychotic medication (Seroquel), Tegretol, and anti-depressants.

24. In December 2003 Tyson was referred by his GP to Lake Macquarie Mental Health Service due to his increasing anger and aggression, low mood, poor sleep and suicidal ideation. Tyson was reviewed by Dr Huw Raggatt, who diagnosed him with a depressive disorder, prescribed antidepressants by way of treatment and offered Tyson anger management therapy.

25. From 2004 to 2013 Tyson presented intermittently at a range of mental health facilities. He had six recorded admissions to the Hunter New England Mental Health Unit, the last three of which took place between 2012 and 2013. He also had four documented episodes of care at Lake Macquarie Mental Health team, these being in 2005, 2007, 2008 and 2012.

26. In 2011, Tyson attempted self-harm by lacerating his arm. His mental health was assessed at the request of police by the Hunter New England Mater Mental Health Service on 28 August 2011, but was not admitted.

27. On 8 February 2012 Tyson was admitted to Mater Mental Health Service in what was his fourth admission. He presented on advice from his private psychiatrist, citing a lack of self-control and risk of violence towards himself and others.

28. On 18 May 2012 Tyson was admitted to Mater Mental Health Service for the fifth time. He presented following a deterioration of his mental state and psychotic episode.

Admissions and events in months preceding death in 2013

29. On 29 May 2013 Tyson was admitted involuntarily and for the sixth time to Mater Mental Health Service after a psychotic episode.

30. Tyson was discharged subject to a Community Treatment Order (CTO) made on 17 June 2013, which prescribed a medication regime of Tegretol twice a day and an intramuscular injection of Paliperdone every four weeks for 6 months.

31. At the end of August 2013, Tyson's dose of Paliperidone was increased. Following this his psychotic symptoms settled somewhat but he became markedly more depressed. One of Ms Matthew's concerns and an issue at the inquest was whether the drug Paliperidone was appropriate for Tyson, and whether it contributed to his condition and therefore his death.

32. On 1 October 2013 Tyson was prescribed antidepressants (30g of Mirtazapine per night, with 5mg of diazepam if required for anxiety) by his GP, Dr Elizabeth Butt, due to increasing low moods and anxiety. Dr Butt recalls that she had never seen Tyson so severely depressed before and she recalls he spoke of wanting to be dead.

33. Dr Raggatt reviewed Tyson on 3 October 2013, noting the fact that Mirtazapine had been prescribed. He stated in a letter written on that day that Tyson presented "with a multitude of depressive and anxiety symptoms, including sleep disturbance, appetite loss, low mood, feelings of worthlessness, poor concentration and some suicidal thoughts, although no intent."

34. Dr Butt also reviewed Tyson on 10 October. By that stage he was slightly improved though still feeling depressed and anxious. He said he wished he was dead, although Dr Butt also recorded he had no suicidal intent. He reported he was taking his medication and was sleeping better. He intended to talk to his caseworker nurse Edwards about work opportunities, as he did not want to continue working for his father. This was the last time Dr Butt saw Tyson prior to his death, although she had an appointment scheduled on the day of his death.

35. On 30 October 2013 Tyson saw his case manager nurse Edwards. Ms Matthews was concerned about the deterioration in Tyson's depression, despite commencing Mirtazapine. Mr Edwards noted that Tyson was anxious and depressed, but he was not suicidal and did not show any psychotic symptoms. Mr Edwards moved forward an appointment for Tyson to see Dr Raggatt from 14 November to 7 November.

36. Two days later, 1 November was Tyson's 30th birthday. Ms Matthews gave Tyson some money to celebrate with friends and have a few drinks. He later told her that he had acquired some "ice" from a friend which he had injected. He told her he did this to try to raise his mood, but it did not work. He spent the following days in a poor state mostly lying in his mother's lap.

37. On 3 November 2013 Tyson was at his mother's home. In the early evening he told her he wanted to take a bath, and when his mother went to the bathroom she found him cutting his wrist with a Stanley knife. He told her he wanted to die. Police and ambulance were called, and when police (Constable Parker and Senior Constable Turnbridge) attended Tyson told them as well that he wanted to die. Police persuaded Tyson to go with the ambulance officers to the hospital and he agreed to do so.

38. Tyson was taken to the Emergency Department of Calvary Mater Hospital by ambulance where he arrived at 6 PM. His wounds were considered "superficial" and were irrigated and closed with

steri-strips and he was given a tetanus injection. He was considered medically fit and he was discharged and then transferred to the PECC unit. He arrived there at about 6:22 PM.

39. At the PECC unit Tyson was assessed by Dr Venkatesh who was at that stage a third year psychiatric registrar. Dr Venkatesh commenced her assessment of Tyson at about 6:50 PM and it took over an hour. As part of her assessment she completed a mental health assessment form. Parts of that form were completed by a registered nurse and Dr Venkatesh added further information. Some parts were not filled out at all, including the section containing a formal suicide risk assessment.

40. Dr Venkatesh recorded that Tyson denied any current thoughts of self-harm or suicide. She considered him to be at low risk of suicide. She recorded he had paranoid ideation, thinking that people would harm him because of his past, but he had logical thought form and no problems with perception. Dr Venkatesh felt there were insufficient grounds to schedule Tyson as an involuntary patient. She says she offered him voluntary admission, but he declined. This is in issue as Ms Matthews says Tyson told her he was not offered voluntary admission.

41. A further issue is whether the assessment by Dr Venkatesh was appropriate and in particular: should Tyson have been scheduled; was the level of suicide risk documented appropriately and whether Tyson's suicide risk was assessed adequately.

42. At some stage during the assessment process the doctor says that she spoke with Ms Matthews by phone. Again there is an issue in the evidence about when this occurred and who made the call and the content of the call. Tyson's sister Leisa overheard part of the call. Ms Matthews states that she questioned how Tyson could be discharged, given his desire to kill himself. Dr Venkatesh, in contrast recorded that Ms Matthews felt "okay to care for safety". Ms Matthews states she then ended the call and called Tyson who said he was sitting outside the emergency department. She collected him and took him home.

43. Tyson was discharged from the PECC unit at about 8:11 PM. Dr Venkatesh did not complete a discharge summary but she did arrange for some documents to be faxed to the Lake Macquarie Mental Health Service for Tyson to be followed-up with that Service. This fax was received at that health service sometime prior to 9 PM.

44. Dr Venkatesh's plan on discharge was to refer Tyson for an intensive community care (ICC) plan to monitor risk. Dr Venkatesh did not take any other action; for example she did not contact Tyson's GP Dr Butt. Dr Butt says that if she had been contacted she would have been able to review Tyson on 5 November. An issue in this inquest is whether the discharge planning was adequate and whether there should have been further contact with Ms Matthews, Dr Butt or the Lake Macquarie Mental Health service.

45. The following day, on 4 November, Tyson attended a previously scheduled appointment with an employment consultant at Lake Macquarie Mental Health Service. He was also seen by on-call staff as Mr Edwards was not present. Tyson expressed concern about his upcoming court date. He stated he did not know if his belief in God was enough to keep him from ending his life. However he established his safety for the rest of the day and overnight, and it was confirmed that Ms Matthews was going to remain with Tyson.

46. The following day 5 November Mr Edwards tried to contact Tyson by telephone. He was unable to contact him and he spoke with Ms Matthews instead. She told him Tyson had gone to work with

his father for the day. Ms Matthews told Mr Edwards about Tyson using ice a few days prior and according to Ms Matthews Mr Edwards said words to the effect that he could no longer help Tyson in light of this. Ms Mathews also disputes that she said Tyson went to work with his father.

47. On 6 November Mr Edwards again tried to contact Tyson and then called Ms Matthews. She reported Tyson was still depressed and was having intermittent thoughts of suicide but had no plan or intent. According to Ms Matthews, Tyson spent that day lying in her arms unable to eat or smile or talk. In the evening Tyson said he wanted to return to his own home and spend the night there. His flatmate Luke later told police that Tyson spent the night at the address. Luke did not suspect anything to be wrong. Luke left the property early the next day to go to work.

48. On 7 November Tyson had appointments to see both his psychiatrist Dr Raggatt and his GP and Mr Edwards also planned to make contact with him. Ms Matthews tried to call Tyson at 9 AM but there was no answer. After dropping her grandchildren a school, she went to his property, and found he had hanged himself. She cut him down and called an ambulance but he could not be resuscitated.

Legislation that is Relevant

49. The following sections of the *Mental Health Act* 2007 (the Mental Health 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 behavior 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 the primary carer 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.

50. There were three medical experts who provided reports and gave evidence at the inquest. They were:

Dr Lee Ingram –reports dated 10 April 2015 and 20 April 2017

Professor Mathew Large – reports dated 17 January 2017 and 6 May 2017

Dr Christopher Ryan –report dated 3 April 2017

51. There is reference to CHIME file reports in this decision. That is an acronym for the computer information system used by the Lake Macquarie Community Mental Health Service. The notes that are recorded in the system can also be accessed by medical practitioners within the mental health units of the Hospitals within the Hunter region.

Issues for determination at the inquest

52. For the purposes of the inquest there was an agreed issues list of matters that were given attention during the hearing. The issues were:

Was the assessment of Tyson by Nurse Aron Edwards on 30 October 2013 appropriate? Should the deceased have been scheduled at that stage?

53. Mr Edwards was and is a registered nurse with the Lake Macquarie Community Mental Health Team. He has acted as a care coordinator or case manager for some seven or eight years. He was allocated to act as care coordinator for Tyson on his release under the community treatment order (CTO) that was made on 18 June 2013. Tyson was discharged on that day from the Mater Mental Health Unit.

54. Mr Edwards had regular interaction with Tyson after his discharge as part of the CTO and on quite a number of occasions Ms Matthews would be present. Tyson was only seen at the offices of the Lake Macquarie Mental Health Team. This was due to the history of aggressive behaviour displayed by Tyson. Mr Edwards explained it was decided by the team that it was safer to see him in their offices which was a more controlled environment.

55. On about 19 August 2013 Mr Edwards saw Tyson in company with Ms Matthews. A CHIME file note records:

“mother reports that although his mental state has not improved she thought that the medication (namely the depot injections) has helped to reduce his aggression towards others”.

When Mr Edwards saw Tyson the following week, he noted that previous aggressive behaviour towards others was subsiding as was his auditory hallucinations. The issue of paranoia and “people out to get him” was lessening and was at that time less likely to be delusional and perhaps more based on thoughtful insight and reflection on what had occurred. He was of the opinion that Tyson was overall improved in his mental state.

56. On his next visit on 16 September 2013 there were no positive symptoms of psychosis; Tyson was happier, no longer experiencing auditory hallucinations. He also indicated that he had decreased his cannabis use.

57. Similarly in an entry in the CHIME records for 19 September 2013:

"Kerrie commented that his medication (Paliperidone 150 mgs) is keeping him quite stable in mental state and his potential for aggression has decreased markedly".

58. On 14 October 2013 the observations were different; Mr Edwards noted that he appeared unkempt, clothes not washed and he was depressed.

59. Mr Edwards received a telephone call on 28 October from Ms Matthews, she told him that Tyson was still depressed and expressing suicidal thoughts.

60. Mr Edwards saw him again on 30 October 2013 with Ms Matthews present. She indicated she was concerned about his deteriorating mental health. She thought the anti-depressant medication prescribed by Dr Butt had not been effective. Ms Matthews in her evidence at the Inquest said that Tyson was bent over and rocking and in a very distressed state. That was not Mr Edwards recollection. That description of Tyson was not, as you would expect, referred to in his notes which he made at or about the time of each interview. He did note that Tyson was expressing hopelessness, helplessness, struggling to get out of bed and attend to activities of daily living such as washing himself. Tyson indicated he was not intending to take his own life.

61. Mr Edwards said he was somewhat concerned in view of the change in his state and made the decision to bring forward his next consultation with his treating psychiatrist Dr Raggatt from 14 November to 7 November 2013. He said he brought the appointment forward to check on the dosage of the anti-depressant that had been prescribed by the general practitioner Dr Butt. He also indicated that Tyson's mental state would also then be thoroughly reviewed. I consider that this action in bringing forward the appointment was reasonable and appropriate.

62. Notwithstanding his concerns he did not consider Tyson was at risk of ending his life. Tyson did not describe any form of plan or intent to take his own life. He said if he did he would have acted in a different way (I conclude from that answer that he would have considered an urgent consultation necessary, at the very least).

63. He did not consider he had grounds to involuntarily schedule Tyson under the *Mental Health Act* and he considered that remaining in the care of his mother was the least restrictive care approach. He also considered and concluded that as Tyson had been reviewed by Dr Raggatt on 3rd October and had seen his general practitioner Dr Butt on 1st and 10th October that other than bringing forward the consultation no further action was then needed.

64. Overall Mr Edwards's evidence concerning his assessment was not controversial other than the difference in symptoms or appearance that was described by Ms Matthews at the interview as compared to that described by Mr Edwards in his evidence and contemporaneous notes. I find that the assessment on 30 October was reasonable and appropriate. I find that Mr Edwards's actions in not scheduling Tyson were appropriate and reasonable. That opinion is confirmed in some respects of Dr Ingram in his second report. Dr Ingram concluded that Tyson received a good level of care overall from the Lake Macquarie Mental Health Service. I conclude that the Doctors comment is reflective of his care on 30 October 2013 as part of that broad statement.

65. Throughout Mr Edwards' interaction with Tyson more often than not he was accompanied by his mother and she was involved in the conversations that Tyson had with him. I consider this typifies Ms Mathews actions in showing her level of involvement and care for her son.

Was the administration of the drug Paliperidone to Tyson appropriate? Did it contribute to his death?

66. The weight of evidence from all the experts and from Dr Raggatt and from Dr Butt, the general practitioner was that the use of the drug which was first prescribed under the terms of the community treatment order in June 2013 was appropriate and reasonable.

67. It was prescribed in view of Tyson's poor compliance with taking prescribed medication and because of his level of psychosis. The drug had the advantage of being injected and it was long-lasting.

68. The three medical experts who gave evidence at the inquest expressed the opinion that the drug was unlikely to have contributed in any significant way to the development of Tyson's depressive symptoms.

69. Dr Raggatt the treating psychiatrist conceded that there was a possibility that the drug may have increased his depressive symptoms however in his opinion the depressive symptoms may have evolved in view of Tyson's difficulties in his life such as the prospect of imprisonment or possibly as a direct effect of the medical treatment. His psychosis issues had improved and Tyson had a better understanding and more insight into his real life.

70. Dr Butt in her evidence at the inquest said this:

"He had become, I suppose, in that time calmer. His delusional thoughts and paranoid thoughts had improved somewhat and… but he was more depressed."

71. Dr Butt saw Tyson on 10 October 2013 and although she observed he was still depressed and anxious he was at the time working for his father and he was sleeping better which she considered was as a result of the prescription of Avanza (Mirtazapine). The medication had been prescribed to him by the doctor on a previous consultation on 1 October 2013.

72. It is worthwhile noting that on both the 1 and 10 October consultations with Dr Butt– when Tyson was observed to be depressed and anxious by the doctor and Tyson was saying then that he didn't want to be alive – there was no action taken by Dr Butt to consider calling for an immediate review of his medication, nor did she raise any specific concern as to the particular medications that he was then taking. Importantly Dr Butt knew on 1 October that Tyson was seeing Dr Raggatt on 3 October and she did not consider, at the time, any particular issue warranted the attention of his treating psychiatrist concerning his medication, in particular the Paliperidone, or any other health related matter.

73. In the CHIME file reports for 19 August and 19 September 2013 it was noted that Ms Matthews considered that his mental state had improved and his potential for aggression had decreased markedly.

74. The priority for treating Tyson at the time was to lessen his psychosis issues and his aggression. There was no criticism by the experts concerning this focus on his treatment and accordingly I am satisfied that treating his psychotic issues was a priority that needed attention before other matters.

75. Professor Large considered that the use of Paliperidone was not likely to have caused Tyson's depression – in the Professor's opinion his depression was more likely as a direct consequence of his amphetamine use and/or alcohol. He was of the view the medication was not a strong depressant.

76. Dr Ryan considered that the drug was unlikely to be the reason for his low mood. His opinion was "almost certainly wasn't the Paliperidone that was responsible for his mood". Dr Ingram agreed with Dr Ryan's opinion. He said that there were so many other factors that would have contributed to the onset of his depressive disorder including relationship breakup and other life events and his alcohol and drug use.

77. I find that it was appropriate to treat Tyson with Paliperidone; it was reasonable for the treating doctor to have prescribed it and for its continuation at the time of Tyson's death. There was no adverse evidence given by any expert that the medication was anything other than appropriate and reasonable. It was an antipsychotic drug which had been prescribed at the time of his release from hospital under the community treatment order. That hospital admission had been an involuntary admission when Tyson was very seriously ill at that stage. All the experts have agreed that it was a reasonable decision in light of Tyson's poor compliance to take prescribed medication.

78. I find that the drug was not a contributing factor in Tyson's death.

Was the assessment of Tyson by Dr Venkatesh on 3 November 2013 appropriate? Should Tyson have been scheduled or admitted at that stage? Was voluntary admission offered? Was the level of risk adequately documented? Was the risk assessed adequately in any event? and

Did Dr Venkatesh contact Ms Matthews prior to the deceased being discharged from the PECC unit on 3 November 2013? What was said, and was this contact sufficient?

79. It is necessary to first resolve two factual issues. Those factual issues are:

1) Was voluntary admission offered to Tyson by Dr Venkatesh and ;

2) Who made a telephone call and the content of the call between Dr Venkatesh and Ms Matthews.

80. Ms Matthews gave evidence that Tyson volunteered to her on the evening that she picked him up from the hospital after his discharge that he wasn't offered voluntary admission. Ms Matthews made a number of statements to assist this inquest and this issue only arose in her statement of 4 November 2016 about three years after the event itself occurred. There is some collateral support for her evidence. That support in summary form is: –

a) Ms Matthews complained to the police officer, Constable Clark that Tyson was not admitted to hospital and she was upset about the fact that he had been discharged and;

b) the phone call on 5 November 2013 between nurse Edwards and Ms Matthews in which she indicated she was disappointed that Tyson was not admitted.

81. Dr Venkatesh was adamant when she gave evidence that she had offered Tyson voluntary admission. She acknowledges that it is not documented and she accepts that it was an important matter to have documented but failed to do so.

82. Dr Venkatesh in her evidence described the nature of the discussion that she had with Tyson on the evening of 3 November. She asked Tyson whether he was feeling better and whether he wanted

to stay in hospital or go home, to which his response was that he wanted to go home. Perhaps it is the way in which it was offered that has confused Tyson in that the words specifically of "voluntary admission" were not said. Dr Venkatesh was present with Tyson in relation to the discussion whereas Ms Matthews account comes from her son. The reliability of Tyson in providing an accurate recall of what was discussed during the consultation is perhaps open to debate. He was in an emotional state when he attended the hospital and likely still fragile when he was discharged.

83. There is an assumption made that if Tyson had been offered voluntary admission he would have accepted it. I'm not sure that conclusion follows in any event. On 28 August 2011 his admission was involuntary. On 8 February 2012 his admission was directed by Dr Raggatt. On 18 May 2012 his admission was as a result of being brought in by his parents. On 29 May 2013 it was an involuntary admission. Dr Venkatesh's evidence that Tyson had indicated that he preferred to be managed by Aron (Nurse Edwards) and the mental health team and Dr Raggatt would therefore appear to be more plausible in light of his previous admission history.

84. I conclude and find that Dr Venkatesh's recollection although it is not recorded is more reliable. She has given evidence that she has an independent recollection of the consultation on 3 November. She has an independent recollection in part because she learnt of Tyson's death shortly after he died. On learning of his death she did a review and analysis of the consultation so as to reflect on the treatment that she had suggested. In other words it's not a recollection of a conversation some three or four years later. It was three or four days after the event when she first came to reflect on its contents.

85. Further her evidence was that it was her usual practice to offer voluntary admission. It was not put to the Doctor that her decision might have been impacted by a scarcity of beds. There is no evidence of that and it was never put to the Doctor as a factor that she considered.

86. Dr Venkatesh's version comes independently and not by way of a response to Ms Matthews' later statement. Dr Venkatesh had not read Ms Matthews' statement until the day before court. For these reasons on balance I prefer the version given by Dr Venkatesh.

87. The second factual issue to determine is whether or not a phone call occurred and whether or not it was instigated by Dr Venkatesh to Ms Matthews or whether Ms Matthews made a phone call to the hospital.

88. Dr Venkatesh indicated in her evidence that she wrote up her notes shortly after concluding the conference with Tyson and her telephone conversation with Ms Mathews. Effectively her notes were written contemporaneously with the interview. Importantly the notes reflect that she had a phone call to the mother and she records various concerns that Ms Matthews was expressing at the time. Those concerns related to her being upset with the Lake Macquarie Health Team and that Tyson's problems are "disregarded as drug induced psychosis". The doctor recorded that she should discuss those concerns with Dr Raggatt and the case manager.

89. In contrast Ms Matthews says she made the telephone call to the hospital and that Dr Venkatesh answered the telephone (she said it was an Indian sounding lady doctor) and that the phone call was very brief to the effect that Tyson had been discharged. Ms Matthews denies that she had any lengthy conversation with the doctor and denies expressing any concerns to the doctor on the evening and denies any conversation concerning Tyson being placed back into her care under an intensive care plan.

90. The suggestion made by Ms Matthews that when she rang an Indian sounding doctor answered the telephone is in my opinion implausible. I do not consider that it is logical that a psychiatric registrar or a medical doctor would be answering incoming calls to a hospital. As a matter of just plain common sense and knowledge about public hospitals the scenario of a doctor answering the telephone is simply unbelievable.

91. There are three aspects of evidence which corroborate Dr Venkatesh's evidence that she called Ms Matthews to discuss Tyson's discharge. The first corroborative piece of evidence is the officer in charge's statement Constable Clark, where he states and gives oral evidence, which he believed to be an accurate account of what was said:

"Kerry Matthews continued to state that she received a phone call from the Mater Hospital approximately one hour later and told to pick up her son from the hospital"

92. The police officer's statement was written on 8 December some four weeks after the events relatively close in time and before any other statement is made in relation to the issue.

93. The second piece of corroborative evidence is contained in the CHIME records for the entry of 4 November 2013 namely the first contact Ms Matthews and Tyson have with the mental health services the following day:

"K) stated that last night she had to ph for police attendance at her home as Tyson had intentionally cut himself wanting to die. He presented to PEC, not admitted and put on ICC for f-up by CC at soonest possibility."

94. The file note is therefore consistent with Dr Venkatesh version of events as it was her evidence that she discussed with Ms Matthews placing Tyson on an ICC plan and to discharge him.

95. It was also submitted that Ms Matthews would have likely expressed her disappointment if her son had been discharged without her knowledge and left in the gutter outside the hospital and that this disappointment would have been conveyed to Mr Edwards or another health clinician within the local mental health service that she spoke to. Consequently reference to the issue would likely have been noted in the CHIME file notes. I agree with this submission.

96. Ms Matthews gave evidence that she did not receive a telephone call from the mental health service the following day 4 November and that she and Tyson were at the front door of the service before they opened at 8:30 AM in the morning. Again the Chime records indicate for 4 November at 13:48 the following:

"Kerrie (mother) answered the phone. She stated that Tyson and herself were on their way to the clinic in order to keep an appointment with ORS"

97. This would indicate that Ms Matthews' evidence is unreliable. I hasten to add that I am not critical of Ms Mathews given the trauma she suffered and the stress that she has been under and the grief that continues. She is an honest witness but mistaken and clearly so. There is other evidence of her unreliability and that includes her assertion that it was Dr Venkatesh who was well known to Tyson and had been treating him during his previous admission to hospital. This was her assertion in her statements. Ms Matthews in her evidence at the inquest conceded that she is mistaken about that and now realises that Dr Venkatesh had not treated Tyson previously at all.

98. Lastly Ms Matthews conceded that her concerns at the time were relevantly and accurately recorded by Dr Venkatesh in the assessment form. Ms Matthews cannot give an explanation as to how the doctor would have known about her concerns at the time given the brevity of the conversation she alleges she had with the doctor. The only possible explanation she offers was that the doctor may have picked up her concerns from a review of the mental health records and then added it to her notes.

99. I am not aware of any entry in the mental health records that record those concerns. No one provided any evidence to support this explanation. I reject that possible explanation. One other factor that I consider leads to the implausibility of the record being altered to show Ms Matthews' concerns is that the assessment form was faxed to the community mental health team on the evening of the assessment at about 9 PM the doctor having concluded her assessment and Tyson being discharged at about 8:11 PM. The suggestion that the doctor looked through the community mental health team notes at the time she was undertaking the assessment with Tyson and had the foresight to jot down Ms Matthews' concerns is highly unlikely or that she added in the concerns after finishing the interview with Tyson and before she saw the next patient is also highly unlikely.

100. Ms Matthews' daughter Leisa Swanson gave evidence that she was rung by her mother when she was at a friend's house for dinner. She left the dinner and went to her mother's house. When she was there her mother telephoned the hospital and she overheard her mother saying to the effect "Tyson can't have been discharged". Mrs Swanson gave evidence that it was only a very short conversation and that it was her mother that made the phone call. She conceded that she was only asked to recall her recollection about the telephone call when she wrote her statement to this inquest so that her recollection is about 3 ½ years after the event.

101. Lastly and belatedly a short statement came into evidence from Ms Sara Ashmore. She was a friend of Leisa Swanson and she stated that Mrs Swanson and her husband and children had come to her house for dinner to celebrate a birthday on the evening of 3 November 2013. She remembered that Lisa received a call before dinner from her mother to inform her that her brother Tyson had attempted suicide by cutting his wrists. Lisa quickly drove to her mother's house to support her. She remembers that once her mum was settled Lisa returned to have dinner at her house and after dinner Lisa received a further phone call from the mother stating that she had been in communication with Tyson who needed to be picked up as he was outside the emergency Department at the hospital as he had been discharged. Ms Ashmore's recollection therefore is two phone calls being made to Leisa and not one. On Ms Ashmore's version Leisa was not present when her mother purportedly made the phone call to learn of Tyson's discharge (which was Ms Matthews' version of events).

102. One other matter that assists in coming to a conclusion that it is preferable to accept Dr Venkatesh's version concerns the events of 28 May 2013. This was again a crisis occurring in Ms Matthews home where Tyson was displaying delusional characteristics and engaging in physically threatening behaviour towards Ms Matthews. She called her general practitioner Dr Butt to come and attend by way of a home visit. When Dr Butt attended she and Ms Matthews came to a decision that they would call the police. The police attended and after the police were there the crisis lessened. Tyson's presentation changed from a critically acute man who was at risk of harming others, his state changed and he became calmer over a period of time. As he appeared calmer Ms Matthews decided there was no need for Tyson to be admitted (although Dr Butt had completed the necessary Schedule under the Mental Health Act to have him detained as an involuntary patient). In some ways it is similar to what happened on 3 November.

103. Dr Venkatesh says that she spoke to Ms Matthews and she indicated that she was prepared to care for Tyson. That is reflected in the note made by the doctor and reflects the same care and concern that Ms Matthews displayed in the past in looking after her son.

104. I am of the opinion that Ms Matthews and Mrs Swanson are mistaken. They are not intentionally telling lies and no one has submitted that they are. Mrs Swanson's evidence is perhaps contaminated by listening to her mother recount what she says occurred at the solicitors' office. It also has the problem that she has been asked to recall something that happened over 3 ½ years ago and her memory of the event is no longer as clear and accurate as it could be. Again this is not a criticism it is sadly just the way it is.

105. Accordingly I find that Dr Venkatesh did call Ms Matthews and did discuss with her a discharge plan for Tyson and that Ms Matthews indicated to the Doctor her acceptance of Tyson coming back into her care for the period of time that was required.

106. There is perhaps another explanation that arises from Ms Matthews' version of events concerning the telephone call. It is possible that she telephoned the emergency Department of the Calvary Mater hospital and not the PECC unit. It is possible that Ms Matthews was told by the emergency department that Tyson had been discharged – because he was from the emergency department. He was transferred to the PECC unit after his discharge from the emergency department. This would also provide an explanation that would perhaps account for two telephone calls.

107. Having resolved those factual issues I return to the resolution and determination of the central issues concerning the assessment process. To do that the Inquest had the assistance of hearing the three medical experts who gave evidence concurrently.

<u>The conclave of experts</u>

108. The three expert witnesses who gave evidence – Dr Ingram, Dr Ryan and Professor Large were qualified consultant psychiatrists. There was no issue that each Doctor had significant expertise in the field of psychiatry and in particular experience with mental health assessments of patients.

109. It was agreed by the parties to put a number of questions to each of the Doctors. I have stated the 7 questions and summarised the important parts of their evidence in the following way: –

1. At the time of Dr Venkatesh's assessment on 3 November 2013 did Tyson meet the threshold for involuntary admission?

110. Dr Ingram's opinion was that Tyson would have met the definition of being mentally ill, however given the terms of Section 12 of the *Mental Health Act* which prescribes that if there is a pathway to a less restrictive approach that is available then it would be appropriate to take that course. He then relies on Dr Venkatesh's assessment and discharge plan including the discussion had with the mother and is therefore of the opinion that Tyson did not need involuntary admission.

111. Dr Ryan's opinion was that, while it would be arguable to sustain a view that Tyson was mentally ill or disordered, however like Dr Ingram there being a less restrictive option available then he was also of the opinion that Dr Venkatesh was correct in not detaining Tyson involuntarily.

112. Professor Large was of a similar opinion. He said this:

"I am of the view that it wouldn't have been reasonable to detain him under the situation where he was having treatment, could have treatment and had a satisfactory place to go". In those circumstances he says "it would have not have been the right thing to do to detain him under those circumstances"

2. Should Dr Venkatesh have offered Tyson voluntary admission on 3 November 2013?

113. Dr Ingram was of the opinion that Tyson should have been offered voluntary admission. He considered it may have been helpful at least managing the more acute symptoms and the risk factors to mitigate future risk.

114. Dr Ryan also agreed Tyson should have been offered voluntary admission but not necessarily as a specific question more in the way that indicated it was one of a number of options – such as "you can be voluntary admitted if you want". Provided it was offered that was all that would be required.

115. Professor Large was of a different view. He concluded that as Tyson's underlying diagnosis was a substance abuse disorder (consistent with the opinion of Dr Raggatt may I emphasise) and antisocial personality then this particular disorder doesn't respond necessarily well to hospitalisation. On balance however he said:

"I suppose he probably should have been offered a voluntary admission" but he qualified that by indicating in a pragmatic way that not every hospital may have enough bed space to offer it. There was no evidence one way or the other as to available bed space on this evening for Tyson.

116. I am satisfied that Dr Venkatesh did offer voluntary admission to Tyson as I have previously outlined.

3. Did Dr Venkatesh sufficiently document matters relied upon in assessing the level of suicide/risk and/or Tyson's treatment needs? and

4. Was the conclusion by Dr Venkatesh "Risk currently low-changeable on drug use" appropriate? and

5. Would completing the standard risk assessment in the mental health assessment form have made a reasonable and competent clinician to reach a different conclusion about the level of risk?

117. Dr Ingram was of the opinion that because the risk assessment form wasn't completed in full and only a brief formulation of some of the doctor's reasoning he concluded it didn't allow you to work out how she came to the conclusion about risk level. On that basis he was critical of the doctor's recordkeeping. He said he was not able to work out how she arrived at a low assessment of risk. He thought that if she meant that Tyson was low risk sitting in the Emergency Department with the constraints within that environment and the supports there then perhaps he was at relatively low risk. More sensibly he considered that on leaving the emergency department he would not have been considered at low risk although he did agree with the comment "changeable depending on drug use" as being appropriate.

118. Dr Venkatesh did not complete the screening tool known as the standard risk assessment checklist on the assessment form. Dr Ingram was concerned that she should have largely for the reason that it would have prompted a number of positive responses and may have resulted in her

arriving at a different conclusion as to the level of risk. He considered she would have arrived at a higher level of risk.

119. Dr Ryan and Professor Large were both of the same opinion that it was completely unhelpful to identify people as being low, medium or high risk of suicide. They deal with this point extensively in each of their reports however in essence in terms of psychiatric patients that are being assessed it is not sensible to try to distinguish between them and ultimately no one really knows what it means.

120. Dr Ryan was of the opinion that as Dr Venkatesh had not made clear what she meant by "low risk" it probably would have been better not to document anything because it is not clear what she meant. He said that if she was thinking by "low" she meant the chance – the probability of Tyson killing himself between the time she saw him and the time he be seen by the community team – then he agrees Tyson would be a low risk.

121. If she meant the likelihood of dying by suicide was low relative to the population then she was wrong.

122. If she meant his chance of killing himself was low relative to other times in his life then he considered that she didn't have enough data and he didn't consider anyone would likely be able to say anything sensible on it. He concluded by saying that he doesn't like his registrars within hospitals that he supervises to state whether a patient is low, medium or high risk because it is meaningless.

123. Dr Ryan was of the opinion that Dr Venkatesh did sufficiently document the level of treatment needs. As to the level of suicide risk he stated that it was complicated by the fact that it didn't make sense to assess someone's suicide risk or to provide a level of risk because in practical terms it doesn't have any impact in terms of the decision you make on a patient. This was because Tyson was being assessed as an acute patient in a psychiatric centre; he was by that fact at a greatly elevated risk of suicide – of dying by suicide into the future. He was of the opinion that it was more meaningful to look at the documentation to understand how Dr Venkatesh came to her assessment of Tyson's predicament and how that predicament was, with him, going to be translated into some ongoing management plan.

124. Professor Large provided an explanation relating to the confusion about risk and in particular "relative risk". He commented that Dr Venkatesh appeared to define risk as being relative to how the patient might be themselves – how they are at the particular time as distinct from risk which is whether this patient is at a higher or lower risk to another patient. He said that the Department of Health had never defined what they meant by "risk". Therefore there can be confusion not only among health clinicians but by lay people trying to understand what is meant.

125. The professor considered the documentation adequate. As I understand his evidence in a pragmatic way he took into account the location- that you're in an Emergency Department of a hospital and Dr Venkatesh saw some seven patients that shift and three others in the ward and accepting that you're not getting personalised service he thought the documentation was perfectly adequate.

126. Professor Large concluded that there was a lack of clarity about what is meant by risk.

127. His view is given support as the current New South Wales policy directive entitled "Clinical care of people who may be suicidal" and under a section "Comprehensive mental health assessment" the following is stated:

"Risk measurement checklists or tools should not be used in isolation to determine treatment decisions. Use of suicide risk factors, 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 as no rating scale for clinical algorithm has proven predictive value in the clinical assessment of suicide. There is moderate to low quality evidence for their use, they have insufficient sensitivity and specifically and therefore lack reliability for predictive purposes."

128. Dr Venkatesh in her evidence at the inquest indicated that when she had concluded that Tyson's risk was "currently low and changeable depending on drug use" she meant to convey that he was sufficiently low risk, because he was no longer saying he felt like harming himself or had any suicidal intent and she felt that he was sufficiently low risk to discharge, provided he was going to be seen the next day. I accept her interpretation as to what she meant.

129. Overall I accept the evidence of both Dr Ryan and Professor Large that there was an appropriate level of documentation in this matter particularly for a third year registrar psychiatrist as Dr Venkatesh then was. Each of these doctors has considerable experience in terms of supervising registrars in an emergency psychiatric care area. Dr Ingram had less experience in this particular field and he was frank about that in his evidence.

130. In view of the criticism by the experts of predicting suicide by risk and its attempted classification and the many issues as to its interpretation it is Dr Venkatesh interpretation of risk I will accept. She considered Tyson at low risk at the time she saw him. No criticism is levelled at the doctor for not scheduling Tyson as a mentally ill or mentally disordered patient. In those circumstances I find that her assessment of Tyson on the night was reasonable and appropriate, notwithstanding her use of the words "low risk".

131. I also find that the omission to complete the checklist did not contribute to a misdiagnosis of Tyson's mental health condition on the night. I find there would not have been a different outcome even if the checklist had been completed.

132. Suicide checklists or risk measurement checklists are not helpful- not to clinicians or for that matter lay people who can be unintentionally misled by the terminology used. I consider that has happened in this matter. Ms Mathews did not consider her son to be at "low risk" and from all of the evidence by the experts he wasn't, if you compared Tyson's risk of suicide to the risk of suicide in the general population.

133. Again Dr Ryan in his report said:

"The first and most important thing to understand about so-called "suicide risk assessment" is that it is not possible to usefully categorise patients, who are seen in psychiatric crisis in an Emergency Department or inpatient unit, into those at relatively higher and those at relatively lower, likelihood of future suicide. In reality, all psychiatric patients, who present to these settings, are at a very greatly elevated likelihood of dying by suicide. Although it is possible to use some features of such patients presentations – especially a past history of suicide attempt and a diagnosis of major depression – to categorise patients into those at a statistically higher risk of suicide than those who do not exhibit such features, the degree to which these features increase the likelihood of suicide in this already high risk group is so small as to be of no utility in guiding management decisions."

6. Was the discharge plan adequate in the circumstances?

134. Dr Ingram concluded that placing Tyson on the ICC plan, including contacting Ms Matthews and confirming she would care for Tyson with the proviso that Tyson understood its terms and Ms Matthews agreed to it and accepted responsibility for it then in all those circumstances he considered the plan was sufficient and adequate. That is on the proviso that Dr Venkatesh's evidence was accepted.

135. Professor Large had no further comment other than to highlight the Dr Venkatesh had placed Tyson on an intensive care plan as distinct from some lesser care plan. He said by placing him on such a plan recognised that Tyson had an elevated risk. He stressed the use of the word "intensive".

136. I have already indicated that I prefer Dr Venkatesh's evidence in relation to her contacting Ms Matthews and her agreement to have Tyson back in her care. Further there is a statement that Tyson was advised of the PECC hotline number which indicates that if Tyson needed further advice between the night of his discharge on the following day when he was to see the mental health care team he was given information about what to do.

137. I am satisfied that the discharge plan was adequate and reasonable in the circumstances.

7. If Tyson had been considered to be at moderate or high risk of suicide would a reasonable and competent clinician have included any additional steps in the discharge plan?

138. Dr Ingram considered some further intermediate strategies could have been put into place – such as medication or access to emergency services. Because he was a paranoid psychotic some specific steps to target this issue should have been implemented – perhaps more psychotics to supplement existing medication and reduces levels of stress and psychosis.

139. Dr Ryan agreed with Dr Ingram that some sort of discussion about what would happen if things weren't going well should have been made. He indicated that they are not always documented and because not documented doesn't mean that it hasn't happened. He disagreed that additional antipsychotics should have been looked at. He considered there was no evidence to suggest they would have been useful. He did not consider even some sort of sedating agent would be useful in view of substance abuse issues. He considered that he would get better from his psychosis if he continued to take his medication and didn't consume illicit drugs.

140. Professor Large agreed with the opinion of Dr Ryan. He ventured further by saying that the issue of taking antipsychotics doesn't stop you from using amphetamines again, and it doesn't stop you from becoming psychotic if you use amphetamines again.

141. The Professor also agreed with Dr Ryan that the offer of a further review or readmission in the event of deterioration is usually made but not often documented.

142. All of the experts agreed that a discussion with a family member or friend would need to be undertaken for the ICC plan to be undertaken. I conclude that there are no further additional steps that needed to be taken in relation to the discharge plan. I do not accept Dr Ingram's opinion that some further medication was necessary on that night. Tyson was to be reviewed by Dr Raggatt in a few days' time. He was the treating psychiatrist and would have been in a better position to consider further medication or in altering the level of medication at the time. I have also commented that information was passed on to Tyson about the PECC hot line number in the case of a further emergency.

Was the level of care provided to Tyson following his discharge on 3 November adequate?

143. The care provided to Tyson was given on the 4, 5 and 6 November 2013. On each of those days the evidence establishes that contact was made (or attempted) with Tyson or Ms Matthews. The CHIME notes demonstrate that Tyson's condition was being monitored appropriately and regularly. As I had previously indicated Dr Ingram in his second report made a general comment that there was no criticism of Tyson's post discharge care with the Lake Macquarie Mental Health team. I concur with that opinion.

144. Doctor Ryan in his report said:

"Mr Matthews' care during these days was conducted primarily by Ms Forbes and Mr Edwards, but notably the care was provided by the entire team and was apparently directed and co-ordinated through daily team meetings attended by staff familiar with Mr Matthews who had a range of skills and experience. The staff members included psychiatry registrars and, in the case of the 6 November meeting, a psychiatrist, who had seen Mr Matthews previously. The care as documented seems to me consistent with the sort of care provided in intensive community follow-up teams and nothing in the documentation leads me to believe that it was conducted with anything other than reasonable care and skill.

"Ms Forbes and Mr Edwards diligently undertook the plan discussed at the relevant morning meetings, made and documented their assessments, and provided advice is appropriate to their assessments."

145. There is no evidence to suggest any criticism could be levelled either at Mr Edwards or any other staff member. Accordingly no adverse findings are made.

146. I am not convinced that a copy of the assessment form or a discharge plan (even if one had been prepared) being sent to Dr Butt would have improved the outcome. The evidence of Dr Butt concerning the normal practice relating to incoming e-mails or faxes coming into her practice of doctors indicated that a document goes to a particular doctor if nominated on the piece of correspondence. Unless it calls for a direct response it is noted and then filed in the file of the patient. I consider this is what likely would have occurred in any event. Dr Butt, I am sure, would have assisted if she was specifically asked to do something by the patient or if directed by the Lake Macquarie Health Team however that is not the case here.

Application to re-open the Inquest

147. After the hearing concluded on 7 June as a result of further correspondence from Ms Matthews I allowed the Inquest to be mentioned on 18 July for submissions to be made by Ms Matthews (who was then representing herself – Mr John Anthony, solicitor who had previously represented Ms Matthews had sought leave to withdraw) concerning the reopening of the inquest to ventilate and allow in additional evidence. Ms Matthews provided letters dated 22 June (plus a letter from her former solicitor of that date), 25 June, 4 July and 11 July, and emails dated 27 June, 5 July, 8 July and 12 July, together with attachments. These have been collected as exhibit "D" in the inquest. The material included an information leaflet for Invega Sustenna (Paliperidone) and some additional material in relation to how Tyson appeared to her after he commenced taking this medication. She also wanted to provide a copy of her telephone statements for 3 November 2013 and she wanted the Crown Solicitor or a coroner to issue a subpoena addressed to the Calvary Mater hospital and the Mater Mental health unit to produce their telephone records to assist in establishing the

number of phone calls made either by Ms Matthews or the hospital. There was also a long letter which commenced with the words "I want the inquest to be opened again…" which contained requests for certain people to be called again including Dr Raggatt and for additional people to be called as witnesses including nurse Jennifer Sampson, Senior Constable Leanne Turnbridge and the nurse who assessed Tyson in the PECC unit. There were other criticisms relating to the state of the evidence related to why certain questions were not asked of certain people. In addition Ms Matthews provided a short unsigned statement from Ms Sara Ashmore which related to her recollection of Leisa Swanson being at her house on the evening of 3 November.

148. At the conclusion of Ms Matthews submissions and after hearing from counsel for the other parties and counsel assisting I allowed the inquest to be reopened for the purpose of admitting into evidence the telephone records of Ms Matthews, her observation of how Tyson appeared in the months preceding his death, the statement of Sara Ashmore and the pamphlet related to the medication Paliperidone. There was no objection to this course of action by the other parties however I declined Ms Matthews request to reopen the inquest for the purpose of hearing further witnesses or asking witnesses to return and be subject to further questioning. I concluded that hearing from the police officer who attended on the evening of 3 November at Ms Matthews home and that police officer's opinion as to whether or not Tyson should be involuntary admitted was not helpful. For the purposes of detaining a patient on an involuntary basis under the Mental Health Act required assessment by a trained medical officer. A police officer would not have the requisite training and experience to be able to give that evidence notwithstanding their experience in attending these types of events.

149. Ms Matthews' observations of how Tyson looked prior to his death was taken into account as a result of what she told the inquest during the three days of hearing. So for example Ms Matthews thought it relevant that Tyson's weight had decreased yet his weight was recorded in the post-mortem report which was part of the evidence. Further Ms Matthews showed photographs of Tyson prior to him taking medication and after taking the medication at the inquest. The side effects of the medication Paliperidone would be known to the three expert medical witnesses and also to Dr Raggatt. This issue was fully ventilated. While I admitted the information in exhibit "D", I did not consider that there was any benefit in reopening the inquest and allowing further cross-examination concerning the medication.

150. The issue of the phone call and who instigated it and what was said I believe has been carefully covered in this decision. Even if I had accepted Ms Mathews' version as being the correct version I do not consider it affects the ultimate findings made as to the reasonableness of the assessment by Dr Venkatesh and Tyson's subsequent discharge. If Ms Mathews had not specifically agreed to care for him under the ICC plan she acquiesced in caring for him in any event. She collected him from the PECC unit and took him home and the following day to his meeting at the Lake Macquarie Mental Health Service. She cared for him throughout the following days.

151. The statement of Ms Ashmore has been referred to by me in this decision (and was admitted into evidence) so that again I did not see a benefit in reopening the inquest for the purpose of allowing further cross-examination on this point. Her evidence is accepted as to her recollection.

152. It should also be remembered that Ms Matthews was represented by counsel and by an instructing solicitor at the Inquest. Any complaint concerning questions that were not asked or should have been asked had no bearing in my opinion on the ultimate outcome and decisions made from the evidence heard at the inquest. I am completely satisfied that all relevant evidence was

contained within the volumes of material that made up the police brief that were admitted into evidence on the first day of the hearing. Obviously a lot of that material was not mentioned or referred to in the hearing but that does not mean it was not taken into account or was not part of the evidence – it was!

Conclusion

153. I find that Tyson's death was self-inflicted. There is compelling evidence to support this finding. Tyson had a long history of mental health problems, including schizophrenia or drug-induced psychosis and depression. He had in the past made threats of self-harm and had committed self-harm. Four days prior to his death he again committed self-harm, and said at that time that he wanted to die. Finally, the circumstances of Tyson's death indicate that he acted with an intention to end his life, by deliberate hanging. The police investigation did not reveal any evidence that another person was involved.

154. The legislation that is relevant was included in the decision. I did so because it is those specific sections of the *Mental Health Act* that guides a medical officer in determining involuntary admission. The conclusion of the medical experts, very experienced and qualified medical practitioners was that Tyson was not able to be detained as an involuntary patient under the Act. I have accepted that opinion.

155. There have been changes to policy and procedure since Tyson's tragic death. For example in the current policy within the guidelines published by the HNELHD which became effective from 2016 it is now recommended that there should be contact by health clinicians with the carers of a patient not only to be involved in the process of assessment but also their post discharge care.

156. I have also referred to the changes made in the policy guidelines as to the assessment check tools. These changes in policy have occurred since this tragedy.

157. I am aware that Ms Mathews is very committed in wanting to improve outcomes for mental health patients – particularly those people that are suicidal or at risk of suicide. That is a matter that is far outside the scope of this Inquest.

158. I believe more can be done however it requires a larger input from a collective of people and organisations – not only medical health clinicians but also from our State and Federal Governments. For example I have read of a foundation called "Zero Suicide Institute" – it has the aim of attempting to ensure there are no suicides – that is, the lofty aim of totally preventing suicide. I commend the aims and approach and perhaps that type of foundation is worth considering in NSW.

159. I know Ms Mathews did her very best to look after Tyson as only a loving mother could do.

160. Before turning to the findings that I am required to make, I acknowledge and thank Mr Jake Harris, Counsel Assisting and Ms Kathleen Hainsworth, instructing Solicitor for the NSW Crown Solicitor's Office. I am very appreciative and grateful for their valuable assistance and contributions both before, and during the inquest. I am also aware of their compassion that they showed to Ms Matthews in this tragic matter. I also acknowledge the assistance of Counsel for the interested parties who participated in a respectful and dignified manner. Finally I express my thanks and appreciation for the efforts of the police officer-in-charge of the investigation Senior Constable Glenn Clark.

Findings

161. I make the following formal findings:

I find that Tyson Matthews died on 7 November 2013 at 1/40 York Street Teralba New South Wales 2284.

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

Magistrate R G Stone

Deputy State Coroner

Newcastle

22nd August 2017